

# Action Plan in response to the PPO Report into the death of Mr Carl Langdell on 11/02/2021 at HMP Wakefield

Rec No	Recommendation	Accepted / Not accepted	Response Action Taken / Planned	Responsible Owner and Organisation	Target Date
1	The Governor and Head of Healthcare should ensure that staff consider all relevant risk information about prisoners when assessing their risk of suicide and self-harm and start ACCT procedures when appropriate.	Accepted	All operational staff have received ACCT v6 training, and additional upskilling ACCT sessions were delivered to staff in October 2021. This included improvements to the risk identification and management process, and the importance in ensuring that staff consider all relevant risk factors when assessing prisoners at risk of self-harm and suicide.	Governor HMPPS Head of Healthcare Practice Plus Group	Completed
2	The Governor and Head of Healthcare should ensure that prisoners are assessed after an interview with or invitation to attend inquest to assess their risk of suicide or self-harm.	Accepted	Following the death of Mr Langdell, all prisoners who have been invited for an interview or invitation to attend an inquest will be discussed at the weekly multidisciplinary Safety Intervention Meeting (SIM), chaired by the Senior Management Team.  The SIM will discuss the appropriate support and interventions required for the prisoner, which may include reviewing and recommending actions to reduce their risk of suicide or self-harm.	Governor HMPPS Head of Healthcare Practice Plus Group	Completed



3	The Governor should ensure that staff understand the importance of having meaningful conversations with prisoners where possible, including when carrying out welfare checks during the restricted regime.	Accepted	In October 2021, a local Notice to Staff (NTS) was published reminding staff of the requirements when undertaking welfare checks and priority key work requirements, including the need to engage in meaningful conversation with prisoners. The quality of welfare checks are monitored weekly by wing managers and fed back to the Head of Function	Governor HMPPS	Completed
4	The Head of Healthcare and the Governor should review the internal communication systems used within the prison to ensure that clear processes are in place to refer prisoners to mental health services.	Accepted	A Notice to Staff was reissued to remind staff about the Tag referral process to the Mental Health team. The process is also covered as part of the staff induction programme.  Once a referral has been made, the member of staff making the referral must ensure they record this information on NOMIS. To support staff with the referral process, a duty mental health nurse is available to help throughout the core day.  All referrals will be discussed at the weekly safety intervention meeting.	Governor HMPPS  Head of Healthcare Practice Plus Group	Completed
5	The Head of Healthcare should ensure that all staff are aware of the requirement to maintain full and contemporaneous healthcare records.	Accepted	Documentation training with staff is an ongoing programme within the healthcare department. Training covers the importance of maintaining full and contemporaneous records and is delivered on a 1-1 basis during supervision and externally.	Head of Healthcare Practice Plus Group	Ongoing
6	The Governor and Head of Healthcare should ensure	Accepted	All members of staff named within the report have received a copy of the report, and the Head of	Head of Safer Prisons	Completed



	that a copy of this report is shared with all staff named in this report and that a senior manager discusses the Ombudsman's findings with them.		Safer Prisons has discussed the findings with them.	HMPPS	
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