Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Carl Royal, a prisoner at HMP Wakefield, on 24 November 2025

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

- Resolve complaints
- Investigate deaths
- Identify and disseminate learning
- Ensure trust and confidence in the criminal justice system
- Special investigations

WHAT WE VALUE

- Ambitious thinking
- Professional curiosity
- Diversity & inclusion
- Transparency
- Teamwork

OGL

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1. The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

2. If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

3. In July 1996, Mr Carl Royal was sentenced to life imprisonment for sexual offences. He died of throat cancer on 24 November 2025, at HMP Wakefield. He was 57 years old. We offer our condolences to Mr Royal's family and friends.

4. The Ombudsman's office wrote to Mr Royal's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They did not respond.

5. NHS England commissioned an independent clinical reviewer to review Mr Royal's clinical care at HMP Wakefield.

6. The clinical reviewer concluded that the clinical care Mr Royal received at Wakefield was of a reasonable standard and was equivalent to that which he could have expected to receive in the community. The clinical reviewer made two recommendations not related to Mr Royal's death that the Head of Healthcare will wish to address.

7. The PPO investigator investigated the non-clinical issues relating to Mr Royal's care.

8. We did not find any non-clinical issues of concern. We make no recommendations.

9. We wish to highlight the exceptional level of support staff at Wakefield, and in particular, the prison's family liaison officer (FLO) provided to Mr Royal. The FLO liaised on Mr Royal's behalf with healthcare staff and supported him to make important end of life decisions. While Mr Royal was in the prison's healthcare unit, she facilitated visits from a fellow prisoner and from Mr Royal's daughter, including attending the prison on her day off to support Mr Royal's daughter through her visit. The FLO's actions would have been a great source of comfort to Mr Royal and his daughter during his final days.

10. At the inquest, held on 9 December, the Coroner concluded that Mr Royal died from natural causes.

11. We shared our initial report with HMPPS and the prison's healthcare provider, Practice Plus Group. They found no factual inaccuracies.

Adrian Usher **May 2026**
Prisons and Probation Ombudsman

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