Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Craig Royce a prisoner at HMP Chelmsford on 25 December 2016

**A report by the Prisons and Probation Ombudsman
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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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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.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Craig Royce was found hanged in his cell at HMP Chelmsford on 25 December 2016. He was 46 years old. I offer my condolences to Mr Royce's family and friends.

Mr Royce was managed under Prison and Probation Service suicide and self-harm monitoring procedures (ACCT) for three short periods at Chelmsford, but there were a number of weaknesses in the way his risk was managed. Case reviews were not multi-disciplinary and did not effectively identify Mr Royce's main concerns or seek to address them. Staff relied too much on his presentation rather than his underlying risk factors. ACCT procedures were stopped inappropriately twice and there was no meaningful focus at case reviews on actions needed to reduce his risk. It is particularly concerning that there was no meaningful input from healthcare into the ACCT process at all.

The clinical reviewer considers that the clinical care of Mr Royce's mental health, epilepsy and substance misuse was inadequate.

It is the depressing conclusion of this investigation that the overall care afforded to Mr Royce was not sufficient to keep him safe. I am particularly disappointed that many of the issues highlighted were identified in previous investigations into deaths at Chelmsford. The governor needs to take urgent steps to address these repeated concerns.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **October 2017**

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Summary

Events

1. Mr Royce had a long history of mental illness due to substance misuse and epilepsy. On 13 August 2016, police arrested him for possession of an offensive weapon and criminal damage. A hospital mental health team assessed him after a community psychiatric nurse raised concerns that his mental health was deteriorating, but concluded he was not suitable for detention under the Mental Health Act. On 15 August, Mr Royce was remanded to Chelmsford.

2. On 22 August, a resettlement services caseworker referred him to Phoenix Futures for psycho-social support with his substance misuse. A GP began Prison Service suicide and self-harm monitoring (known as ACCT) on 5 September, after Mr Royce said he had constant suicidal thoughts.

3. On 6 September, a caseworker from Phoenix Futures assessed Mr Royce but did not have access to his records and accepted his word that he was not a heavy cannabis user. A referral to the cannabis support group was never followed up and Mr Royce had no further contact with substance misuse services.

4. The prison psychiatrist assessed Mr Royce the same day. She concluded he was not suffering from depression or psychosis and discharged him from her caseload with a plan that he should work with Phoenix Futures. This referral was never made. Also on 6 September, ACCT monitoring was stopped because Mr Royce said he no longer had suicidal thoughts.

5. ACCT monitoring was started again on 16 October after Mr Royce was found with a ligature in his shared cell trying to attach it to his bunk bed. He said his cellmate had been bullying him and was encouraging him to hurt himself. This ACCT was closed on 20 October.

6. On 26 October, Mr Royce was sentenced to 20 months in prison for possession of an offensive weapon and criminal damage. On 3 November, he was issued with notice that he was 'presumed unsuitable' for early release on home detention curfew (HDC). Mr Royce's mother received a letter from him on 1 December in which he said a probation liaison officer had told him he could be released on HDC in January if he had a suitable release address.

7. On 20 December, Mr Royce became very distressed during a pastoral visit from the Anglican Chaplain. He said he was very upset about several deaths in his close family, his relationship breakdown and was convinced he was not the father of his two children. The Chaplain started ACCT monitoring.

8. Mr Royce spoke to his mother on 22 December. She told him her landlord would not allow her to provide accommodation for him on release. Mr Royce said, "If I don't get out of here, I'm fucking topping myself I'm telling you".

9. At 8.11pm on 24 December, Mr Royce was found hanged in his cell. The emergency response was swift and paramedics attended quickly and managed to restart his heart. Mr Royce was taken to hospital, where it was determined there was no activity in his brain. He died at 8.25am on 25 December 2016.

Findings

10. We found that Mr Royce's clinical care was not equivalent to that which he could have expected to receive in the community. Despite having a history of drug induced mental illness Mr Royce had no meaningful contact with mental health or substance misuse services at Chelmsford.

11. Mr Royce was non-compliant with his epilepsy medication and suffered frequent seizures. The prison did not have an epilepsy protocol and Mr Royce did not have a comprehensive care plan as he should have done.

12. We identified several areas of learning in the ACCT process applied to Mr Royce including: case reviews were not multi-disciplinary and did not effectively identify Mr Royce's main concerns or seek to address them; staff relied too much on his presentation rather than his underlying risk factors; ACCT procedures were stopped inappropriately twice and there was no meaningful focus at case reviews on actions needed to reduce his risk; and there was no meaningful input from healthcare into the ACCT process.

13. Mr Royce made several allegations that he was being bullied but there did not appear to have been any consideration of the impact of this on his risk of suicide and self-harm.

14. Mr Royce was given an erroneous expectation that he was eligible for early release in January. He appeared to have suffered some distress as a result. We were not able to find out how he was given this expectation but it does not appear to have been from formal contact by offender management unit staff.

Recommendations

- **The Governor and head of healthcare should ensure that:**
    - **Prisoners with dual diagnosis receive appropriate integrated treatment.**
    - **Mental health services meet the needs of prisoners at Chelmsford, with a referral system that results in face to face assessments using all relevant information for appropriate continuity of care and follow-up, and that prisoners have access to services equivalent to those in the community.**
- **The Governor and Head of Healthcare should ensure that the prisoners with epilepsy are accommodated and managed appropriately and that staff adhere to a protocol for epileptic prisoners in line with NICE guidelines.**
- **The Governor and Head of Healthcare should ensure that staff manage prisoners identified as at risk of suicide or self-harm in line with national guidelines, including:**
    - **Holding multi-disciplinary case reviews attended by all relevant people involved in a prisoner's care. A member of healthcare staff should attend all first case reviews.**

- **Setting ACCT caremap actions which are specific, meaningful and aimed at reducing prisoners' risks to themselves.**

- **Ensuring that all caremap actions have been completed before ACCT monitoring is stopped.**

- **Ensuring post closure reviews take place at the proper time and take into consideration events since the closure of the ACCT.**
- **Ensuring all prisoners with mental health issues have mental health assessments when ACCTs are opened.**

- **The Governor and head of healthcare should ensure that:**
    - **All information about bullying and intimidation is fully coordinated and investigated.**
    - **Those suspected of involvement are appropriately challenged and monitored.**
    - **Staff consider whether victims are at increased risk of suicide or self-harm.**
    - **Apparent victims are effectively supported and protected with meaningful, long term solutions, which address their individual situation.**

The Investigation Process

15. The investigator issued notices to staff and prisoners at HMP Chelmsford, informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

16. The investigator visited Chelmsford on 10 January 2016. She obtained copies of relevant extracts from Mr Royce's prison and medical records, CCTV of the emergency response, recording of Mr Royce's telephone calls and listened to the emergency radio message of 24 December.

17. NHS England commissioned a clinical reviewer to review Mr Royce's clinical care at the prison.

18. The investigator interviewed nine members of staff, four jointly with the clinical reviewer, and six prisoners.

19. We informed HM Coroner for Essex of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

20. One of the Ombudsman's family liaison officers contacted Mr Royce's mother to explain the investigation. Mr Royce's mother made several comments via her solicitor on our initial report. We have corrected some factual inaccuracies and addressed other matters in separate correspondence.

21. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Chelmsford

22. HMP Chelmsford is a local prison that takes prisoners directly from courts. It holds nearly 730 men aged 18 years and older. At the time of Mr Royce's death, Care UK was commissioned to provide 24-hour healthcare including secondary mental health services.

HM Inspectorate of Prisons

23. The most recent inspection of Chelmsford was in April 2016. Inspectors found progress had stalled since the previous inspection in 2014. The quality of most ACCT documents was reasonable, with generally effective care maps and mostly good monitoring and recording, although reviews were not sufficiently multi-disciplinary, including a lack of input by health services staff. Prisoners spoke positively about the care they had received. Relationships between staff and prisoners was a strength.

24. The quality of healthcare had deteriorated and inspectors considered provision of healthcare inadequate, exacerbated by staff shortages. The integrated mental health team was not used effectively to meet the needs of the population. Too few interventions were provided for prisoners with substance misuse issues. Offender management work was poor and also undermined by staff shortages. Ongoing contact between prisoners and offender supervisors had deteriorated and was too limited. Few prisoners applied for home detention curfew (HDC).

Independent Monitoring Board

25. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to August 2016, the IMB repeated concerns from previous reports that the level of physical and mental health care service was inadequate.

Previous deaths at HMP Chelmsford

26. Mr Royce's was the sixth apparently self-inflicted death at Chelmsford since February 2015. We made recommendations in three of them to address deficiencies in suicide and self-harm monitoring procedures (ACCT) including lack of multi-disciplinary case reviews. We repeat the recommendation in this report.

Assessment, Care in Custody and Teamwork (ACCT)

27. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.

28. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There

should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

29. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Home Detention Curfew (HDC)

30. Home Detention Curfew enables eligible, suitable prisoners serving between 12 weeks and just less than four years to be released up to 135 days before the half-way point in their sentence, subject to an electronically monitored curfew.

31. The scheme is aimed at low risk prisoners. Some groups, such as registered sex offenders and foreign national prisoners liable to removal from the UK, are barred from the scheme. Prisoners sentenced for offences including murder, child cruelty, and possessing an offensive weapon are 'presumed unsuitable' for HDC unless they can demonstrate exceptional circumstances.

Key Events

Events prior to custody

32. Mr Craig Royce had a history of epilepsy, substance misuse, drug induced psychosis, frequent suicidal thoughts and attempted suicide. In 2015, he was admitted to a mental health unit on two occasions after episodes of drug induced psychosis.

33. On 13 August 2016, Mr Royce was arrested and charged with possession of an offensive weapon and criminal damage. Mr Royce told the police he suffered from epilepsy, depression and had once driven a car into a shop to try to kill himself. Police officers observed him apparently responding to delusional thoughts throughout the night. They put him on constant supervision and referred him for a mental health assessment.

34. A Community Psychiatric Nurse (CPN) saw Mr Royce the next morning, 14 August. She noted his long history of epilepsy, psychoactive substance abuse, mental and behavioural disorder due to cannabinoids abuse and non-compliance with medication. She said Mr Royce appeared confused and told her he was hearing voices. She concluded that his mental health might be deteriorating and referred him for a further mental health assessment at hospital.

35. An approved mental health practitioner (AMHP) team including two forensic consultant psychiatrists assessed Mr Royce the same day in the late morning. They concluded he was not suitable for detention under the Mental Health Act (MHA). In his discharge letter, they asked the prison reception nurse to:

> "Please reassess this gentleman's risk and exercise the ACCT process if required. Please arrange for him to see the GP with regards to prescribed medications. To be assessed by the IDTS nurse/IDTS GP re his current illicit substance misuse."

36. Mr Royce returned to hospital on 14 August after suffering a seizure in police custody. He was discharged the same day and taken back to the police station. He suffered a further seizure in the early hours of 15 August and was again treated at hospital and discharged to police custody.

37. On 15 August 2016, Mr Royce was remanded to HMP Chelmsford charged with possession of an offensive weapon.

Arrival at Chelmsford

38. A member of the Criminal Justice Liaison and Diversion Team (CJLDT) at the police station faxed the prison with a detailed summary of Mr Royce's mental health history based on the CPN's assessment. She added that Mr Royce had been assessed by the AMHP team but they did not feel he needed to be detained under MHA powers. She said Mr Royce was at risk of epileptic seizures and deteriorating mental health due to ongoing drug abuse. She repeated the AMHP's recommendation in Mr Royce's discharge letter above.

39. A mental health nurse noted the CJLDT's report and referred Mr Royce for a mental health assessment. She said Mr Royce appeared calm and settled. He

denied any drug and alcohol issues and said he had been in prison before. Mr Royce strongly denied he was at risk of suicide or self-harm. He said he had been admitted to a mental health unit in the last year but could not remember the date. Mr Royce said he had taken cannabis and crack cocaine in the last month.

40. The same day, 15 August, Mr Royce saw the nurse prescriber. He read the discharge letter from the hospital dated 15 August. He said Mr Royce appeared healthy, fit and cheerful. Mr Royce denied audio or visual hallucinations and any thought of suicide or self/harm. He referred Mr Royce for a mental health assessment and to the GP because of his epilepsy. In the meantime, he continued Mr Royce's prescription for sodium valproate (given to him at hospital for his epilepsy).

41. A note on the envelope of Mr Royce's wing file said, "Needs to be located on a lower bunk due to epilepsy. Suffers from seizures". Mr Royce spent the night in a single cell on the second floor of E wing, the prison's integrated drug treatment service (IDTS) wing. As part of his basic custody assessment Mr Royce completed an Equality and Disability Questionnaire. He said he had been diagnosed with bi-polar disorder but did not mention his epilepsy. As a result, he did not complete a personal emergency evacuation plan.

42. Also on 15 August, an officer completed a cell sharing risk assessment (CSRA) and concluded Mr Royce was suitable to share a cell. He noted the CSRA form that Mr Royce suffered from epileptic seizures. Another officer completed a first night in prison (FNIP) interview and recorded that Mr Royce had no immediate concerns. On 16 August, he was moved to a ground floor cell on F Wing, the induction unit.

43. The same day, a multi-disciplinary team of members of the mental health team and the integrated drug treatment service (IDTS) discussed Mr Royce. They considered the CJLDT report and noted that Mr Royce had not appeared psychotic or in low mood during his reception health assessment. The team concluded that Mr Royce should remain under the care of the prison GP who would review his mood and medication.

17 August – 15 October 2016

44. On 17 August, Mr Royce did not collect his sodium valproate (epilepsy medication) during the morning medication round. He moved to a third floor cell (C3/05) on C Wing. At 11.15pm, a nurse gave him his missed dose of sodium valproate after he had a seizure in his cell. She put a note on SystmOne asking for the nurse on duty in the morning to review Mr Royce, but there is no record that this took place.

45. On 18 August, a nurse saw Mr Royce after he had another seizure in resettlement unit. Staff reported that Mr Royce had been "talking rubbish" but she said he appeared alert and coherent. At 7.50pm, officers called the nurse again after Mr Royce complained his head was "feeling funny". She could find anything obviously wrong with him and put him on the list for review the next day.

46. On 19 August, a nurse reviewed Mr Royce. Mr Royce said his seizures were due to him not having cannabis daily, which controlled them. The nurse advised him to take his medication and noted he was on the lower bunk in a shared cell.

47. On 22 August, a Reducing Re-offending Officer from the National Association for the Care and Resettlement of Offenders (NACRO) referred Mr Royce to the substance misuse team because of his cannabis use. On 23 August, Phoenix Futures (who provide psycho-social support for substance misuers) completed their referral form and added Mr Royce to their list for assessment.

48. On 23 August, a nurse saw Mr Royce in his cell after his cellmate said he was having a seizure. Mr Royce was in bed, confused and sweating. The nurse checked his vital signs which were all normal.

49. On 25 August, Mr Royce told a locum GP that he was being bullied at work and in his cell. He said his cellmate was selling his tobacco and harassing him. Mr Royce said he felt like harming someone as a result. He asked to move to a cell on ground floor because he was scared of having a fit on the stairs. The GP said he spoke to an officer who reassured him this would happen. He did not record the name of the officer and there is no evidence that he told the officer about Mr Royce's allegations of bullying. The same day Mr Royce did not take his epilepsy medication.

50. On 26 August, Mr Royce told a pharmacy technician at the medication hatch that he had felt "possessed" in the night. She said he was pleasant and polite but not very coherent. He again refused to take his medication and she said she would tell the mental health team. There is no record that she did so.

51. On 1 September, Mr Royce gave an officer a note asking to move wings because a prisoner wanted to fight him and he was worried about the effect on his epilepsy of being hit on the head. No action appears to have been taken to explore Mr Royce's concerns. On 2 September, one of the prison GPs reviewed Mr Royce's medical record and booked an appointment for him to review Mr Royce's mood and medication in the light of the multi-disciplinary meeting on 16 August.

52. A prison GP saw Mr Royce on 5 September. He noted Mr Royce's history of drug induced mental and behavioural disorders as a result of heavy cannabis use. Mr Royce denied hearing voices and feeling "possessed". He said he had constant suicidal thoughts and that, if he got time "I will kill myself". Mr Royce also told him that he was afraid to kill himself because he had no guts. He said Mr Royce was fidgety, laughing and joking but demonstrated some pressure of speech and looked distracted. Mr Royce said he had not taken his epilepsy medication for two weeks. He began Prison Service suicide and self-harm monitoring procedures (known as ACCT) and referred Mr Royce back to the mental health team for assessment.

53. As part of the ACCT immediate action plan, Mr Royce moved to a cell on the ground floor of C Wing. The same day, the multi-disciplinary team decided the prison psychiatrist should assess Mr Royce.

54. At 9.30am on 6 September, a Supervising Officer (SO) completed Mr Royce's ACCT assessment. Mr Royce said he had told a prison GP that he would cut his throat if he made him take epilepsy medication. He said he felt threatened on C Wing but thought this was more his perception than fact, although he found other prisoners intimidating. Mr Royce said he had lost his number for the prison telephone system and had not made any calls since his arrival. The SO arranged for Mr Royce to use the office telephone to call his mother. He put Mr Royce on the waiting list for move to G Wing (the enhanced wing for employed prisoners with good behaviour).

55. After his ACCT assessment, Mr Royce saw a case manager from Phoenix Futures. He told her he started smoking cannabis aged nine and felt it cured most medical conditions including stopping his seizures. He said he did not believe research that cannabis adversely affected mood and mental health. Mr Royce said he heard voices but had not been diagnosed with a mental illness. He said he was being monitored under ACCT procedures and had thought about suicide but never attempted it. He suffered from panic attacks. She referred Mr Royce to the cannabis awareness group and made a note to review his progress on 20 September.

56. Mr Royce saw the visiting psychiatrist immediately afterwards. A mental health nurse was also present. The psychiatrist noted Mr Royce's history of drug induced psychosis due to cannabis and psychoactive substances. He told her he had used LSD, crack cocaine, magic mushrooms, amphetamines and ecstasy. He said he had been epileptic for ten years. Mr Royce denied hearing voices and having paranoid or suicidal thoughts. She concluded there was no evidence Mr Royce was depressed or psychotic. She said there was no follow up needed and discharged Mr Royce from her clinic. She noted Mr Royce's record that he should work with the psychosocial team on his use of illicit substances.

57. At 11.15am, a SO chaired Mr Royce's first ACCT review with another SO and a mental health nurse. The SO noted that Mr Royce had been assessed by the mental health team and the other SO was organising a move to G Wing. Mr Royce said he had no current suicidal thoughts and the review team agreed to close the ACCT. The SO wrote two actions on the caremap and marked them all as completed. These were:

- He felt intimidated on C wing (seek staff support and apply to G Wing).
- No contact with Mum (waiting for new pin, given call from office).

58. On 12 September, Mr Royce was hit on the head by a previous cellmate. CCTV evidence (which was viewed by staff at the time but which we have not seen) showed the other prisoner (not named on the record) going into Mr Royce's cell. The same day Mr Royce attended an ACCT post-closure interview with a SO. Mr Royce said his issues had been resolved but he had problems with his current cellmate. She wrote that staff would try to move him to a different cell. Mr Royce's cellmate was moved to a different cell the next day.

59. On 21 September, Mr Royce's cellmate told officers Mr Royce was having a seizure in bed on the top bunk. A nurse examined him and advised Mr Royce to sleep on the bottom bunk. She noted Mr Royce's record that he should be

reviewed because he was not compliant with his epilepsy medication. There is no record that this review took place.

60. On 21 September, the cellmate accused Mr Royce of assault. The cellmate was moved to D Wing and officers placed Mr Royce on the basic level of the Incentives and Earned Privileges (IEP) Scheme in line with their violence reduction procedures.

61. On 23 September, Mr Royce did not attend his secondary health screening. On 25 September, a nurse saw Mr Royce after another seizure. Mr Royce was disoriented but his basic observations were normal. The nurse encouraged him to take his medication and booked Mr Royce an appointment with the GP. He managed to persuade Mr Royce to take a single tablet of his epilepsy medication.

62. On 26 September, Mr Royce reported to the night patrol officer that he had a seizure at about 4.00am. He was unable to attend the GP clinic the next morning because of a video-link appearance at court. Instead a prison GP saw him at the door of his cell in the afternoon. The GP said Mr Royce looked well but was not taking his medication. He advised him to do so and made another appointment to discuss the matter further. That evening Mr Royce had another seizure. A nurse said he was oriented but his behaviour was “slightly bizarre”. Mr Royce denied taking any illicit substances.

63. On 27 September, a nurse saw Mr Royce for a follow up assessment in his cell. Mr Royce was stable and oriented and said his medication was doing him more harm than good. He asked for “medical cannabis”.

64. Mr Royce discussed his medication with a GP on 29 September. He said his anti-epileptic medication caused his seizures whereas cannabis helped him control them. Mr Royce said he used to take psychoactive substances but had stopped. He agreed to start taking his medication again. (Mr Royce’s medical record contains numerous entries after this date that he accepted only part or refused to collect his medication and would not take it.)

65. On 12 October, intelligence was received from another prisoner that Mr Royce was going to “top himself” because he had received a letter from his wife saying she was going to leave him and the baby she was carrying was not his. No action appears to have been taken to explore this with Mr Royce.

16 October – 19 December 2016

66. On 16 October, an Operational Support Grade (OSG) began ACCT procedures at 2.30am after finding Mr Royce with a noose round his neck, trying to use the slats in the upper bunk to self-strangulate. He called for assistance and said that Mr Royce had tried to self-strangulate twice before night orderly staff arrived and removed the noose from him. Mr Royce’s cellmate was moved because they were arguing and Mr Royce threatened to harm him if he was not moved out of their cell. Mr Royce was observed every 20 minutes pending assessment.

67. At 10.00am on 16 October, Mr Royce told a SO at his ACCT assessment that his cellmate had encouraged him “to do things to himself” in order to be given more tobacco. He had told Mr Royce to run head first at cell door, was very controlling and had goaded him to try to kill himself. Mr Royce said he had tried to kill

himself the previous night because the bullying was too much for him. Mr Royce said he wanted the ACCT closed because now his cellmate had moved out, his only issue that mother's letters were not coming through as quickly as he would like. The SO made a note to find Mr Royce's PIN so he could make telephone calls.

68. Mr Royce attended his first ACCT review with two SOs at 11.00am. Mr Royce said he was fine now he was in a cell on his own. The review team agreed to reduce Mr Royce's observations to hourly. They considered closing the ACCT but decided not to because the review team was not multi-disciplinary. The SO scheduled the next review for 17 October and said he would try to get the mental health team to see Mr Royce. He added one action to the caremap: to resolve Mr Royce's missing PIN number for the prison telephone system. No action appears to have been taken under Prison Service violence reduction procedures to monitor or investigate Mr Royce's allegations of bullying.

69. A SO held a review on 17 October with Mr Royce and no one else. Before the review, the SO spoke to a nurse by telephone, but it is not recorded what she said. Mr Royce said the stress caused by his cellmate's behaviour had made him tie the ligature but he now felt stupid for doing so. He said he was not at risk of suicide and then added "you should put me in with someone who is also mental and suicidal". The SO kept the ACCT open and added an action to the caremap for Mr Royce to make applications for work and education. He assessed Mr Royce's risk as low. He booked a review for 20 October and said that if Mr Royce started taking his epilepsy medication his ACCT could be closed at that review.

70. On 18 October, a prisoner punched Mr Royce in the face after an argument in the queue for medication. Mr Royce's ACCT record described him as "visibly shook up". The prisoner who assaulted Mr Royce was placed on basic regime under the IEP scheme under Prison Service violence reduction procedures. On 19 October, Mr Royce moved to a single cell on the second landing (C2/11).

71. A SO chaired the next review on 20 October, with Mr Royce, another SO, an officer and a prison chaplain. A nurse provided a telephone report. Mr Royce said he was feeling much happier in a single cell and had started taking his epilepsy medication. The issue with his PIN number had been resolved and he was able to call his mother. The review team agreed to close the ACCT.

72. On 26 October, Mr Royce attended court and was sentenced to 20 months in prison. A nurse saw him in reception and described him as "fit and well, laughing and joking". The next day, Mr Royce telephoned his mother for the first time using the prisoner telephone system (PIN) since arriving at Chelmsford.

73. Mr Royce continued to regularly miss or partially accept his medication and on 2 November he asked to see the GP to discuss it. On 3 November, a prison GP reported that Mr Royce was feeling better now he was taking a reduced dose of one sodium valproate tablet every evening.

74. On 3 November, Mr Royce was sent a standard form notifying him that he was presumed unsuitable for early release on Home Detention Curfew (HDC)

because of his offence unless there were exceptional circumstances that justified an appeal.

75. On 5 November, Mr Royce had a fight with another prisoner. The incident was dealt with under the prison's violence reduction procedures.

76. On 13 November at midnight, wing staff called a nurse after Mr Royce said he was worried he was about to have a fit. A nurse saw him again at 2.30am after he complained of chest pain. His baseline observations were normal and the nurse advised him to take his sodium valproate. Later the same day, Mr Royce complained of pain all over his body but refused paracetamol because he did not like taking anything apart from cannabis or morphine. Another nurse referred him to the GP to review his medication.

77. Mr Royce did not attend the GP clinic for his appointment on 28 November. Later, a nurse was called by officers after Mr Royce had a seizure. His baseline observations were normal and she gave him his morning sodium valproate, which he had not collected.

78. Mr Royce wrote his mother a letter which she received on 1 December. Mr Royce said he had just had a visit from a "probation liaison officer" who told him he could be released on a "tag" (i.e. on Home Detention Curfew - HDC) by January. Mr Royce said this made him feel "a million dollars". He asked his mother if he could stay with her or if his ex-partner would consider letting him go home on a temporary basis so that he had a release address for HDC. No one in the prison's Offender Management Unit (OMU) remembered speaking to Mr Royce and there is no record that he received a formal visit from OMU or probation staff.

79. The same day, a prison GP saw Mr Royce having an epileptic seizure in his cell. The GP said it was a 'grand mal' (serious) seizure. Mr Royce gradually came round but remained confused for some 30 minutes. He increased Mr Royce's sodium valproate to his original dose and made another appointment to see him.

80. Mr Royce told a prison GP on 7 December that he was having daily seizures. He said he had tried about five different types of anti-epileptic medication and the only thing that reduced his seizures was cannabis. Mr Royce admitted he had taken Spice (a synthetic cannabinoid) a month previously. He denied hearing voices but said he hated himself and was having difficulty coping in prison. He said he felt angry and anxious and thought his mental health was deteriorating. Mr Royce denied feeling suicidal because he had two sons and was looking forward to seeing them. The GP prescribed Diazepam. He considered beginning ACCT procedures but was reassured by Mr Royce's response that he was not suicidal and was thinking of his children.

81. On 8 December, Mr Royce was transferred to HMP Highpoint. He was returned to Chelmsford the same day because Highpoint does not have 24-hour healthcare and was not equipped to deal with his unstable epilepsy. It was subsequently noted on Mr Royce's medical record that he was medically unfit for transfer to a lower category prison.

82. On 12 December, a SO completed the post-closure interview with Mr Royce for the ACCT closed on 20 October. This interview should have taken place on 27 October. The SO said all the actions on Mr Royce's caremap were complete. He was unemployed and did not have any hobbies or use the gym. Mr Royce had good support from his mother and was aware of the support available to him in prison. The SO concluded the ACCT should remain closed.

20 December – 23 December 2016

83. On 20 December, Mr Royce requested a pastoral visit and an Anglican Chaplain visited him in his cell at about 10.30am. She said Mr Royce cried and was so distressed that he became unintelligible at times. He was upset about the break-up of his long-term relationship a couple of years previously and believed he was not the father of his two children. Mr Royce said several times that he wanted to kill himself. He said he had tried to hang himself the previous night but had not had the courage to go through with it. He said the other prisoners made fun of him so he stayed in his cell. Mr Royce appeared to think he was due to be released in January or February. She said he did not want her to leave him and told her he would not be there tomorrow.

84. At 11.30am, at the conclusion of her visit, the Anglican Chaplain began ACCT procedures. She detailed her conversation on the concern and keep safe form. Mr Royce was observed hourly pending his ACCT assessment. Apart from leaving his cell to collect his medication and his evening meal, Mr Royce spent the rest of the day asleep or watching television. According to his ACCT record he slept all night.

85. At 9.00am on 21 December, a SO spoke to Mr Royce for over an hour during his ACCT assessment. The SO said Mr Royce was very tearful about breaking up with his partner and the deaths of his sister, brother and father. He said he felt suicidal and had made a ligature but was too scared to kill himself. He told the SO that he had previously tried to kill himself by driving his car into a supermarket and stripping naked and trying to run into traffic because voices told him to. The SO said Mr Royce came across as mentally vulnerable and anxious. Mr Royce said he felt extremely low and that his medication was not supporting him. He was looking forward to possible release on HDC in a few weeks and going home to his mother. The SO said it was difficult to get Mr Royce to focus and he often changed the subject.

86. That afternoon, a SO held an ACCT review with an officer and Mr Royce. The SO said he spoke to a nurse by telephone and she did not raise any clinical issues. Mr Royce said he had relationship issues and was finding it hard to cope. He was tearful when speaking about family but said he had support from his mother and sons. The SO asked him if he felt suicidal and Mr Royce said he had suicidal thoughts but added, "Don't worry about me Guv, I really don't have the guts to kill myself". He said he was reassured that Mr Royce did not have active plans to take his own life. He felt Mr Royce engaged well and talked openly.

87. The review team discussed being in prison over Christmas and Mr Royce said he would be okay. The SO set the level of observations at three during the day and hourly on patrol state (when prisoners are locked in their cells). He considered Mr Royce was at low risk of suicide. He added one action to the caremap – for

Mr Royce to apply for counselling sessions about his relationship issues. He said he wanted to give Mr Royce some responsibility and intended to check he had made the application at the next review.

88. On 22 December, Mr Royce telephoned his mother. The investigator listened to a recording of the call. Mr Royce's mother told him that her landlord had refused his permission to let Mr Royce live with her should he be given early release on HDC. Mr Royce tried to persuade his mother to let him stay with her and lie to the landlord, but she refused. Mr Royce then asked his mother to beg his ex-partner to take him back. He said, "If I don't get out of here, I'm fucking topping myself I'm telling you". He said he had put a rope around his neck the other night and had now hidden it in his window bars. Mr Royce called his mother back later in the day and said, "You've got to get someone to help me otherwise I'm fucked".

89. At noon on 22 December, he told an officer that he was worried about his dreams because they felt very real. She told him to keep positive and Mr Royce said he was trying and added that he was happy with which staff were on duty over Christmas.

90. On 23 December, Mr Royce came out of his cell for association time with other prisoners. That evening, Mr Royce asked an officer to read a letter he had written. She said they had a long chat about it. Mr Royce talked about his two sons for a long time and how he was staying strong for them. He told her he would be going to bed with a smile on his face. She agreed to post the letter for him.

24 December 2016

91. Mr Royce telephoned his mother during morning association time. He sounded very low in mood, angry, upset and frustrated that he did not have a release address for HDC. Referring to being in prison he said, "There's nothing worse than this". He said he had started to feel better after speaking to a female officer the night before and his seizures were much better since he started taking diazepam. Now he felt very down. Mr Royce's mother said she would try to find somewhere bigger to live so he could have an address for early release. Mr Royce said it was "horrible" in prison.

92. Mr Royce's ACCT record shows he appeared to be in a good mood during the rest of the day and told staff he was fine. At 3.25pm, a SO held an interim ACCT review with Mr Royce and an officer, because Christmas is recognised as a time of heightened risk for vulnerable prisoners. Mr Royce said he felt fine and had no issues. He said he was hoping to be released in January. The SO judged him to be at low risk of suicide and made no changes to his level of observations.

93. Mr Royce collected his evening meal at 4.30pm and an officer noted he seemed in a good mood. She checked Mr Royce again at 5.30pm and he put his thumbs up and told her he was "good".

94. CCTV shows an officer checked Mr Royce at 7.15pm. He said Mr Royce was watching television and gave him a thumbs up. He checked Mr Royce again at 8.11pm and saw he was suspended by a torn sheet from the window bars. He radioed a Code 1 emergency (indicating a prisoner not breathing). The control

room called an ambulance immediately. Nine seconds later another officer followed him into the cell and a third officer joined them. Two officers supported Mr Royce's bodyweight and the third cut the sheet with his cut down tool (known as a fish knife). They laid Mr Royce on the floor and one officer began chest compressions.

95. A nurse arrived and another brought the C Wing emergency bag. The nurse asked the officer to continue chest compressions while she inserted an airway and gave Mr Royce oxygen using a bag and mask (an Ambu-bag). A Healthcare Assistant took over the Ambu-bag while the nurse attached a defibrillator to Mr Royce.

96. Two ambulance paramedics arrived at 8.22pm. They moved Mr Royce to the landing and began advanced life support procedures supported by the prison nurses. The paramedics worked on Mr Royce for over an hour and managed to restart his heart before transferring him to hospital. Mr Royce was put on life support in the Intensive Care Unit. Tests revealed no brain activity, and he died at 8.25am the next morning on 25 December.

97. Essex police removed a note written by Mr Royce from his cell after he died. Mr Royce apologised to his mother and sons but said he was unable to carry on because he was convinced his ex-partner was with someone else and he was not the father of his two children and the pain was too much. Mr Royce's family said they were told that the note had been recovered from Mr Royce's waste bin.

Contact with Mr Royce's family

98. The prison family liaison officer told Mr Royce's mother in person on 24 December that he had been taken to hospital. He drove her to the hospital that night and she was with her son when he died the next morning.

99. The prison contributed towards the costs of Mr Royce's funeral in line with national guidance.

Support for prisoners and staff

100. The duty manager debriefed the staff involved in the emergency response at 9.45pm on 24 December. He reminded staff of how to access the prison care team. Members of the care team and the prison chaplaincy subsequently approached the staff involved to offer support. The response nurse did not receive any contact or offers of support from her healthcare manager.

101. The prison posted notices informing other prisoners of Mr Royce's death and offering support. Staff reviewed all prisoners assessed as a risk of suicide and self-harm in case they had been adversely affected by Mr Royce's death.

Post-mortem report

102. The post-mortem examination concluded that Mr Royce died as from anoxic brain injury due to suspension. No toxicology was taken.

Findings

Clinical care

Mental health and substance misuse

103. Dual diagnosis is the co-existence of mental health and substance misuse problems. The NHS Guide for the Management of Dual Diagnosis for Prisons advises prisons to adopt a protocol for a coordinated approach to managing prisoners with dual diagnosis which should address methods of assessment, referral, joint care planning, reviews and release arrangements. This is vital to ensure communication between the different teams working with the prisoner on the separate aspects of their care.

104. Mr Royce arrived at Chelmsford with a significant amount of information about his history of mental illness and substance and recent assessments by a Community Psychiatric Nurse and an approved mental health practitioner team from the hospital. They raised concerns that his mental health was deteriorating due to his substance misuse and non-compliance with medication and recommended he see a GP and the substance misuse team. The reception nurse referred Mr Royce appropriately for a mental health assessment and a multi-disciplinary team of mental health and substance misuse staff discussed him the following day. They did not assess Mr Royce in person and did not take him on to the caseload of the primary mental health team. They decided he should be under the care of the GP but there was no apparent plan for this to happen. Mr Royce did not see a GP in response to this until 5 September.

105. The Integrated Drug Treatment Service (IDTS) at Chelmsford focuses on prisoners with alcohol and opiate addiction. Prisoners with cannabis misuse issues should be referred to Phoenix Futures who provide psycho-social support services. The multi-disciplinary team did not refer Mr Royce to Phoenix Futures despite his long history of cannabis misuse. He was seen by Phoenix Futures on 23 August as a result a referral from NACRO. However, the case worker did not have his history and took Mr Royce's word that his drug use was minimal. A referral to the cannabis awareness group was not followed up and this was the only contact Mr Royce had with substance misuse services at Chelmsford. The visiting psychiatrist indicated in her notes on 6 September that her plan was for Mr Royce to receive psycho-social support but Phoenix Futures did not receive a referral from her or the mental health nurse present at her assessment and was unaware of this referral and Mr Royce's history.

106. Although Mr Royce asserted that he had taken Spice (a new psychoactive substance) while at Chelmsford, the investigation did not find any evidence that he had used illicit substances while in custody. We are, though, seriously concerned that Mr Royce, a man with a long history of mental health issues due to substance misuse, received no meaningful input from the primary mental health team or substance misuse services at Chelmsford. He does not appear to have been recognised as a dual diagnosis patient and there was no coordination between mental health and substance misuse services.

107. The PPO published a learning lessons bulletin on 'Prisoner Mental Health' in January 2016. In this bulletin, we identified that difficulties in coping with mental

health problems can be made worse when a prisoner also has to cope with difficulties of battling substance dependence. We recommended that mental health and substance misuse services should work together to provide a coordinated approach to prisoner care which should involve the use of agreed dual diagnosis tools to assess prisoner needs and regular meetings to discuss and plan join care. We make the following recommendation:

The Governor and the Head of Healthcare should ensure that:

- **Prisoners with dual diagnosis receive appropriate integrated treatment.**
- **Mental health services meet the needs of prisoners at Chelmsford, with a referral system that results in face to face assessments using all relevant information for appropriate continuity of care and follow-up, and that prisoners have access to services equivalent to those in the community.**

Epilepsy

108. The National Institute for Health and Care Excellence (NICE) clinical guideline on Epilepsies: diagnosis and management, says:

“All children, young people and adults with epilepsy should have a comprehensive care plan that is agreed between the person, their family and/or carers as appropriate, and primary and secondary care providers.”

And:

“If seizures are not controlled and/or there is diagnostic uncertainty or treatment failure, children, young people and adults should be referred to tertiary [specialist] services soon [i.e. within four weeks] for further assessment.”

109. Protocols in use at other prisons state that prisoners with epilepsy should be accommodated on the bottom bunk of a shared cell on the ground floor of a wing. Chelmsford did not have a protocol for managing prisoners with epilepsy and Mr Royce did not have a comprehensive care plan as he should have. In his clinical review, the clinical reviewer concluded that this was a “major failure” in Mr Royce’s care. Mr Royce’s epilepsy was unstable and he had frequent seizures. Most of the wing staff interviewed were not aware that he was epileptic. His wing file noted he should be allocated a lower bunk, but his records indicate that this did not always happen.

110. Healthcare input mostly consisted of the nurses who responded to his seizures encouraging Mr Royce to take his medication, with limited success. There are several entries on his medical record asking for him to be reviewed after a seizure but this did not happen consistently and there is no evidence that the frequency or severity of his seizures was monitored. The lack of effective communication and management of Mr Royce’s condition resulted in an inappropriate transfer to HMP Highpoint, which does not have sufficient healthcare resources to manage chronic conditions like epilepsy. Mr Royce was not referred to a neurologist despite having frequent seizures and being only partially or non-compliant with his medication.

111. We make the following recommendation:

The Governor and Head of Healthcare should ensure that the prisoners with epilepsy are accommodated and managed appropriately and that staff adhere to a protocol for epileptic prisoners in line with NICE guidelines.

Conclusion

112. The clinical reviewer found the clinical care that Mr Royce received at Chelmsford was not equivalent to that he would have expected to receive in the community. Unfortunately, this investigation replicates the findings of HM Inspectorate of Prisons in 2016 that healthcare provision at Chelmsford was inadequate.

ACCT procedures

113. Mr Royce had a range of risk factors for suicide including: first time in prison, previous attempted suicide and suicidal ideation, poor mental health, substance misuse, family relationship breakdown and future court appearances including sentencing. Staff began ACCT procedures to support Mr Royce three times at Chelmsford. The first was when he expressed suicidal intent to a prison GP on 5 September. This monitoring ended the next day. The second time was on 16 October, when Mr Royce was found trying to hang himself from his bunk bed. This period of ACCT monitoring ended on 20 October but would also have ended less than 12 hours but for the lack of multi-disciplinary input at the first case review. The third time was on 20 December, when Mr Royce was extremely distressed and told the Anglican Chaplain several times that he would kill himself and had attempted to hang himself the night before. This period of monitoring continued until Mr Royce's death. The investigation identified several failings in ACCT procedures, particularly:

- the lack of healthcare and other multi-disciplinary involvement in case reviews;
- risk assessments not based on assessment of risk factors;
- ineffective and inadequate caremap actions; and
- ACCT plans closed before actions identified on the caremap were complete.

114. Prison Service Instruction (PSI) 64/2011 requires that case reviews should be multi-disciplinary where possible. The PSI contains a mandatory action that there is a member of healthcare staff at the first case review. A nurse was present at the first case review on 6 September but, barring a couple of brief telephone calls with nurses who raised no issues, this was the only healthcare input into Mr Royce's three periods of ACCT monitoring. Multi-disciplinary reviews should help facilitate effective communication between departments and this was wholly lacking in Mr Royce's case. This is a particularly serious concern because of Mr Royce's mental health issues, epilepsy, non-compliance with his medication and suicidal ideation.

115. PSI 64/2011, states that caremap actions should have detailed and time-bound actions aimed at reducing the risk. They should reflect the prisoner's needs, level of risk and the triggers of their distress. A prison GP listed his reasons for opening Mr Royce's first ACCT on the concern and keep safe form. These were:

- History of mental health problems.
- Not taking medication.
- Suicidal "all the time".
- Said "I will kill myself"
- Odd behaviour.
- History of drug induced psychosis from cannabis.

116. Two issues were added to the caremap at the first case review: that Mr Royce felt intimidated by other prisoners and he did not have a number for the prison telephone system and had not been able to contact his mother since he arrived. These were marked as complete because a SO had said he would look into transferring Mr Royce to G Wing, he had been given a telephone call in the wing office (which failed to connect) and was waiting for a new number to access the prison telephone system.

117. We do not consider that it is appropriate to mark actions as complete when only the first step to resolving them has been taken. We also do not consider that the promise to ask about a transfer to another wing (which did not in fact happen) was sufficient to address Mr Royce's feelings of intimidation. There was no exploration of what Mr Royce meant or whether he would benefit from formal staff support under Prison Service violence reduction procedures. The problem of Mr Royce's access to the prison telephone system was not resolved until his second period of ACCT monitoring in October. Mr Royce first called his mother (who was his main support) using this system over two months after he arrived at Chelmsford on 27 October.

118. Neither do we consider that these two actions properly addressed all the concerns listed by the prison GP. We are concerned that Mr Royce's risk of suicide was assessed as low and his assertion that he no longer felt suicidal was taken at face value, although he had specifically stated the day before that he would kill himself if he got "time" and had a range of other risk factors for suicide. We therefore consider it was inappropriate for staff to have stopped ACCT monitoring on 6 September.

119. The same or very similar failings were also a feature of Mr Royce's second and third periods of ACCT monitoring in October and December:

- No one from healthcare attended the first case reviews.
- There was too much reliance on Mr Royce's denials of suicidal intent rather than an objective assessment of his underlying risk factors for suicide.

- The caremaps did not adequately reflect Mr Royce's issues and triggers.
- Mr Royce did not have a mental health assessment on either occasion despite having suicidal thoughts, being found with a ligature and stating several times he felt like killing himself.
- In October, there was no apparent consideration of Mr Royce's need for extra support despite his allegation that bullying by his cellmate had led him to attempt suicide.
- In October, ACCT procedures were stopped before caremap actions were completed.
- In December, Mr Royce was assessed as at low risk of suicide at his first case review despite telling the ACCT assessor the same morning that he felt suicidal and had made a ligature and an officer the day before that he had attempted suicide during the night of 19/20 December.

120. We also note that post-closure monitoring stopped after three days on 24 October and the post-closure review scheduled for 27 October did not take place until 12 December. The review also stated that Mr Royce's caremap actions were complete. In fact, one of them was that Mr Royce should apply for activities but Mr Royce stated on 12 December that he was unemployed, had no hobbies and did not use the gym. Furthermore, as Mr Royce was sentenced to 20 months on 26 October, missing the original post-closure review date effectively meant an opportunity to assess his feelings about this was missed. (Mr Royce had previously told a prison GP that he would kill himself if he got "time".)

121. Staff judgement is fundamental and the ACCT system relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk. However, none of the staff who had contact with Mr Royce between 21 and 24 December considered him at high risk of suicide, despite the range of his risk factors, his statements that he wanted to kill himself and his assertion that he had attempted suicide and made a ligature.

122. While a prisoner's presentation is obviously important and reveals something of their level of risk, it is only one piece of evidence in judging risk. Staff should make a considered, objective evaluation of all risk factors when assessing the risk of suicide and self-harm and document their decision. We consider that staff were too reliant on Mr Royce's assertions that he was too scared to kill himself. Consequently, the level of agreed monitoring was insufficient to protect him. We cannot know whether better ACCT procedures and more effective intervention would have prevented Mr Royce's actions but we consider that not enough was done to ensure his safety. We recommend:

The Governor and Head of Healthcare should ensure that staff manage prisoners identified as at risk of suicide or self-harm in line with national guidelines, including:

- **Holding multi-disciplinary case reviews attended by all relevant people involved in a prisoner's care. A member of healthcare staff should attend all first case reviews.**

- **Setting ACCT caremap actions which are specific, meaningful and aimed at reducing prisoners' risks to themselves.**

- **Ensuring that all caremap actions have been completed before ACCT monitoring is stopped.**

- **Ensuring post closure reviews take place at the proper time and take into consideration events since the closure of the ACCT.**

- **Ensuring all prisoners with mental health issues have mental health assessments when ACCTs are opened.**

Bullying and violence reduction

123. Chelmsford's violence reduction policy sets out the action staff should take if a prisoner is bullied. This policy includes:

- Encouraging prisoners to tell staff what care and support they need and developing a care plan to implement this.
- Keeping the prisoner up to date with the progress of enquiries and what action staff are taking.
- Checking the prisoner's welfare at the time of the incident and in the following days and weeks.
- Being vigilant as to the impact such issues can have to heighten the man's risk of self-harm, and providing support where required, and starting ACCT monitoring if necessary.

124. On 25 August, Mr Royce told a prison GP that his cellmate was bullying him. On 1 September, he asked to move to another wing because another prisoner wanted to fight him. On 6 September, he said he felt threatened on C Wing. On 12 September, Mr Royce was hit by another prisoner and told staff he had problems with his cellmate. On 16 October, he was found with a noose around his neck attempting to hang himself because he was fed up with his cellmate bullying and trying to control him. On 18 October, he had a fight and on 5 November another prisoner hit him.

125. In our Learning Lessons report, 'Violence reduction, bullying and safety', published in October 2011, we identified the importance of implementing local violence reduction strategies, investigating all allegations of bullying.

126. We would expect that, where possible, the prison should investigate all incidents of violence and antisocial behaviour. There is some evidence that the other prisoners concerned were investigated. However, we are concerned that prison staff did not put victim support measures in place for Mr Royce or consider the impact of bullying on his risk of suicide and self-harm, particularly after he was found with a noose on 16 October. It does not appear that the GP told staff about Mr Royce's allegation he was being bullied in August. We repeat the recommendation from our investigation into a death at Chelmsford in September 2016:

The Governor and head of healthcare should ensure that:

- **All information about bullying and intimidation is fully coordinated and investigated.**
- **Those suspected of involvement are appropriately challenged and monitored.**
- **Staff consider whether victims are at increased risk of suicide or self-harm.**
- **Apparent victims are effectively supported and protected with meaningful, long term solutions, which address their individual situation.**

Home detention curfew

127. Mr Royce was correctly assessed as presumed unsuitable for early release on HDC and his prison record shows this information was sent to him on 3 November. However, it is apparent from the letter his mother received on 1 December that Mr Royce had been given an expectation that he might be released on HDC in January 2017. It is also apparent from the recorded telephone calls to his mother in the couple of days before he hanged himself, that Mr Royce was upset and frustrated that he did not have a suitable release address for HDC.

128. We do not know who gave Mr Royce the false hope that he would be released in January or how this happened. We have seen no evidence that it resulted from a formal communication from Chelmsford's offender management unit. The Prison Service's electronic information system (NOMIS) automatically records an HDC eligibility date when the prisoner's sentence is calculated. This page is uneditable and remains on the system even if the HDC clerk subsequently amends the record that the prisoner is not eligible. It is possible therefore that if Mr Royce asked a member of staff to look up his sentence dates they would have been unaware he was ineligible for HDC. We make no recommendation.

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