Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ryan McArthur on 26 April 2025, following his release from HMP Hull

A report by the Prisons and Probation Ombudsman

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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

WHAT WE VALUE

Summary

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. Since 6 September 2021, the PPO has investigated post-release deaths that occur within 14 days of the person's release from prison.

3. 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.

4. Mr Ryan McArthur died in hospital from a head injury on 26 April 2025, following a fall from height, ten days after his release from HMP Hull. He was 36 years old. We offer our condolences to those who knew him.

5. On 26 April, Mr McArthur was seen walking on the roof of a school. He then fell from the edge of the roof and sustained a serious head injury when his head struck the concrete. It appears this was an accidental fall.

6. We did not identify any significant learning relating to the pre-release planning or post-release supervision of Mr McArthur.

7. We make no recommendations.

The Investigation Process

8. HMPPS notified us of Mr McArthur's death on 2 May 2025.

9. The PPO investigator obtained copies of relevant extracts from Mr McArthur's prison and probation records.

10. We informed HM Coroner for Greater Lincolnshire of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

11. The Ombudsman's office contacted Mr McArthur's father to explain the investigation and to ask if he had any matters he wanted us to consider. He did not respond to our letter.

12. We shared our initial report with HMPPS and the prison's healthcare provider, Spectrum Community Health CIC. They found no factual inaccuracies.

Background Information

HMP Hull

13. HMP Hull is a local inner-city prison with a complex population of remand and sentenced prisoners. Around 130 prisoners are released each month.

Probation Service

14. The Probation Service works with all individuals subject to custodial and community sentences. During a person's imprisonment, they oversee their sentence plan to assist in rehabilitation, prepare reports to advise the Parole Board and have links with local partnerships to which they refer people for resettlement services, where appropriates. Post-release, the Probation Service supervises people throughout their licence period and post-sentence supervision.

Key Events

Background

15. On 26 November 2024, Mr Ryan McArthur was sentenced to six months in prison for breach of a criminal behaviour order. He was released on 6 February 2025.

16. On the day of his release, Mr McArthur attended probation for his initial appointment and went to his accommodation provided by Community Accommodation Service Tier 3 (CAS3), which provides temporary housing for prison leavers. After this, he did not return to the CAS3 accommodation and as a result, it was withdrawn from him for failing to reside as instructed. As Mr McArthur had breached his licence conditions, his community offender manager (COM) revoked his licence, and a warrant was issued for his arrest.

17. On 4 April, Mr McArthur was arrested for shoplifting. He was sent to HMP Hull to serve a 14-day recall.

18. On 7 April, Mr McArthur was given an additional 12-week suspended sentence for shoplifting.

Pre-release planning

19. When Mr McArthur arrived at Hull, he told staff during his reception screening that he had epilepsy and had a history of drug use in the community. He told staff at Hull that he used to take Subutex (a medicine that helps with opioid withdrawal symptoms) but had not taken any since coming into custody this time. He said that he would like to start an opioid substitute treatment (OST) like Subutex and asked to be referred to the substance misuse service (SMS).

20. On 10 April, Mr McArthur told an SMS worker that he was due to start methadone that week. However, when he got to the medications hatch, he was told not to collect as there was a problem. He then decided that he no longer wanted to start methadone treatment in prison. The SMS worker asked a GP at Hull to complete a drug screen and review Mr McArthur for potential treatment, should he change his mind.

21. That afternoon, a GP visited Mr McArthur to ask again if he wanted to start OST. Mr McArthur again said he did not want any treatment in prison and would arrange it after his release.

22. On the morning of Mr McArthur's release, an SMS worker asked if he would like to be issued with a supply of naloxone (a medication that can rapidly reverse opioid overdose). Mr McArthur declined.

Release from HMP Hull

23. On 16 April, Mr McArthur was released from Hull. He was released with one week's worth of medication for epilepsy. He told a nurse that he was going back to his home address.

24. On the day of his release, Mr McArthur attended the probation office for his initial appointment. His COM told him that his licence would last until 29 June. Mr McArthur was upset by this and said he wanted to discuss with his solicitor as he thought it was against his human rights. Mr McArthur did not have a mobile phone and told his COM that he was hoping to stay with his father, as he did not have any other accommodation.

25. Mr McArthur declined any additional support from his COM and refused a referral to commissioned rehabilitative services (CRS) which support with housing, finances, substance misuse and mental health. Mr McArthur's COM signposted him to a homelessness charity in case he was unable to live with his father.

Circumstances of Mr McArthur's death

26. On 23 April, Mr McArthur did not attend his probation appointment. Police told his COM that he had fallen from a school building over the weekend and was in a critical condition in hospital. Mr McArthur had been seen walking along the roof. He fell from the edge of the roof and sustained a serious head injury when his head struck the concrete. He was taken to hospital by emergency services for treatment. Police were satisfied that there was no third-party involvement.

27. Later that day, the police told Mr McArthur's COM that he had died in hospital.

Post-mortem report

28. The post-mortem report concluded that Mr McArthur died from a head injury caused by a fall from a height.

29. Previous cannabis use was detected but the active metabolite was very low at the time of death making it less likely that cannabis was affecting cognition. The other drugs detected were in therapeutic ranges. There were therapeutic antiepileptic concentrations, thus reducing the chance of seizures.

Findings

30. The evidence suggests that Mr McArthur's death was caused by an accidental fall.

31. We found no issues with the pre-release planning or post-release supervision of Mr McArthur.

32. We make no recommendations.

Adrian Usher
Prisons and Probation Ombudsman **December 2025**

Inquest

At the inquest, held on 20 January 2026, the Coroner concluded that Mr McArthur's death was due to an accident.

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