

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Barry Doyle, a prisoner at HMP Wymott, on 9 July 2025

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100

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



© Crown copyright, 2026

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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. On 15 October 2021, Mr Barry Doyle was sentenced to seven years in prison for sex offences. He died on 9 July 2025 from coronary atheromatous disease (a build-up of fat in the arteries near the heart), contributed to but not caused by hypertension and diabetes mellitus, while a prisoner at HMP Wymott. He was 74 years old. We offer our condolences to those who knew him.
4. The Ombudsman's office wrote to Mr Doyle'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 Doyle's clinical care at HMP Wymott.
6. The clinical reviewer concluded that the clinical care Mr Doyle received at Wymott was of a good standard and at least equivalent to that which he could have expected to receive in the community. She found good evidence of compassionate interactions between Mr Doyle, healthcare and custodial staff. The clinical reviewer made one recommendation not related to Mr Doyle's death that the Head of Healthcare will want to address.
7. The PPO investigator investigated the non-clinical issues relating to Mr Doyle's care.
8. We did not find any non-clinical issues of concern. We make no recommendations.
9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out one factual inaccuracy and this report has been amended accordingly.
10. At an inquest held on 9 April 2026, the Coroner concluded that Mr Doyle died of natural causes.

Adrian Usher
Prisons and Probation Ombudsman

January 2026

**Prisons &
Probation**

Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100