

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Robert Barry, on 30 January 2025, following his release from HMP Durham

A report by the Prisons and Probation Ombudsman

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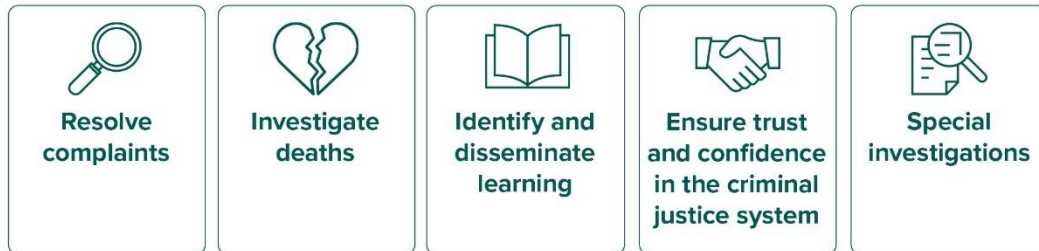
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OUR VISION

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



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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 Robert Barry died of acute upper gastrointestinal haemorrhage on 30 January 2025, following his release from HMP Durham on 27 January 2025. This was caused by a duodenal ulcer (an ulcer in the lining of the small intestine). Mr Barry was 45 years old. We offer our condolences to those who knew him.
5. The clinical reviewer concluded that the care Mr Barry received at Durham was of a good standard and equivalent to that which he could have expected to receive in the community. We make no recommendations.

The Investigation Process

6. HMPPS notified us of Mr Barry's death on 28 March 2025.
7. The PPO investigator obtained copies of relevant extracts from Mr Barry's prison and probation records.
8. NHS England commissioned an independent clinical reviewer to review Mr Barry's clinical care at HMP Durham.
9. We informed HM Coroner for Newcastle and North Tyneside of the investigation. They send us a copy of the death certificated and informed us that an inquest will not be held. We have sent the Coroner a copy of this report.
10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Durham

11. HMP Durham is a category B reception and resettlement prison which holds male prisoners. Spectrum provide physical healthcare and clinical substance misuse services. Tees, Esk and Wear Valleys NHS Foundation Trust provide mental health services.

Probation Service

12. 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 appropriate. Post-release, the Probation Service supervises people throughout their licence period and post-sentence supervision.

Key Events

Background

13. On 14 December 2024, Mr Robert Barry was sent to HMP Durham on remand.
14. During his initial health screen, Mr Barry told staff that he did not drink alcohol and did not disclose any health issues.
15. On 20 December, Mr Barry was convicted of assault and theft and sentenced to eight weeks in custody.
16. On 24 December, the pre-release team at Durham saw Mr Barry to identify his needs and completed a duty to refer form (a homelessness referral form to the local authority) to Newcastle council because he said he would have nowhere to live on release.

Pre-release

17. On 15 January, a multi-disciplinary team (MDT) meeting was held between healthcare staff, Mr Barry's community offender manager (COM), and Mr Barry. Probation records note that a Community Accommodation Service tier 3 application (CAS3 – an accommodation service that provides prison leavers with up to 84 nights in accommodation) would be made.
18. On 19 January, Mr Barry's prison offender manager (POM) met with him on the wing. Mr Barry told his POM that he would be homeless on release. The POM contacted his COM as well as the pre-release team.
19. On 22 January, Mr Barry attended an appointment by video-link with the COM and Mr Barry's Integrated Offender Management police officer (IOM, a cross-agency strategy that unites probation and police in managing repeat offenders). That day, the COM completed the CAS3 application.
20. On 23 January, the pre-release team made a referral to the Reconnect service (a community service which provides various support services to prison leavers).
21. On 24 January, Mr Barry was accepted for a CAS3 accommodation.
22. On 27 January, Durham's drugs and alcohol recovery team referred Mr Barry to Newcastle Treatment and Recovery (an NHS service that provides various substance misuse services) for community treatment.
23. In a pre-release medical check, Mr Barry said that he felt fit and well. At no point during his imprisonment had Mr Barry sought any help for symptoms that might have been related to an ulcer.

Release from HMP Durham

24. On 27 January, Mr Barry was released from Durham.

25. Mr Barry attended an initial probation appointment with another probation officer who completed his appointment as the COM did not work on that day. They discussed his CAS3 accommodation.

Circumstances of Mr Barry's death

26. On 30 January, the COM spoke to staff at Newcastle Treatment and Recovery to see if Mr Barry had been attending his appointments. They told her that Mr Barry was in hospital with an internal bleed, after he became unwell at home.
27. At approximately 4.00pm the same day, the COM was informed that Mr Barry had died.

Cause of death

28. A post-mortem examination was not carried out as the Coroner accepted the cause of death provided by a doctor. The doctor gave the cause of death as acute upper gastrointestinal haemorrhage, caused by duodenal ulcer. The Coroner told the investigator that they would not be conducting an inquest into Mr Barry's death.

Findings

Clinical care

29. The clinical reviewer concluded that the care Mr Barry received at Durham was of a good standard and was at least equivalent to that which he could have expected to receive in the community. He found that there was nothing the healthcare team could have done to predict or prevent Mr Barry's death. He also found that the healthcare team appropriately referred Mr Barry to community teams for ongoing support in the community. He made no recommendations.

Adrian Usher
Prisons and Probation Ombudsman

December 2025

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