

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ronnie Stewart, a prisoner at HMP Holme House, on 9 December 2022

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, 2025

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. In March 2008, Mr Ronnie Stewart was sentenced to an indeterminate sentence for public protection for grievous bodily harm. He died of pulmonary aspergillosis (a long-term lung condition caused by mould in the lungs) and acute bronchopneumonia due to chronic obstructive pulmonary disease (COPD), at North Tyneside General Hospital. He was 55 years old. We offer our condolences to Mr Stewart's family and friends.
4. The PPO family liaison officer wrote to Mr Stewart's daughter to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Stewart's daughter had no questions but asked for a copy of our report.
5. NHS England commissioned an independent clinical reviewer to review Mr Stewart's clinical care at HMP Holme House.
6. The clinical reviewer concluded that the clinical care Mr Stewart received at HMP Holme House was of a good standard and equivalent to that which he could have expected to receive in the community. She found that Mr Stewart received a high standard of healthcare at Holme House, including difficult conversations with Mr Stewart regarding his illness that were handled compassionately.
7. The PPO investigator investigated the non-clinical issues relating to Mr Stewart's care.
8. We did not find any non-clinical issues of concern. We make no recommendations.
9. Mr Stewart's family received a copy of the initial report. They did not make any comments.
10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.
11. The inquest into Mr Stewart's death concluded on 27 June 2023 and returned a verdict of natural causes.

Adrian Usher
Prisons and Probation Ombudsman

April 2024

**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