

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ronald Cole a prisoner at HMP Full Sutton, on 27 May 2025

A report by the Prisons and Probation Ombudsman

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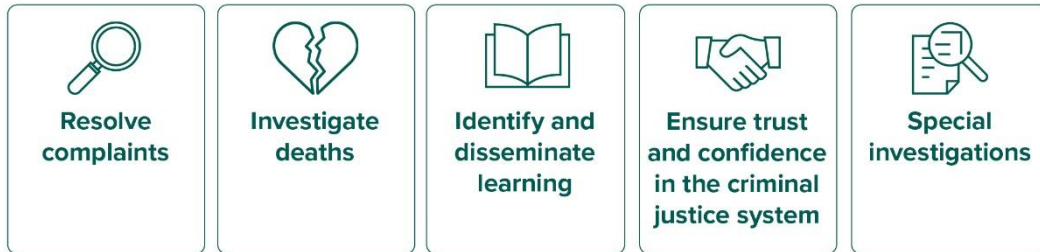
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OUR VISION

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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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 30 October 1991, Mr Ronald Cole was sentenced to life in prison for murder. On 27 May 2025, while a prisoner at HMP Full Sutton, he died from community acquired pneumonia, caused by chronic obstructive pulmonary disease (COPD). This was contributed to but not caused by: heart failure, pulmonary hypertension and chronic kidney disease stage 3-4. He was 78 years old. We offer our condolences to Mr Cole's family and friends.
4. The Ombudsman's office contacted Mr Cole'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 Cole's clinical care at HMP Full Sutton. The clinical review is attached as Annex 1.
6. The clinical reviewer concluded that the clinical care Mr Cole received at Full Sutton was of a reasonable standard and partially equivalent to that which he could have expected to receive in the community. She found that Mr Cole received healthcare access in a timely manner, despite his repeated refusal to move to the healthcare unit. However, she was concerned that healthcare staff did not comply with the prison medical emergency response codes and call a code blue (indicating a prisoner is having breathing difficulties) on 22 May, despite the incident meeting the criteria. She assessed that Mr Cole's medical care was not affected as the ambulance arrived within 20 minutes.
7. The PPO investigator investigated the non-clinical issues relating to Mr Cole'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 did not find any factual inaccuracies.
10. At an inquest held on 23 January 2026, the Coroner concluded that Mr Cole died of natural causes.

Adrian Usher
Prisons and Probation Ombudsman

November 2025

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