Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Mark Saville, a prisoner at HMP Stafford, on 28 December 2024

A report by the Prisons and Probation Ombudsman

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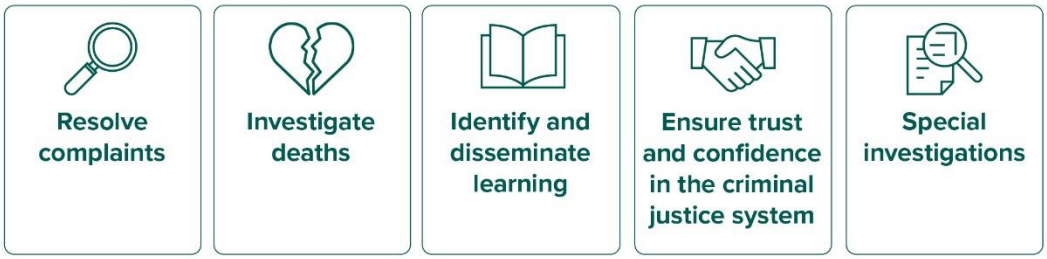
OUR VISION

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

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 2013, Mr Mark Saville was sentenced to 14 years imprisonment for sexual offences. He had previously been released from prison in February 2019 but was recalled in July 2020. He died of cardiomyopathy (disease of the heart muscle which makes the heart struggle to pump blood) on 28 December 2024, in hospital. He was 61 years old. We offer our condolences to Mr Saville's family and friends.

4. The Ombudsman's office wrote to Mr Saville'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 Saville's clinical care at HMP Stafford.

6. The clinical reviewer concluded that the clinical care Mr Saville received at Stafford was of a good standard and equivalent to that which he could have expected to receive in the community. She found that he had good cardiac care including staff facilitating outpatient appointments and appropriate tests being undertaken regularly. She also found that the emergency response was appropriate and well managed.

7. The PPO investigator investigated the non-clinical issues relating to Mr Saville's care. We did not find any non-clinical issues of concern. We make no recommendations.

Governor to Note

8. On 28 December 2024, Mr Saville's cellmate told staff that Mr Saville was feeling unwell. Prison staff attended promptly and supported him adequately, but no one turned on their body worn camera. Staff said that they did not do so because they were prioritising helping Mr Saville and preserving his life. The Governor will want to ensure that staff are reminded of the importance of turning on their cameras in emergency situations such as this.

9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

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

Inquest

The inquest hearing was held on 1 July 2025. The Coroner concluded that Mr Saville died of natural causes.

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