Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Saterlay, a prisoner at HMP Fosse Way, on 15 October 2025

A report by the Prisons and Probation Ombudsman

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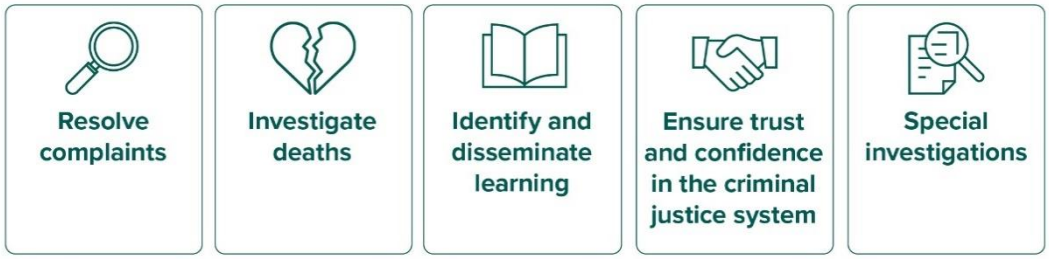
OUR VISION

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 August 2017, Mr John Saterlay was sentenced to 10 years in prison for sexual offences. He died of critical coronary artery atherosclerosis on 15 October 2025, at HMP Fosse Way. He was 80 years old. We offer our condolences to Mr Saterlay's family and friends.

4. The Ombudsman's office wrote to Mr Saterlay's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They had no questions but asked for a copy of our report.

5. NHS England commissioned an independent clinical reviewer to review Mr Saterlay's clinical care at HMP Fosse Way. The clinical reviewer's report is attached as Annex 1.

6. The clinical reviewer and the PPO investigator jointly interviewed the Deputy Head of Healthcare at HMP Fosse Way on 10 December 2025. The transcript of the interview is attached as Annex 2.

7. The clinical reviewer concluded that the clinical care Mr Saterlay received at Fosse Way was of a good standard and equivalent to what he could have expected to receive in the community. She found that he was appropriately assessed for malnutrition and pressure ulcers and falls risk assessments were regularly completed. The healthcare team cared for Mr Saterlay in a responsive and respectful manner, despite his health needs becoming challenging at times in an environment where the healthcare provision was not 24-hours a day. The clinical reviewer made no recommendations.

8. The investigator investigated the non-clinical issues relating to Mr Saterlay's care. We did not find any non-clinical issues of sufficient concern to merit a recommendation.

Director to note

Family Liaison

9. The Prison Safety Policy Framework states that prisons must respond quickly and sensitively when a prisoner becomes seriously ill or receives a terminal diagnosis. Governors/Directors must ensure that appropriate arrangements are in place for a member of staff to engage with the prisoner's next of kin or nominated contact. The Prison Safety Policy Framework also requires that, when a prisoner suffers sudden life-threatening harm, staff should obtain the prisoner's wishes about who should be contacted wherever possible. If this cannot be done, careful consideration must be

given to identifying who it is appropriate to inform. This may include individuals with whom the prisoner has limited or no recent contact, such as estranged relatives or those subject to contact restrictions.

10. In the months leading up to Mr Saterlay's death, his health worsened and he was considered terminally ill. However, the prison did not appoint a family liaison officer until the day he died.

11. The Investigations Manager at Fosse Way told us that there was a no-contact order in place with Mr Saterlay's next of kin. Mr Saterlay's next of kin had told the prison that they could contact her in an emergency.

12. National policy states that, even where contact restrictions exist, careful consideration must still be given to determining who should be informed. In this case, national policy should have been followed. We bring this to the Director's attention.

13. The initial report was shared with HM Prison and Probation Service (HMPPS). Practice Plus Group pointed out some factual inaccuracies and this report has been amended accordingly.

14. Practice Plus Group also pointed out some factual inaccuracies with the clinical review. The investigator passed these onto the clinical reviewer who amended their report.

15. Mr Saterlay's family received a copy of the initial report. They did not make any comments.

Inquest

16. At the inquest held on 16 March 2026, the coroner concluded that Mr Saterlay died of natural causes.

Adrian Usher **April 2026**
Prison and Probation Ombudsman

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