Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Rodney Savage, a prisoner at HMP Haverigg, on 14 January 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 January 2023, Mr Rodney Savage was sentenced to nine years in prison for sex offences. He died of metastatic pancreatic cancer (cancer of the pancreas which had spread to other parts of the body) on 14 January 2025, while a prisoner at HMP Haverigg. He was 71 years old. We offer our condolences to Mr Savage's family and friends.

4. The Ombudsman's office wrote to Mr Savage's next of kin, his wife, to explain the investigation and to ask if she had any matters she wanted us to consider. She raised concerns about a delay in diagnosing Mr Savage's cancer in November 2024 and his pain management at Haverigg. These concerns have been addressed in the clinical review.

5. NHS England commissioned an independent clinical reviewer to review Mr Savage's clinical care at Haverigg. The clinical review report is attached as Annex 1.

6. The clinical reviewer concluded that the clinical care Mr Savage received at Haverigg was of a good standard and was equivalent to that which he could have expected to receive in the community. She found that Mr Savage was managed with compassion and cared for by confident, competent staff at Haverigg. She also found evidence of good multidisciplinary team working. The clinical reviewer made no recommendations.

7. The PPO investigator investigated the non-clinical issues relating to Mr Savage's care.

8. We did not identify any non-clinical learning, and 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. Mr Savage's family received a copy of the draft report. They did not make any comments.

11. This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

12. At an inquest held on 15 January 2026, the Coroner concluded that Mr Savage died of natural causes.

Adrian Usher
Prisons and Probation Ombudsman

August 2025

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