Action Plan in response to the PPO Report into the death of

Mr Christopher Walton on 6 February 2025 at HMP Ranby

Rec No	Recommendation	Accepted / Not accepted	Response Action Taken / Planned	Responsible Owner and Organisation	Target Date
1	The Head of Healthcare should investigate why Mr Walton's abnormal blood and urine tests were not reviewed by a doctor and put systems in place to ensure that this does not happen in the future.	Accepted	In January 2025, GP provision was less than we have in place now. To ensure robust clinical oversight and assurance that systems are in place to evidence timely clinical review, GP sessions have increased in line with the needs of the service. The Head of Healthcare reviews open tasks, which form part of the monthly Data Quality report published by NHS North of England Commissioning Support Unit (NECS).	Head of Healthcare, Northamptonshire Healthcare NHS Foundation Trust	November 2025
2	The Head of Healthcare should rewrite the Medications in Possession document as a Standard Operating Procedure (SOP), which should include: • A system to monitor that a prisoner is taking medications as prescribed.	Accepted	Since this incident, the process for auditing in-possession medication through spot checks has been strengthened. The updated audit procedure now specifically includes medications prescribed for all long-term conditions. This enhancement aligns with the recommendations made during the initial learning review and reflects our	Head of Healthcare, Northamptonshire Healthcare NHS Foundation Trust	December 2025

	• A medical review to be triggered if a prisoner is not taking their medications to investigate why this might be the case.		commitment to ensuring safe and effective medication management. These elements recommended are part of the Northamptonshire Health Foundation Trust SOP regarding in possession medications which will be adopted as the new provider of healthcare services at HMP Ranby from 1st October 2025.		
3	The Head of Healthcare should rewrite the older person care plan to include: • Regular reviews by healthcare to monitor for signs of physical and mental deterioration. • Reviews of mobility and monitoring for signs of weight loss.	Accepted	We would like to note that the actions outlined in this recommendation are already being actively implemented. The Primary Care Matron, along with the Advanced Clinical Practitioner (ACP) are leading on this initiative. Each Primary care nurse has been assigned a specific long-term condition, effectively making them a link nurse responsible for overseeing care in that area. These link nurses are now running regular clinics tailored to each Long term condition, during which patients are reviewed, and their care plans are personalised accordingly. We also hold a record, provided by Primary Care Matron, detailing which nurse is assigned to each condition. This structured approach ensures ongoing monitoring for signs of physical and mental deterioration, including mobility and weight changes, in line with the recommendation	Head of Healthcare, Northamptonshire Healthcare NHS Foundation Trust	December 2025

| 4 | The Head of Healthcare should develop a workforce strategy to address chronic understaffing as a matter of urgency. | Accepted | Northamptonshire Healthcare Foundation Trust (NHFT) assumed responsibility for the service on 1st October and inherited the existing recruitment pipeline. Since then, we have taken proactive steps to strengthen the workforce model and address understaffing.

Key developments include:

• An extensive recruitment campaign has been launched, utilising social media platforms and targeted outreach to attract qualified candidates and strengthen the workforce across key clinical roles.

• Introduction of new roles to enhance service delivery:
  o Band 8A Pharmacist – Full-time
  o Band 8A Psychologist – Full-time
  o Band 5 Practice and Performance Manager – Full-time

• A dedicated HR Business Partner (HRBP) has been appointed specifically for Nottinghamshire and Lincolnshire prisons to support recruitment and retention efforts.

• A dedicated turnaround team, led by the Assistant Director, is in place to drive | Head of Healthcare, Northamptonshire Healthcare NHS Foundation Trust | February 2026 |

			strategic workforce improvements and operational resilience. • We are actively onboarding new staff with a robust induction programme and ongoing support to ensure staff are well-prepared and integrated into the service. • Regular updates are provided to the Workforce Safety and Assurance Board (WSAB), including risk assessments and agency staffing data, to maintain oversight and transparency. • Enhanced bank rates are in place for substantive staff who work additional shifts. These measures reflect our commitment to building a sustainable, well-supported workforce capable of delivering high-quality care.		
5	The Head of Healthcare should address the high number of "Code Calls" by: • introducing an "Urgent Assessment" system whereby a prison officer can request a same day assessment to be undertaken by a Registered Nurse; and	Accepted	The current system in place addresses both the recording and clinical triage of Code Calls: • Recording and Review: All Code Calls are documented in the daily briefing and reviewed each morning by healthcare managers. Any calls deemed inappropriate are discussed with prison	Head of Healthcare, Northamptonshire Healthcare NHS Foundation Trust	December 2025

			staff and retained for audit purposes, ensuring transparency and accountability. • Urgent Assessment Process: Prison officers have direct access to the Primary Care emergency nurse carrying the Hotel Radio. All prison staff are familiar with the process for requesting healthcare support, which can be initiated via radio or telephone. Upon receiving a request, the Hotel nurse conducts a clinical triage by exploring the concerns that resulted in the request and reviewing the patient's record in SystmOne and determines whether the individual requires same-day assessment or a scheduled appointment based on clinical need. This system ensures that urgent healthcare needs are addressed promptly while maintaining oversight and appropriate level of clinical response.		
	• implementing an audited log of calls to ensure the system is being used appropriately.				
6	The Head of Healthcare should ensure that there is: • Adequate training for nurses responsible for assessing the clinical condition and appropriate treatment pathways for prisoners. • At least one nurse trained in advanced clinical assessment skills	Accepted	All nurses within the service are registered professionals with the Nursing and Midwifery Council (NMC) and are required to complete regular training to maintain their registration and clinical competence. In addition to this, all staff undertake annual NHFT training aligned to their specific roles.	Head of Healthcare, Northamptonshire Healthcare NHS Foundation Trust	December 2025

	during all day shifts within one year and that nurses should be trained to this level before answering Urgent Assessment calls.		To further enhance clinical assessment capabilities, nurses are actively supported to enrol in specialist training programmes such as the Minor Injuries and Minor Illness (MIMI) course and the Advanced Physical Assessment and Consultation Skills (APACS) course. These courses equip staff with the skills needed to assess clinical conditions and determine appropriate treatment pathways. Staff who are detailed to provide urgent care for patients are always provided with the necessary clinical skills required and can seek specialist support from medics and other colleagues as required.		
7	The Governor should: • Update the at-risk line message given to callers so that it tells them how often messages are checked, whether they can expect a callback, details of the email service and how to escalate immediate safeguarding concerns.		The at-risk line message was updated on 10 November 2025 with the following. Thank you for calling HMP Ranby's At-risk line. This voicemail service is monitored four times throughout the day. Please leave the following details: • Your name and contact information • The name and prison number of the individual you are concerned about • A brief explanation of your concern Due to GDPR (General Data Protection Regulation) regulations, we may not be able to	Head of Safety, HMPPS	**Completed**

• Implement a robust quality assurance process, including regular spot checks by managers, to confirm calls are logged accurately and that entries are detailed enough to support appropriate follow up.		return your call. However, please be assured that all concerns are taken seriously and will be followed up with a welfare check when required. Alternatively, you may submit your concern by completing an electronic form via the PACT website: www.prisonadvice.org.uk. **Important:** This line is not suitable for urgent concerns involving immediate risk to life. If you believe someone is at immediate risk, please call the switchboard on **01777 862000** and ask for the **Orderly Officer**, stating that your concern is an emergency. **Monthly Contact Protocol** Once a month, a Safer Custody Manager or Regional Safer Custody Lead will contact the at-risk line to assess the response time for returned calls. **Daily Monitoring Procedure** The Safer Custody Team will conduct daily cross-checks between the Safer Custody log and DPS (Digital Prison Services) entries to ensure that all logged calls have been appropriately logged and actioned.		