Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Christopher Walton, a prisoner at HMP Ranby, on 6 February 2025

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

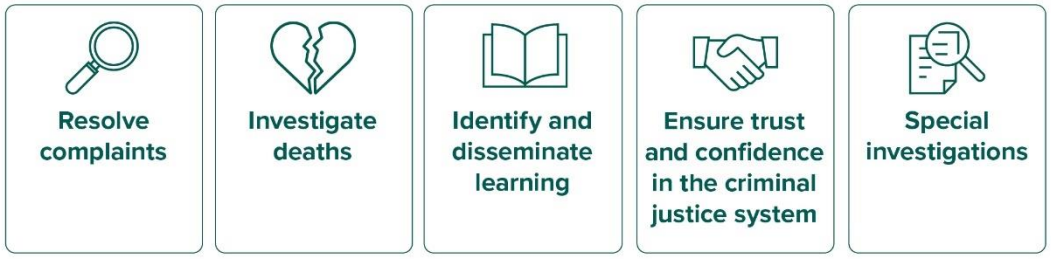
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100

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

Summary

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. Mr Christopher Walton died in hospital on 6 February 2025, following a heart attack nine days earlier at HMP Ranby. He was 67 years old. We offer our condolences to his family and friends.

4. The clinical reviewer concluded that the clinical care Mr Walton received at Ranby was not equivalent to that which he could have expected to receive in the community. He found that there were multiple missed opportunities to respond to Mr Walton's deteriorating health and that symptoms consistent with serious cardiovascular disease went unnoticed by healthcare staff. Despite clear signs of decline, Mr Walton was not reviewed by qualified staff when concerns were raised, and care plans were inadequate and not followed. After Mr Walton's death, it became apparent that he had not been taking his medication for at least three weeks.

5. Mr Walton's family told us that they raised concerns about Mr Walton's health in five voicemails left on the safer custody at-risk line (one on 18 January, two on 19 January and two on 26 January). All voicemails should be recorded in the at-risk line log, along with the action taken, before being deleted. We know that staff listened to the 18 and 19 January voicemails and a welfare check was carried out on 19 January. However, the 18 January voicemail was not recorded in the at-risk line log.

6. There are no voicemails about Mr Walton recorded in the at-risk line log on 26 January. Given we know that not all voicemail messages were being recorded in the log, we consider that voicemails were left by the family on 26 January which were not recorded or actioned by prison staff. We are not satisfied that the prison has a robust process in place to ensure that voicemail messages are actioned appropriately nor that there is an effective quality assurance process in place. We also consider that the message provided to callers to the at-risk line needs to be clearer about what they can expect.

Recommendations

- 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.

- 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.
    - A medical review to be triggered if a prisoner is not taking their medications to investigate why this might be the case.
- 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, and.
    - Reviews of mobility and monitoring for signs of weight loss.
- The Head of Healthcare should develop a workforce strategy to address chronic understaffing as a matter of urgency.
- 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
    - Implementing an audited log of calls to ensure the system is being used appropriately.
- 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, and
    - At least one nurse trained in advanced clinical assessment skills during all day shifts within one year and that nurses should be trained to this level before answering Urgent Assessment calls.
- 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, and
    .
    - 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.

The Investigation Process

7. HMPPS notified us of Mr Walton's death on 6 February 2025.

8. NHS England commissioned an independent clinical reviewer to review Mr Walton's clinical care at HMP Ranby.

9. The PPO investigator investigated the non-clinical issues relating to Mr Walton's care. She interviewed 11 members of staff from Ranby with the clinical reviewer on 15 April.

10. The Ombudsman's office wrote to Mr Walton's wife to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Walton's family said that Mr Walton was unwell during their visits on 18 January and 26 January, and they had raised concerns with staff at Ranby and left voicemails on the at-risk line. They asked what medical assessments were carried out and what actions staff took to address their concerns. They also asked how Mr Walton's medication and diet was monitored, and whether signs of a possible heart attack were missed. We have addressed these concerns in our report and in a separate letter.

11. We shared our initial report with HMPPS and the prison's healthcare provider, Northamptonshire Healthcare NHS Foundation Trust. They found no factual inaccuracies. HMPPS and Northamptonshire Healthcare NHS Foundation Trust provided an action plan which is annexed to this report.

12. We sent a copy of our initial report to Mr Walton's wife. She did not notify us of any factual inaccuracies.

Previous deaths at HMP Ranby

13. Mr Walton was the fifth prisoner to die at Ranby since February 2022. Of the previous deaths, two were self-inflicted, one was drug related, and one was from unknown causes. There are no similarities between the findings in our investigation into Mr Walton's death and the findings from our investigations into the previous deaths. Up to the end of September 2025, there have been four further deaths. Two of these were from natural causes and two were drug related.

Key Events

14. On 1 August 2024, Mr Christopher Walton was sentenced to five years in prison for fraud. On 13 August, he was moved to HMP Ranby.

15. Before arriving in custody, Mr Walton had a history of stroke and high blood pressure. While at Ranby, he took medication for both conditions, which he kept in his cell.

16. On 18 January 2025, Mr Walton's family visited him and told an officer at the visit that he seemed unwell. At the end of the visit, the officer took Mr Walton back to the wing and told the wing officer that they were concerned he may have had a stroke.

17. The officer radioed a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties that alerts healthcare staff to attend and the control room to call an ambulance). Two nurses arrived at Mr Walton's cell and found him sitting on his bed, talking in full sentences. They took his clinical observations and calculated a NEWS2 score of zero. (The National Early Warning Score (NEWS2) is a tool used to assess clinical deterioration. A score is calculated from the clinical observations taken and the higher the score, the higher the risk. A score of zero is low risk.) Mr Walton said he had felt tired over the past week but otherwise felt well. The nurses checked for sings of a stroke by asking him to raise his arms and grip with both hands but found no issues. They cancelled the ambulance as they considered he did not need hospital treatment at the time. One nurse noted that he had hypertension (high blood pressure) and blood tests were booked for Monday (20 January).

18. Later that day, an officer recorded in Mr Walton's prison record that a family member had left a voicemail on the at-risk line (a phone number that members of the public can leave a voicemail on to raise concerns about a prisoner) raising concerns about his health. The officer noted that they phoned the family member back, but they did not answer. They did not record the voicemail in the at-risk log. There is no evidence that a welfare check was carried out for Mr Walton in response to the voicemail, or that this concern was passed on to healthcare staff.

19. On 19 January, an officer listened to the at-risk line voicemail and logged that there were two calls from Mr Walton's family raising concerns about his health and that he had not been in contact. The officer asked an officer on the wing to carry out a welfare check on Mr Walton. The wing officer noted that he spoke to Mr Walton in his cell and asked how he was feeling, Mr Walton said he was okay and that he would contact his family to let them know.

20. On 20 January, Mr Walton's cellmate told the wing officer that he was concerned about Mr Walton as he was 'hallucinating and a bit off his feet'. The officer called the healthcare unit and asked for someone to see Mr Walton.

21. Later that day, a healthcare assistant saw Mr Walton in his cell and took his clinical observations and recorded that these were within normal range. They requested a urine sample and left the bottle with Mr Walton to collect a sample.

22. Later that evening, the evening wing officer contacted the healthcare unit as Mr Walton was still unwell. The officer spoke with a nurse who asked for the urine

sample to be brought up to the healthcare unit. The wing officer delivered the sample. Mr Walton was not seen by healthcare staff that evening.

23. On 24 January, Mr Walton's urine sample result showed elevated creatinine and albumin levels (possible sign of poor kidney function). A review of this by a doctor was advised. The test results were not reviewed by a doctor until after Mr Walton's death.

24. On 26 January, Mr Walton's family visited him again. They told the investigator that they again raised concerns about Mr Walton's health with prison staff at the visit and later left voicemails on the at-risk line saying Mr Walton had been experiencing chest pain. The custodial manager who oversees visits at Ranby told us that it was rare for families to raise health concerns during a visit and if they did, staff would advise the prisoner to make an application to see healthcare staff. Ranby has no record of any voicemails from Mr Walton's family on the at-risk line log for 26 January. The voicemails are not stored.

25. Mr Walton was not seen again by healthcare staff until 28 January.

Events on 28 January

26. On 28 January, at around 3.00pm, Mr Walton's cellmate told the wing officer that Mr Walton was looking very unwell. The officer phoned the healthcare unit and spoke to a nurse and asked for him to be assessed as soon as possible. The nurse advised that an appointment would be made for Mr Walton to be seen the following day. The officer told the investigator that he was concerned about Mr Walton and was considering calling a code blue, even if not required, as he wanted healthcare staff to see Mr Walton.

27. After the phone call ended, the officer returned to Mr Walton's cell and found him lying on his back and struggling to breathe. The officer radioed a code blue and put Mr Walton in the recovery position.

28. When healthcare staff arrived, they confirmed cardiac arrest and started CPR. They attached a defibrillator, which delivered a shock, and resuscitation efforts continued until Mr Walton began to show signs of Return of Spontaneous Circulation (ROSC).

29. Mr Walton was taken to hospital where he underwent treatment for a heart attack and was admitted to the intensive care unit. However, Mr Walton's condition deteriorated and he died in hospital nine days later, on 6 February.

30. After Mr Walton's death, staff at Ranby found medication in his room which suggested he had not been taking his medication as prescribed.

Post-mortem report

31. The post-mortem report concluded that Mr Walton died of acute cardiac failure (heart failure) caused by myocardial infarction (heart attack) and aortic stenosis (narrowing of the arteries).

32. At the inquest, held on 7 May 2025, the Coroner concluded that Mr Walton died of natural causes.

Findings

Clinical findings

33. The clinical reviewer concluded that the care Mr Walton received at Ranby was not of the required standard and therefore not equivalent to that which he could have expected to receive in the community.

34. The clinical reviewer found that the clinical assessment of Mr Walton on 18 January was not consistent with his condition as described by prison staff, prisoners, and family members. Despite officers contacting healthcare staff twice on 20 January, Mr Walton was not assessed by a qualified member of staff.

35. The clinical reviewer also found that the in-possession medication process and older persons care plan were not sufficient. Mr Walton was in possession of his medication for high blood pressure and to reduce the risk of heart attack and stroke. After Mr Walton's death, a week's worth of medication was found in his cell. Mr Walton had not collected his medication from the pharmacy since the end of November, which meant he had not taken at least three weeks' worth of his medication.

36. We recommend:

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.

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.**
- **A medical review to be triggered if a prisoner is not taking their medications to investigate why this might be the case.**

The Head of Healthcare should rewrite the older person care plan to include:

- **Regular reviews by healthcare staff to monitor for signs of physical and mental deterioration.**
- **Reviews of mobility and monitoring for signs of weight loss.**

37. The clinical reviewer found that the healthcare service at Ranby was impacted by staff shortages and an over reliance on agency staff, along with a high volume of 'code blue' calls. Although Ranby operates a nurse-led healthcare service, none of the nurses had training in advanced clinical assessment skills. We recommend:

The Head of Healthcare should develop a workforce strategy to address chronic understaffing as a matter of urgency.

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**

- **implementing an audited log of calls to ensure the system is being used appropriately.**

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 during all day shifts within one year and that nurses should be trained to this level before answering Urgent Assessment calls.**

Good practice

38. The clinical reviewer noted that the immediate use of CPR and the use of a defibrillator were likely to have been key factors in managing to achieve a return of spontaneous circulation (ROSC – resumption of a sustained heart rhythm) following Mr Walton's cardiac arrest. He commended the swift actions of prison officers and healthcare staff.

At-risk line

39. The at-risk line is a dedicated phone number that members of the public can use to leave a voicemail when concerned about a prisoner at Ranby. The line is checked four times in a 24-hour period (once in the morning, afternoon, evening and night) by the orderly officer (the senior officer in charge) and all voicemails should be logged on the at-risk line log. Once the voicemails have been listened to, they are deleted.

40. On 18 January, Mr Walton's family left a voicemail on the at-risk line expressing concerns about Mr Walton's health. We know that the prison listened to this voicemail as an officer noted on Mr Walton's electronic prison record that he had tried to call the family back but got no answer. However, there was no record of this voicemail on the at-risk line log. Also, there is no evidence that the officer carried out any further action in response to the voicemail, such as a welfare check or forwarding the concerns to healthcare staff.

41. Mr Walton's family told the investigator that they left another two voicemails on 26 January, after Mr Walton had complained of pain in his arms and chest at a visit that morning.

42. There is no record on the at-risk line log of any voicemails regarding Mr Walton on 26 January. We know that not all voicemails are recorded in the at-risk line log as evidenced above. Based on the evidence we have, we consider that Mr Walton's family left voicemails on 26 January which the prison failed to record or action.

43. The investigator interviewed the Head of Safety at Ranby who said the at-risk line system relies on orderly officers listening to messages, logging them accurately and taking the appropriate action. As the orderly officer deletes the voicemail once they have actioned it, there is no way to verify whether a message was received or acted upon, unless it was logged. The Head of Safety said that it was not usual practice for the orderly officer to return a call and so families would not receive an acknowledgement that their voicemail had been heard. He acknowledged that a 24-hour live service would be the ideal but resources did not permit. He said there was also an email service that people could use to raise concerns, details of which were on the prison portal, which provided a clearer audit trail.

44. When asked if there was a quality assurance process in place to check that voicemails were being logged and handled correctly, the Head of Safety said that there were quarterly test calls from regional staff. The regional staff member would leave a message requesting a callback and when the orderly officer returned the call, the response time was recorded.

45. The investigator made a test call to Ranby's at-risk line. The recorded message does not tell the caller how often messages are checked, and it does not tell them that they will not receive a call back. There is no mention of the email service and no alternative contact method or signposting should the caller have an urgent safeguarding concern.

46. Our investigation has shown that not all calls made to the at-risk line are being logged. The current quality assurance process is ineffective in establishing whether orderly officers are listening to, logging and actioning voicemails. All it establishes is that orderly officers will return a call made by regional prison staff. This requires urgent review. We recommend:

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.**

- **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.**

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

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Third Floor, 10 South Colonnade
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