

# Action Plan in response to the PPO Report into the death of Mr Raymond Connor on 22 February 2025 at HMP Whatton

Rec No	Recommendation	Accepted / Not accepted	Response Action Taken / Planned	Responsible Owner and Organisation	Target Date
1	The Head of Healthcare should carry out an investigation into why Mr Connor's rising PSA level was not acted upon between August and November 2024.	Accepted	<p>A Complex Case Review took place following the death of Mr Connor to focus on good levels of care and areas requiring some improvement. It was identified that during the period (August 24 to November 24), there were significant changes to the GP provision and Locum support was utilised. The current GP and ANP team are now substantive and are in agreement that they will case manage patients with complex health problems; ensuring results (including PSA bloods) are forwarded to them to review. Amendments have also been made to the Multi-Professional Complex Case Conference to include a list of patients with a cancer diagnosis or a significant long-term condition in order for treatment plans and results to be reviewed and actioned.</p> <p>The Head of Healthcare has also made major changes to ledgers; where GPs now see face to</p>	Head of Healthcare Practice Plus Group	Completed

			face patients in the morning and afternoons are blocked for 2 x emergency patients, CSU rounds, Meeting attendance and administrative tasks (Bloods, urine screen, ECG, hospital letters, prescribing etc).		
2	The Head of Healthcare should ensure that there is an effective recall system for patients receiving regular injections such as Prostop.	Accepted	Investigations into the delays in the patient receiving the Prostop injection identified a level of human error, where the injection was given but no recall or follow up appointment was made. This has since been addressed. The staff member concerned no longer works as part of the team. Clinical staff have also received training to ensure after all long acting treatments (including Prostop injections, patches); a recall appointment is made and a task is sent to Pharmacy to order the correct medications. Recalls are subject to monthly management checks and patients, receiving such medications, are listed and discussed at bi-monthly Multi-Professional Complex Case Conference's to monitor compliance.	Head of Healthcare Practice Plus Group	Completed