

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ryan Flanagan, a prisoner at HMP Chelmsford, on 23 March 2021

A report by the Prisons and Probation Ombudsman

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



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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.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Ryan Flanagan died on 23 March 2021 in Broomfield Hospital, having been found unresponsive in his cell at HMP Chelmsford on 17 March. He had suffered heart failure, which caused brain damage. Mr Flanagan was 37 years old. I offer my condolences to Mr Flanagan's family and friends. Our investigation was suspended during police investigations, and I apologise for the delay in issuing our report.

Mr Flanagan was awaiting an operation on his back, but otherwise had not complained of any health issues. On 17 March, he did a workout in his cell with no apparent problems. Later that evening he had to interrupt a telephone call to his parents as he had chest pain. Shortly afterwards, his cellmate found him on the cell floor. Staff, then paramedics, provided first aid and transferred Mr Flanagan to hospital. He did not regain consciousness.

We are concerned that there appears to have been a delay in using an emergency response code, an issue we have raised with Chelmsford before, as well as a delay going into Mr Flanagan's cell. We are also concerned that Mr Flanagan's family were informed that he had gone to hospital by another prisoner and had to confirm this themselves with the prison. The Governor should address problems with the prison's CCTV system and ensure that effective action is being taken to prevent prisoners having access to mobile telephones.

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

Kimberley Bingham
Acting Prisons and Probation Ombudsman

November 2022

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Summary

Events

1. On 18 January 2020, Mr Ryan Flanagan was remanded to HMP Chelmsford. At a reception health screening, he reported a compressed disc in his lower back, for which he sometimes took painkillers and was awaiting a date for an operation. At a secondary health screening, he said that he had previously stayed in a psychiatric hospital.
2. Mr Flanagan said that his medication for his back pain was not strong enough, so at the end of January, the doctor prescribed a stronger painkiller. In February, he said that pain relief was still not strong enough, and the doctor prescribed pain relief cream.
3. In July, Mr Flanagan asked to see the mental health team, complaining about lockdown restrictions. Staff gave him in-cell activity packs and reiterated the support available. In August, Mr Flanagan complained again about back pain. Staff chased up the anticipated operation on his compressed disc. At a medication review in December, a doctor prescribed Mr Flanagan pregabalin (a drug to combat pain from nerve damage). In February and March 2021, staff found drug paraphernalia and a mobile phone in the cell Mr Flanagan shared.
4. On the evening of 17 March, Mr Flanagan did a workout in his cell, washed, ate, and then telephoned his parents using a mobile phone. He ended the call prematurely, complaining of pain in his chest. At approximately 8.30pm, his cellmate noticed that Mr Flanagan was lying unresponsive on the cell floor. He shouted for help, which alerted other prisoners who also tried to attract attention. A prison officer went to the cell and called for further assistance. Other staff arrived, went into the cell, and attempted to revive Mr Flanagan. Joined by medical staff they continued until ambulance paramedics arrived and took over. They transferred Mr Flanagan to hospital.
5. Mr Flanagan remained in a coma. His condition did not improve, and following discussion between doctors and his family, the decision was taken to switch off life support. Mr Flanagan died at 12:45am on 23 March.

Findings

Mr Flanagan's healthcare

6. Until he collapsed, there were no indications that Mr Flanagan was in ill-health. There was a suggestion that two days before Mr Flanagan collapsed, he mentioned chest pain to another prisoner. On the evening he collapsed, he had to interrupt a telephone call to his parents. There is no record of him reporting these incidents and staff could not have anticipated what happened.
7. During his time in Chelmsford, Mr Flanagan had frequent interaction with healthcare services about his back pain. There were no other concerns about Mr Flanagan's physical or mental healthcare. The clinical reviewer concluded that Mr Flanagan's

healthcare was equivalent to that he could have expected to receive in the community.

Substance misuse

8. Mr Flanagan had a history of substance misuse, but on arrival in prison said he had no current issues. While there was some intelligence about Mr Flanagan's possible involvement in the drug trade in Chelmsford, there was no evidence of him actually taking any illicit substances. Post-mortem reports did not make any significant findings on drugs and concluded that they did not contribute to his death. We are also concerned that Mr Flanagan was in possession of a mobile phone on more than one occasion while in prison.

Emergency response

9. When a prison officer went to Mr Flanagan's cell, he made a dynamic risk assessment and decided he did not feel safe to enter until assistance arrived. This seems a reasonable decision in the circumstances, but we are concerned that staff were not clear on the policy for entering cells.
10. The first prison officer to arrive at Mr Flanagan's cell said that he radioed an emergency code. The electronic evidence provided to us did not bear this out, and we cannot be confident that such a message was transmitted. We have raised this issue with Chelmsford before. The CCTV footage was of too poor a quality to clearly see whether this caused a delay in assistance reaching Mr Flanagan.

Liaison with Mr Flanagan's family

11. When Mr Flanagan went to hospital, another prisoner telephoned his parents to tell them before the prison family liaison officer made contact.

Recommendations

- The Governor should review the local security strategy and ensure that everything possible is being done to prevent mobile phones entering the prison.
- The Governor should ensure that all prison staff are made aware of, and understand, their responsibilities during medical emergencies, including that staff:
 - understand and use the appropriate emergency code when they discover a medical emergency;
 - are clear when they may unlock cell doors; and
 - enter cells as quickly as possible in life-threatening situations where it is safe to do so.
- The Governor should ensure that CCTV cameras are properly maintained and fit for purpose.
- The Governor should ensure that an appropriate member of staff, preferably a designated family liaison officer, contacts a prisoner's family to notify them immediately when a prisoner is seriously unwell.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Chelmsford informing them of the investigation and asking anyone with relevant information to contact him. He obtained copies of relevant extracts from Mr Flanagan's prison and medical records. He liaised with officers from Essex Police investigating Mr Flanagan's death and had access to notes of police interviews.
13. The investigator interviewed one member of staff and one prisoner at Chelmsford. NHS England commissioned a clinical reviewer to review Mr Flanagan's clinical care at the prison.
14. We informed HM Coroner for Essex of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
15. One of the Ombudsman's family liaison officers contacted Mr Flanagan's father, to explain the investigation and to ask if he had any matters he wanted the investigation to consider. Mr Flanagan's father asked about Mr Flanagan's medical care, and about the emergency response. These issues are addressed in this report. He also asked a specific medical question, which is addressed in the clinical review.

Background Information

HMP Chelmsford

16. HMP Chelmsford is a local prison that takes prisoners directly from the courts. It holds 750 men. The Castle Rock Group is commissioned to provide 24-hour healthcare, which includes a range of primary care and secondary mental health services. The prison has a 12-bed inpatient unit.

HM Inspectorate of Prisons

17. HM Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Chelmsford in May and June 2018. Inspectors found that safety was poor and noted several areas of significant concern. The Chief Inspector of Prisons considered invoking the Urgent Notification (UN) protocol (which alerts the Secretary of State that immediate action to rectify problems is required). However, a new Governor was in post and Chelmsford had been put under special measures by HM Prison and Probation Service (HMPPS), which meant that HMPPS had identified Chelmsford as needing additional, specialist support to improve its performance. He therefore did not issue a UN.
18. The most recent inspection of HMP Chelmsford was an unannounced inspection in August 2021. Inspectors found that serious concerns remained, and the Chief Inspector of Prisons invoked the Urgent Notification protocol. There were concerns over safety, purposeful activity, rehabilitation, and respect. There were issues around the use of emergency codes. Inspectors found that times answering cell bells were too long with inadequate oversight of response times.

Independent Monitoring Board

19. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to August 2021, the IMB reported that the withdrawing of mandatory drug testing during the COVID-19 pandemic meant that there was no reliable data on drug use in the prison. Intelligence reports indicated that illegal drugs were readily available.

Previous deaths at HMP Chelmsford

20. Mr Flanagan was the ninth prisoner at Chelmsford to die since the beginning of 2019. Two of the previous deaths were due to natural causes and one was due to drug use. The others were self-inflicted. We have made recommendations in previous cases about delays in calling a medical emergency code. There has since been a further self-inflicted death at Chelmsford.

Key Events

21. On 18 January 2020, Mr Ryan Flanagan was remanded to HMP Chelmsford on charges of conspiracy to commit burglary. At a reception health screening, he told the nurse that he suffered from a compressed disc in his lower back, for which he sometimes took painkillers. He was awaiting a date for an operation. Otherwise, he said he had no physical or mental health problems. A doctor prescribed him paracetamol and naproxen (medication that reduces inflammation).
22. On 20 January, Mr Flanagan had a secondary health screening. He said that he had previously stayed in a psychiatric hospital (Mr Flanagan had been diagnosed with schizophrenic disorders in 2007 but the medical record contains no further information). In 2017, he had a history of mental and behavioural disorders due to substance misuse.
23. On 26 January, Mr Flanagan said that his medication for his back pain was not strong enough. On 29 January, the doctor prescribed co-codamol (a combination of paracetamol and codeine, a stronger painkiller than paracetamol alone). In February, he told a healthcare assistant that he still felt that his pain relief was not strong enough. She referred Mr Flanagan to the doctor, who prescribed algesal cream (pain relief applied to muscle and joint pain). After a court appearance in March, Mr Flanagan again complained of back pain.
24. Mr Flanagan received two warnings for not attending work. In April, he was involved in a fight with another prisoner and spent some time in the segregation unit. He was caught using a mobile phone, which he handed to officers. Intelligence reports indicated suspicion that Mr Flanagan was involved in the trade in illicit drugs in the prison. He was suspected of having further access to a mobile telephone.
25. In July, Mr Flanagan asked to see the mental health team. He said he was bored during lockdown restrictions and was unhappy with how a manager had treated a clothing issue he had raised. A healthcare support worker encouraged him to remain occupied, gave him in-cell activity packs, and detailed the support that was available to him.
26. In August, Mr Flanagan complained to the prison doctor about his back pain but declined any further pain relief. A new referral was made to chase up his anticipated operation on his compressed disc.
27. Mr Flanagan suffered pain from a cracked tooth and, in December, had the tooth extracted. That month, a doctor reviewed Mr Flanagan's medication, and prescribed pregabalin (a drug used to treat pain caused by nerve damage). The same month, Mr Flanagan was involved in a fight with another prisoner. Intelligence indicated that this might have been in relation to a debt relating to the trade in illicit substances.
28. On 8 January 2021, Mr Flanagan tested positive for COVID-19. His medical records do not contain any further information. In interview, his cellmate, who also tested positive, said that after feeling unwell for about a week they seemed to return to normality. Mr Flanagan returned to his work as a cleaner.
29. On 11 February, intelligence reports showed that staff found a bag with a green substance and cigarette papers in the cell. The cellmate said that they were his. On

10 March, a further report shows that staff found a mobile phone and a quantity of needles in the cell. Mr Flanagan admitted ownership. Staff confiscated these, and Mr Flanagan said that the needles had been in his possession for some time, and he had forgotten about them. He was placed on report (to face a disciplinary charge).

30. A note on Mr Flanagan's medical record showed that on 24 February, he was notified of a pain management appointment at Broomfield Hospital for 18 March. On 5 March, Mr Flanagan told a nurse that he was concerned that he might be transferred to a different prison before he had had his back operation. The nurse told him that the healthcare department could put a medical hold on any transfers if an operation was scheduled.
31. On 16 March, a nurse saw Mr Flanagan about his back pain. The nurse recorded that the pregabalin he was currently prescribed was insufficient pain management and recommended that this be supplemented with paracetamol.
32. On 17 March, the cellmate returned to their cell at approximately 4.00pm, and Mr Flanagan at around 5.00pm. Around 6.15pm, Mr Flanagan began a physical training session in the cell. The cellmate said that he did not appear to suffer any difficulties while doing so. After washing and eating, Mr Flanagan watched television. Mr Flanagan's father told the investigator that at 8.13pm, he telephoned his parents (using a mobile phone). After a few minutes' conversation, he said that he had pain in his chest and would have to end the call and call back later.
33. Shortly before 8.30pm, the cellmate noticed that Mr Flanagan was lying on the cell floor. He sometimes did so to stretch his back, but usually lying face up, whereas on this occasion he was on his front. The cellmate asked if he was okay, and Mr Flanagan did not respond. He went to him, and Mr Flanagan had gone red. He began to shout and call for help. He turned Mr Flanagan onto his side. Mr Flanagan had a pulse but did not appear to be breathing. He pressed his cell bell, shouted, and kicked the door. This alerted other prisoners, who also shouted, and some pressed their cell bells.
34. An Operational Support Grade (OSG) said in her police statement that she and a prison officer were compiling the numbers to submit a roll check when they heard a cell bell activated. They continued their assessment, but after approximately two minutes the officer said that he needed to respond to the cell bell. The officer said that he heard noise and was directed by other prisoners to Mr Flanagan's cell. He looked through the observation panel and could see Mr Flanagan on the floor and the cellmate shouting. The officer said that he called a code blue (an emergency code which indicates a prisoner is not breathing or is having difficulty breathing). Radio traffic recordings do not contain this message. In her police statement, the OSG said that the officer called to her within 30 seconds of going to answer the cell bell.
35. The officer said in interview that he did not know either prisoner, and made a dynamic risk assessment that it was not safe for him to enter the cell at that stage. The OSG joined him and used her radio to call a code blue emergency. This was at 8.24pm. This prompted the control room to call an ambulance. The control room log does not record what time an ambulance was requested; Ambulance Service records showed that the call was received at 8.26pm. The officer, who is first aid

trained, used his radio to reiterate that medical staff were needed. Another officer arrived at the cell approximately two minutes after the OSG. She thought that the protocol was that three prison officers (not including OSGs) should be present to unlock a cell with two prisoners, but decided that in the circumstances they should enter the cell. As she was radioing for permission to open the door, she saw another prison officer arriving on the landing so unlocked the door. They went into the cell, asked the cellmate to leave, and began to perform cardiopulmonary resuscitation (CPR). The radio recordings indicate that the officer said that they were entering the cell two minutes from the OSG making the code blue call.

36. A nurse had responded to the emergency call, and the prison log showed that he arrived at the cell two minutes after the prison officers went into the cell. He could not detect a pulse nor any sign that Mr Flanagan was breathing. They applied a defibrillator (a machine that monitors and, in some circumstances, can restart the heart). He and the officers continued to attempt to revive Mr Flanagan until the ambulance crew arrived and took over. Having detected a pulse, they transferred him to the ambulance and on to Broomfield Hospital. Mr Flanagan was put into an induced coma in the High Dependency Unit.
37. At approximately 10.00pm, a prisoner telephoned Mr Flanagan's parents, telling them what had happened. They contacted the prison and, having been told where Mr Flanagan was, subsequently travelled to the hospital.
38. Mr Flanagan remained in a coma. His condition did not improve, and following discussion between doctors and his family, the decision was taken to switch off life support. Mr Flanagan died at 12:45am on 23 March. His family were with him.

Contact with Mr Flanagan's family

39. On the morning of 18 March, Chelmsford appointed a family liaison officer, who contacted Mr Flanagan's father. In line with Prison Service guidance, Chelmsford offered a contribution to the costs of Mr Flanagan's funeral.

Support for prisoners and staff

40. After Mr Flanagan's death the duty governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
41. The prison posted notices informing other prisoners of Mr Flanagan's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Flanagan's death.

Information after Mr Flanagan's death

42. When staff searched Mr Flanagan's cell after he had died, a vape found in the cell was found to contain traces of tetrahydrocannabinol (the main psychoactive component of cannabis). They also found a mobile phone, which was handed to the police. It is not possible to determine whether these belonged to Mr Flanagan or his cellmate.

43. Intelligence reports after Mr Flanagan had gone to hospital recorded that prisoners told staff that Mr Flanagan had been using steroids in prison.

Post-mortem report

44. Post-mortem tests showed that Mr Flanagan died from hypoxic brain injury, further to cardiorespiratory arrest and dilated cardiomyopathy. His brain had been starved of oxygen after his heart failed due to underlying heart disease. There were no traces of psychoactive substances in his system. There were traces of fentanyl, midazolam and pregabalin. The first two are used in intensive care for pain relief and sedation, and Mr Flanagan had been prescribed pregabalin. The pathologist said that “there were no significant findings on toxicology”. Steroids were not tested for post-mortem.

Findings

Mr Flanagan's healthcare

45. During his time in Chelmsford, Mr Flanagan had frequent interaction with healthcare services about his back pain. The only other issues he raised were some gastric problems early in his time there, and dental issues.
46. Until he collapsed, there were no indications that Mr Flanagan was in ill-health or at risk. Some needles had recently been found in his cell but there had been no evidence to suggest that he was using illicit drugs. There were no reports of him being intoxicated or appearing to be under the influence of anything.
47. His cellmate said that after Mr Flanagan died, he heard that two days before Mr Flanagan collapsed, he had mentioned chest pain to another prisoner. There is no record of him telling anybody else, and the prison were unable to identify the prisoner. He did not tell the healthcare team. On the evening he collapsed he had to interrupt a telephone call to his parents, again complaining of chest pain. Once more, there is no evidence that he sought help at that time or told a member of staff. In the circumstances, there is nothing to suggest that staff could have anticipated what happened.
48. The clinical reviewer said that there were no concerns with Mr Flanagan's physical or mental healthcare, which was equivalent to that which he could have expected in the community.

Substance misuse

49. After Mr Flanagan died, some intelligence reports suggested his involvement in drug trading. In February, there was a drug find in his cell, but his cellmate admitted ownership. In March, there were some needles found in the cell, which Mr Flanagan owned up to, but no associated drugs. When he was taken to hospital a vape found in the cell was found to contain traces of tetrahydrocannabinol (the main psychoactive component of cannabis). Post-mortem toxicology tests did not detect any traces in Mr Flanagan's system. Traces of fentanyl, midazolam and pregabalin were detected. Mr Flanagan had been prescribed pregabalin. Both fentanyl and midazolam are used to sedate patients in intensive care and could have been administered in hospital. The pathologist noted that the toxicological findings were not significant and did not contribute to his death.
50. Mr Flanagan had a history of substance misuse. On arrival at Chelmsford, he did not disclose any current substance misuse issues, so was not referred to the substance misuse team. Although there was some intelligence to suggest that Mr Flanagan might have been involved in the drug trade in Chelmsford, there was no actual evidence of this. Nor was there any evidence of his taking any illicit substances himself.
51. We are also aware that intelligence reports indicated that Mr Flanagan used steroids. While there is some research to suggest a link between steroid use and heart problems, there was no actual evidence of Mr Flanagan using them. Post-

mortem blood tests would not detect the presence of steroids, so we are unable to comment further.

Mobile telephones

52. We are concerned that Mr Flanagan was found in possession of a mobile phone in April 2020, one was found in his cell in March 2021, and one was found in his cell after he died. There were further intelligence reports that indicated that he was suspected of having access to one. When he was taken to hospital, another prisoner telephoned Mr Flanagan's parents on a mobile phone. We are concerned with the apparent ease with which prisoners seem able to access mobile phones, which are often used by prisoners who are organising illicit items coming into prison. We make the following recommendation:

The Governor should review the local security strategy and ensure that everything possible is being done to prevent mobile phones entering the prison.

Emergency response

Cell bells

53. The purpose of emergency cell bells is to enable prisoners to contact staff quickly in an emergency. All emergency cell bells should be answered as quickly as possible and not longer than five minutes from the time that the emergency bell is activated. HMIP noted in their latest inspection of Chelmsford that there were delays in answering cell bells.
54. Mr Flanagan's cellmate said that he pressed his cell bell to attract staff attention. The OSG said in her police statement that she and the officer heard a cell bell, but attempted to finish a task they were involved in before the officer said that he needed to leave to respond to the cell bell. She said this was approximately two minutes. The timings of the cell bell records do not appear to be accurate (they were not reset when the clocks changed for British Summer Time). But from the records it seems that the officer arrived at the cell and answered the cell bell within three minutes of it being pressed.

Emergency response codes

55. Prison Service Instruction (PSI) 3/2013, *Medical Emergency Response Codes*, requires Governors to have a two-code medical emergency response system. As is usual, Chelmsford use code blue to indicate an emergency when a prisoner is unconscious, or having breathing difficulties, and code red when a prisoner is bleeding. Calling an emergency code should automatically trigger the control room to call an ambulance and should alert healthcare staff to attend with the appropriate equipment.
56. The officer said that, on arriving at Mr Flanagan's cell, he called a code blue emergency. The recordings of the radio traffic provided did not include this message, the first reference being a radio message from the OSG. It is possible

that he shouted the code but did not use the radio. The control room log showed that the OSG used the code at 8.24pm, and the Ambulance Service records showed that the request for an ambulance was received at 8.26pm.

57. The landing was covered by CCTV cameras, but the quality of the recordings provided was too poor to clearly see the sequence of events. The officer and the OSG both indicated in interview that the time between them arriving at the cell was minimal. Nevertheless, we are unable to be certain how long it was between the officer arriving at the cell and the control room calling for an ambulance. In emergency situations time can be crucial, and any delays must be kept to a minimum.
58. We have commented several times in previous reports of investigations in Chelmsford on staff failing to follow the correct emergency procedures in calling emergency codes. In response to our recommendations, Chelmsford undertook a programme of training that involved an emergency scenario exercise to reinforce staff knowledge of what to do when faced with such a situation, including correct use of radios. This began in October 2019 and was scheduled to be an annual event. We acknowledge that the officer was a new member of staff, only completing his training and starting his role less than a month before the emergency with Mr Flanagan. It is, though, disappointing that once again we are commenting on the same issue.

Entering Mr Flanagan's cell

59. When the cellmate raised the alarm, the prison was in patrol state (meaning prisoners are locked in their cells for the night and staffing may be reduced). Policy on entering cells at night is contained in Prison Service Instruction (PSI) 24/2011 *Nights Function – Management and Security of Nights*. The PSI says that night staff may unlock a cell on their own if there is or appears to be immediate danger to life. Staff must, though, perform a dynamic risk assessment and should not take action that they feel would put them in danger. Factors to consider include how many prisoners are in the cell and whether the prisoners are known to the member of staff.
60. The officer said in interview that he considered whether to go into the cell before assistance arrived. He was unable to see what was wrong with Mr Flanagan, he did not know either prisoner very well, and the cellmate was in a highly agitated state. In the circumstances, it seems reasonable that he waited for assistance.
61. When the OSG joined the officer at the cell, they did not open the door until another officer joined them. This officer said in police interview that three officers were needed to open a cell, but as she was about to radio that she and the other officer were going into the cell as an emergency, another officer came onto the wing, so she unlocked the cell.
62. PSI 24/2011 says that, aside from emergencies, "authority to unlock a cell at night must be given by the Night Orderly Officer (NOO) and no cell will be opened unless a minimum of two/three (subject to local risk assessment procedures) members of staff are present one of whom should be the NOO". Chelmsford's Prisoner Supervision and Unlocking Operating Procedure says that when F wing is in patrol

state there will be one officer on the wing, with “additional staff required before unlocking”.

63. The recorded timings for cell bells are not accurate. The CCTV footage was of poor quality and while we know in which order staff arrived, we were unable to accurately determine the time lapse between the cellmate raising the alarm and staff going into Mr Flanagan’s cell. While we do not know if the delay made any difference to the outcome for Mr Flanagan, it may do in other emergency situations.
64. It is important that staff are clear on when they can unlock a cell. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of, and understand their responsibilities during medical emergencies, including that staff:

- **understand and use the appropriate emergency code when they discover a medical emergency;**
- **are clear when they may unlock cell doors; and**
- **enter cells as quickly as possible in life-threatening situations where it is safe to do so.**

The Governor should ensure that CCTV cameras are properly maintained and fit for purpose.

Liaison with Mr Flanagan’s family

65. Prison Rule 22 states that prisons should inform the next of kin immediately if a prisoner becomes seriously ill. PSI 64/2011, *Managing Prisoner Safety in Custody*, says that if a prisoner suffers an unpredicted or rapid deterioration in their physical health an appropriate member of prison staff should engage with their next of kin to provide information and support. If a prisoner’s health deteriorates a family liaison officer should be appointed immediately and next of kin should be contacted.
66. When Mr Flanagan went to hospital, another prisoner telephoned his parents. They telephoned the prison, who confirmed which hospital Mr Flanagan had been taken to. The prison family liaison officer did not contact them until the following morning. Mr Flanagan was in an induced coma in the High Dependency Unit. His condition was serious. This was an unacceptable delay. Good practice would have been for a senior member of staff or family liaison officer to meet Mr Flanagan’s parents at the hospital.
67. While we appreciate the difficulties around prisoners having access to mobile telephones, we are concerned that Mr Flanagan’s family were contacted by a prisoner before an appropriate member of prison staff. We make the following recommendation:

The Governor should ensure that an appropriate member of staff, preferably a designated family liaison officer, contacts a prisoner’s family to notify them immediately when a prisoner is seriously unwell.

Inquest

68. The inquest, heard from 15 to 26 April 2024, concluded that Mr Flanagan died from natural causes with the following narratives:
- The culture in Chelmsford prison around answering cell bells was not sufficiently prioritised. This led to a delay which could have possibly contributed to death.
 - The culture in Chelmsford prison around entering cells in emergency situations and code blue alerts and inadequacies in training for entering cells. This led to further delays to the start of resuscitation. This possibly contributed to his death.

**Prisons &
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