

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stephen Quinnell a prisoner at HMP Northumberland on 4 November 2016

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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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 Stephen Quinnell was found hanged in his cell on 4 November 2016 at HMP Northumberland. Mr Quinnell was 35 years old. I offer my condolences to Mr Quinnell's family and friends.

Mr Quinnell had a history of self-harm and suicide attempts. He had been subject to the prison's suicide and self-harm monitoring procedures on six occasions, although he was not subject to monitoring at the time of his death. While I acknowledge the efforts made by staff to support Mr Quinnell, I am concerned that his risk of suicide and self-harm was not always properly assessed and managed, particularly the risk associated with the further charges he faced and his impending court appearance, about which he had repeatedly expressed anxiety. I am also concerned that staff placed insufficient weight on concerns raised by Mr Quinnell's next of kin when assessing his risk of suicide.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

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Summary

Events

1. Mr Stephen Quinnell was sentenced on 22 July 2014 to four years in prison for sexual offences. He moved to HMP Durham initially and then to HMP Northumberland on 8 August 2014.
2. Mr Quinnell was a vulnerable and anxious man, who arrived in prison with a history of attempted suicide and self-harm. Mr Quinnell's next of kin, a close friend, frequently told the prison he was concerned about Mr Quinnell's mental health and suicidal thoughts. Mr Quinnell was subject to suicide and self-harm prevention monitoring (ACCT procedures) on six occasions, but was not subject to monitoring at the time he died.
3. Mr Quinnell was reluctant to join a sex offenders treatment programme (SOTP) because he was concerned that it would bring back distressing memories of the sexual abuse he had suffered as a child. He was aware that he was unlikely to qualify for parole unless he completed this course, which was a source of anxiety for him.
4. There was anecdotal evidence from a prisoner that Mr Quinnell had been bullied at Northumberland because he had accumulated drug debts. Mr Quinnell's toxicology report showed that he had taken an opiate drug before he died, but had not taken his prescribed antidepressants.
5. Mr Quinnell was due to appear in court on the day he died, in connection with further charges. He was anxious about the court appearance and he was particularly concerned that he might have to return to Durham.
6. During a routine check early on 4 November 2016, Mr Quinnell was found hanged in his cell. Staff did not try to resuscitate him as it was clear he had died. He was pronounced dead at 6.25am.

Findings

7. The investigation found that the prison did not properly assess and manage Mr Quinnell's risk of suicide and self-harm, particularly in light of the anxiety he had expressed about the further charges he was facing and his forthcoming court appearance. Staff placed too much reliance on Mr Quinnell's own assertions that he was not intending to self-harm, rather than evaluating the risk factors present, including the concerns expressed about Mr Quinnell's state of mind by his next of kin. Information about Mr Quinnell's court appearance was not shared with his personal officer and there was no evidence that staff had spoken to Mr Quinnell to try to manage his anxieties surrounding this. We also identified deficiencies in the management of ACCT procedures.
8. The officer who discovered Mr Quinnell hanged in his cell said that he did not enter the cell immediately because he was alone on the houseblock and would have felt unsafe unlocking Mr Quinnell without support. While it is understandable that staff would need to risk assess a situation from both a safety

and security view before entering a cell alone, staff should not wait for assistance as a matter of course.

9. While the investigation did consider the anecdotal evidence that Mr Quinnell had been bullied as a result of drug debts, there was insufficient evidence to draw any firm conclusions about this. Despite the toxicology report showing that Mr Quinnell had taken illicit drugs before his death, there was no intelligence to indicate that he was a drug user in prison or that he was in debt. He had not reported any bullying or been supported by the prison's violence reduction policy.

Recommendations

- The Director should ensure that staff understand the procedure for identifying, managing and supporting prisoners at risk of suicide and self-harm. In particular, they should ensure that staff assess the risk of suicide and self-harm based on all available information and known risk factors and not on a prisoner's own presentation.
- The Director should ensure that staff on the houseblock, and in particular personal officers, are made aware of potential triggers for suicide and self-harm, such as further charges and forthcoming court appearances, and that they take appropriate action to manage that risk, including starting ACCT procedures where appropriate.
- The Director should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including that:
 - Case reviews are multi-disciplinary and include all relevant people involved in a prisoner's care, including mental health staff where appropriate.
 - Staff set ACCT caremap actions designed to reduce the prisoner's risk of suicide and self-harm, review them at each case review and complete them all before closing an ACCT.
 - Staff vary the times of ACCT checks, while remaining within set observation periods, to avoid prisoners being able to predict when they will be checked.
- The Director should ensure that all staff understand the importance of entering a cell without delay when a prisoner's life is at risk, when it is safe to do so.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Northumberland informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
11. The investigator colleague visited Northumberland on 11 November 2016, and obtained copies of relevant extracts from Mr Quinnell's prison and medical records.
12. NHS England commissioned a clinical reviewer to review Mr Quinnell's clinical care at the prison. She interviewed 13 members of staff at Northumberland on 13 and 14 December 2016. She jointly interviewed healthcare staff. One prisoner agreed to speak to the investigator, but changed his mind before his interview.
13. We informed HM Coroner for Northumberland of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
14. One of the Ombudsman's family liaison officers contacted Mr Quinnell's friend, who was his nominated next of kin, to explain the investigation and to ask if he had any matters he wanted the investigation to consider. Mr Quinnell's next of kin said that:
 - Northumberland had been aware of the possibility that Mr Quinnell might harm himself;
 - the prison knew he had borderline personality disorder but failed to assess or treat him adequately;
 - Mr Quinnell's anxiety about his court appearance on 4 November was not well managed; and
 - Mr Quinnell's bed should have been secured to the floor to prevent him using it as a ligature point.

Background Information

HMP Northumberland

15. HMP Northumberland is a private sector training prison operated by Sodexo, predominately holding prisoners from the North East. The prison holds up to 1348 men. G4S provides healthcare services.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Northumberland was in September 2014. Inspectors reported that there had been three self-inflicted deaths since their last inspection in 2012, and that previous monitoring of the implementation of the Prisons and Probation Ombudsman's recommendations into deaths had lapsed. The number of prisoners assessed as at risk of suicide or self-harm and being monitored under ACCT procedures was relatively low. Inspectors found the quality of care and mental health services was good. There were a high number of violent incidents and many prisoners felt unsafe. Inspectors noted that the management and monitoring of bullying and violence reduction had received little attention in the months prior to their inspection.

Independent Monitoring Board

17. 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 ending 31 December 2015, the IMB reported that incidents of self-harm had risen by around 20% in comparison to 2014, although the increase was lower than that seen nationally.

Previous deaths at HMP Northumberland

18. Mr Quinnell's death was the fifth self-inflicted death we have investigated at Northumberland since 2015. We have previously identified the need for effective assessments of prisoners at risk of suicide and self-harm.

Assessment, Care in Custody and Teamwork

19. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be at irregular intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT until all the actions are completed.

Key Events

20. Mr Stephen Quinnell was convicted of sexual offences on 1 July 2014 and was sentenced to four years in prison on 22 July. He was moved to HMP Durham on 22 July 2014 and then to HMP Northumberland on 8 August 2014 and located on a vulnerable prisoners unit (VPU).
21. Mr Quinnell had a history of self-harm and suicide attempts in the community, but he denied any thoughts of suicide or self-harm upon arrival at Northumberland. A mental health nurse assessed Mr Quinnell, who had depression, and continued his prescription for antidepressants.
22. Staff started ACCT monitoring on 10 June 2015 because Mr Quinnell had found out that he might face further charges and said he had thought about killing himself. During a review the next day Mr Quinnell said he had made a stupid remark that he regretted. The ACCT was closed on 11 June.
23. Staff started ACCT monitoring again on 14 August after Mr Quinnell was selected for the Sex Offenders Treatment Programme (SOTP) and said that he would end his life if he had to do SOTP. He said that he had been sexually abused as a child and did not want to be reminded of this by listening to other prisoners talking about their offences. A nurse saw Mr Quinnell on 19 August for a mental health assessment. She noted that Mr Quinnell might have a personality disorder, had unstable moods, had poor emotional resilience and could impulsively self-harm. Staff closed the ACCT on 2 September as Mr Quinnell said that while he still had fleeting thoughts of suicide, he had no intention of acting on them. There were outstanding caremap actions at the time the ACCT was closed.
24. Mr Quinnell's offender supervisor opened another ACCT on 7 October because he had told her he had thought about killing himself. Mr Quinnell attended one case review held by officers and the ACCT was closed the next day.
25. On 9 June 2016, Mr Quinnell met with a therapist in the mental health team. Mr Quinnell said he had constant thoughts of suicide and self-harm and always had a plan, although he had not acted on these thoughts because he was scared of failing. He said he had attempted to take his life several times in the past but not recently. Mr Quinnell said he did not want to attend the SOTP because he felt listening to other prisoners' experiences would stir up memories of his own abuse and he would take his life. The therapist assessed Mr Quinnell as having a high level of anxiety. Mr Quinnell felt his antidepressants were not helping. He referred Mr Quinnell for a secondary mental health review.
26. A nurse reviewed Mr Quinnell's mental health on 10 June. Mr Quinnell reiterated his concerns about doing SOTP and asked if the mental health team would support an exemption. The nurse said this was outside of the team's remit but they would provide additional treatment for his anxiety. He assessed Mr Quinnell as at low risk of suicide.
27. Mr Quinnell met the therapist again on 29 June. Mr Quinnell said he had fleeting thoughts of suicide but denied any plan. He again asked about an exemption from the SOTP but the therapist said he could not intervene. Mr Quinnell agreed

to see the doctor to review his medication but he never did so. The therapist agreed with the nurse's assessment that Mr Quinnell was at low risk of suicide but he added him to the MIND counsellors' waiting list because he continued to ruminate about the sexual abuse. He discharged him from his team because Mr Quinnell said he would not gain anything from continuing to talk to him.

28. On 16 August, Mr Quinnell's next of kin telephoned the prison because Mr Quinnell had told him that he had thoughts of self-harm because he was going to be charged with further offences the following day. A PCO started ACCT procedures. At the assessment interview on 17 August, Mr Quinnell said that he always felt suicidal and the impending charges were making matters worse. A member of the mental health team contributed to the first case review by telephone but did not attend the second case review. There was a caremap action that the mental health team should chase up a counselling appointment but this was not completed. The ACCT was closed on 19 August. At his post-closure interview, Mr Quinnell said that the issues that resulted in him considering self-harm were unresolved but the ACCT remained closed.
29. On 26 August, Mr Quinnell received notification that the Parole Board had refused his application for parole because he had not completed the required offending behaviour courses. His application for an oral hearing was refused in September.
30. On 3 October, Mr Quinnell refused to attend a video link hearing relating to additional charges against him. A new date was set for 4 November. According to his solicitor, Mr Quinnell was notified of the new date on 19 October.
31. On 4 October, Mr Quinnell's next of kin told prison staff that Mr Quinnell had telephoned him after cancelling his visit and told him that he intended to take his life. A PCO started ACCT procedures and noted a possible Crown Court appearance as a potential trigger. The immediate action plan stated that Mr Quinnell should be checked four times a night, reviewed hourly when locked in his cell and that staff should hold a conversation with him each morning and afternoon until assessment. It also noted that Mr Quinnell should be referred to the mental health team. A PCO completed the assessment interview, at which Mr Quinnell said he made plans to kill himself every night. She noted that the mental health team had been contacted.
32. The first case review was held on 5 October, with a Senior Prisoner Custody Officer (SPCO) and a Prisoner Custody Officer (PCO) in attendance. No one from the mental health team attended. Mr Quinnell said that from a young age he had always thought about killing himself but was unlikely to do anything at that time. His risk of suicide was assessed as low but ACCT monitoring continued with hourly observations. He was referred to the mental health team.
33. The SPCO met Mr Quinnell for the second case review on 10 October. No one else attended and there was no evidence anyone else was invited. Mr Quinnell said that he was awaiting a court appearance in relation to allegations of sexual abuse made against him but that he was innocent of the charges. He had little faith in the judiciary finding him innocent and said that a court case might have a very negative effect on him. He assessed Mr Quinnell's risk as remaining the same and he stayed on hourly observations.

34. On 11 October, Mr Quinnell was visited by his next of kin, who told staff in the Visitor Centre that Mr Quinnell had told him that he would not be booking any more visits as he intended to take his life. Visitor Centre staff telephoned the houseblock and spoke to a PCO. When the PCO asked Mr Quinnell about this, he expressed surprise, said his friend had misunderstood their conversation, and that he had no thoughts of suicide. This was recorded in the ACCT record.
35. Prison records show that on 17 October, Mr Quinnell's next of kin contacted the prison to tell them that Mr Quinnell was feeling down. The same day, a SPCO carried out an ACCT review with a PCO. Mr Quinnell told them that he had been feeling low but was feeling better and was not going to self-harm. He said he was waiting to see someone from the mental health team but no longer felt he needed to be subject to ACCT monitoring. The SPCO closed the ACCT.
36. Mr Quinnell met a SPCO on 24 October for a post-closure interview. Mr Quinnell said he was still having problems outside the prison but this comment was not explored with him. He said things were okay inside prison. Mr Quinnell said that the issues that had resulted in him considering self-harm were unresolved. There is no record that they discussed Mr Quinnell's impending court appearance or why Mr Quinnell had told his next of kin that he would not be booking any more visits. They agreed that the ACCT should remain closed.
37. A therapist with the mental health team saw Mr Quinnell on 31 October as a result of his self-referral made on 11 October. He said his main difficulty and reason for his low mood and anxiety was his history of sexual abuse. He said he had thought of suicide since he was a teenager but had learnt to manage his thoughts and had no intentions at that time. He said he was worried about a court appearance on Friday 4 November and denied the charges. She assessed Mr Quinnell's level of anxiety as high, although slightly lower than in June. Mr Quinnell said he thought that he would be better off dead and thought of harming himself 'more than half the days'. They discussed different approaches and agreed that Mr Quinnell would benefit from counselling because he felt he could not move forward until he discussed the abuse. She added Mr Quinnell to the counsellors' waiting list.
38. On 3 November, at around 7.40pm, an operational support officer carried out a routine check on Mr Quinnell and saw him sitting on his bed watching television. Mr Quinnell said, "I'm okay boss" and gave a 'thumbs up' sign. Mr Quinnell did not press his cell bell that night and as he was not subject to ACCT monitoring, he did not check on him again.

Friday 4 November

39. Mr Quinnell was due to appear at Crown Court on 4 November. Mr Quinnell wanted to appear by video link, but prison records show that he was to appear in person. Mr Quinnell was adamant that he did not want to move from Northumberland or return to Durham.
40. At approximately 5.30am, the operational support officer began his morning roll check. He arrived at Mr Quinnell's cell at around 5.45am, and used his torch to look into the cell. He saw the bed was standing upright and Mr Quinnell was

hanging from the bed frame. None of the beds on Mr Quinnell's houseblock are secured to the floor.

41. The operational support officer immediately went into the office (20 feet away) and radioed a code blue (a medical emergency code that is used when a prisoner is unconscious) at 5.45am. Another operational support officer telephoned for an ambulance at 5.46am. The operational support officer picked up the first aid bag and defibrillator, broke the seal on his key pouch and returned to the cell. He said as he was working alone in the houseblock he waited outside the cell until assistance arrived. He said he would not enter a cell alone as there was always the risk that a prisoner could overpower him and take his keys.
42. Staff responded to the emergency call at 5.45am. They used the prison's car to drive to the houseblock (because of the size of the site) and arrived at the cell at 5.50am. The operational support officer passed a PCO the cell key, who unlocked the door and the officers went in. The PCO said he saw the bed had been stood up on one end and Mr Quinnell had a ligature around his neck, which was attached to the head of the bed. They cut the ligature and could see that Mr Quinnell was clearly dead so did not attempt resuscitation. The PCO noticed a note on top of Mr Quinnell's locker, which he assumed was a suicide note, although he did not read it.
43. The paramedics arrived at the prison at 6.12am and, after examining Mr Quinnell, they pronounced him dead at 6.25am.

Contact with Mr Quinnell's next of kin

44. The prison's family liaison officer and his deputy left the prison at 9.45am, to inform Mr Quinnell's next of kin. There was no answer at his address and a governor advised they should travel to the Crown Court, as Mr Quinnell was due there that morning. They met Mr Quinnell's next of kin at the court and explained what had happened. The prison contributed to Mr Quinnell's funeral in line with national instructions.

Support for prisoners and staff

45. After Mr Quinnell's death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. No issues were raised. The staff care team also offered support.
46. The prison posted notices informing other prisoners of Mr Quinnell'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 Quinnell's death.

Events after Mr Quinnell's death

47. The police discovered two suicide notes in Mr Quinnell's cell, one of which was dated September and the other undated. Mr Quinnell wrote of the sexual abuse he had suffered throughout his childhood, the recent allegations made against him and the breakdown of relations with his family.

48. A former prisoner who knew Mr Quinnell in Northumberland between around May 2015 and March 2016, told the investigator that Mr Quinnell had drug debts and was being bullied. He said that he had protected Mr Quinnell while he was at Northumberland.

Post-mortem report

49. A post-mortem, carried out on 5 November 2016, concluded that Mr Quinnell died from hanging. A toxicology test detected therapeutic doses of buprenorphine, an opioid analgesic used for moderate to severe pain or opiate withdrawal. Mr Quinnell had not been prescribed this medication. There was no trace of the antidepressants he had been prescribed.

Findings

Managing Mr Quinnell's risk of suicide and self-harm

50. Prison Service Instruction (PSI) 64/2011 on safer custody lists a number of risk factors and potential triggers for suicide and self-harm. Mr Quinnell had a number of risk factors for suicide and self-harm including a history of anxiety and depression, suicide attempts in the community, a history of childhood sexual abuse, he was estranged from his family and had been refused parole. In addition, Mr Quinnell had been charged with further offences and had a court appearance on 4 November, about which he had repeatedly expressed anxiety and which constituted a significant risk factor.
51. We found that staff did not properly assess and manage Mr Quinnell's risk, particularly in respect of the further charges and his impending court appearance. In spite of staff starting ACCT monitoring on 16 August and 4 October 2016 after Mr Quinnell's next of kin alerted the prison to Mr Quinnell's thoughts of self-harm, staff failed to properly manage Mr Quinnell's risk of suicide and self-harm. On both occasions, staff closed the ACCT in spite of the circumstances that triggered the ACCT (the further charges and court appearance) remaining unchanged. Mr Quinnell confirmed at both post-closure interviews that the issues that had resulted in him considering self-harm were unresolved and yet staff did not decide to reopen ACCT procedures. It is particularly concerning that staff closed the last ACCT on the same day that Mr Quinnell's next of kin contacted the prison to say that he was concerned about Mr Quinnell's low mood. On this occasion, staff placed too much weight on Mr Quinnell's own assertions that he was feeling a bit better, and they did not evaluate the overall picture of risk. At the time of the post-closure review on 24 October 2016, Mr Quinnell had been informed of the date of the court appearance, but this was not discussed with him. We make the following recommendation:

The Director should ensure that staff understand the procedure for identifying, managing and supporting prisoners at risk of suicide and self-harm. In particular, they should ensure that staff assess the risk of suicide and self-harm based on all available information and known risk factors and not on a prisoner's own presentation.

52. There was no evidence that staff discussed Mr Quinnell's concerns about his court appearance with him, particularly his anxiety about whether he would have to attend in person and whether he would return to Northumberland or be moved to Durham, which he was anxious to avoid. Mr Quinnell's personal officer said he was unaware of the court appearance until after Mr Quinnell's death. Given that the court appearance was a significant risk factor for Mr Quinnell, we found it concerning that his personal officer was unaware. We make the following recommendation:

The Director should ensure that staff on the houseblock, and in particular personal officers, are made aware of potential triggers for suicide and self-harm, such as further charges and forthcoming court appearances, and that they take appropriate action to manage that risk, including starting ACCT procedures where appropriate.

53. We found deficiencies in the implementation of ACCT procedures. Prison Service Instruction (PSI) 64/2011 states that case reviews should be multidisciplinary where possible. Even when multidisciplinary attendance is not possible, it is implicit that ACCT reviews, which are based on teamwork, should involve more than one member of staff. During the time Mr Quinnell was subject to ACCT monitoring, a mental health nurse attended only one case review, despite ongoing concerns about Mr Quinnell's mental health, and there were instances of case reviews being attended by just Mr Quinnell and one officer. There were occasions where staff did not complete a caremap, or closed the ACCT before all the caremap actions were completed. Observations were often carried out at regular intervals meaning Mr Quinnell could have anticipated the checks. We make the following recommendation:

The Director should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including that:

- **Case reviews are multi-disciplinary and include all relevant people involved in a prisoner's care, including mental health staff where appropriate.**
- **Staff set ACCT caremap actions designed to reduce the prisoner's risk of suicide and self-harm, review them at each case review and complete them all before closing an ACCT.**
- **Staff vary the times of ACCT checks, while remaining within set observation periods, to avoid prisoners being able to predict when they will be checked.**

Mental health

54. The clinical reviewer found that Mr Quinnell's mental health was assessed in line with NICE guidelines. He was appropriately referred for counselling and had access to the same range of psychological and talking therapies that would have been available to him in the community. The clinical reviewer concluded that Mr Quinnell's interactions with the mental health team were comparable to the service he would have received in the community.

Bullying and debt

55. Anecdotal evidence from a prisoner suggested that Mr Quinnell had been bullied because of drug debts. Mr Quinnell's toxicology result showed he had taken illicit drugs before he died. However, there were no security intelligence reports or other information to indicate that Mr Quinnell was suspected of taking illicit drugs or that he was being bullied. Prison staff told the investigator that they were not aware that Mr Quinnell had accumulated debts, although they said this was possible given the high number of prisoners who were in debt.

Emergency response

56. Northumberland's Night Staff Instructions, published in 2014, say that if a member of staff considers that a prisoner's life is in danger, they can use the key from their sealed pouch to open the cell door. Before doing so, they must be as sure as possible that the situation has not been 'set up' to create a diversion.

When he discovered Mr Quinnell hanging in his cell, the operational support officer immediately radioed a code blue, took emergency equipment to the cell and accessed the cell key by breaking the seal on the pouch, but he did not open Mr Quinnell's cell door because he said he would never enter a cell alone. This is not in accordance with the Night Staff Instructions, which state that staff should enter a cell in an emergency if it is safe to do so. Although we accept that the short delay in entering Mr Quinnell's cell made no difference to the outcome on this occasion, we note that Mr Quinnell was in a single occupancy cell, that any delay could be critical in future cases and we therefore make the following recommendation:

The Director should ensure that all staff understand the importance of entering a cell without delay when a prisoner's life is at risk, when it is safe to do so.

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