

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jaspal Khela a prisoner at HMP & YOI Portland

**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.

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

Mr Jaspal Khela was found hanged in his cell at HMP & YOI Portland on 16 September 2016. He was 48 years old. I offer my condolences to Mr Khela's family and friends.

Mr Khela had been in prison for nearly ten months when he died. Although prison staff had identified him as at risk of suicide and self-harm on two occasions in January and May 2016, Mr Khela's actions on the night of 15 September were unexpected. There was little to indicate that Mr Khela was at imminent risk of suicide. We consider it would have been difficult for staff at Portland to have predicted his actions or prevented his death.

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

Richard Pickering
Deputy Prisons and Probation Ombudsman

October 2017

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Summary

Events

1. On 18 December 2015, probation staff recalled Mr Jaspal Khela to custody at HMP Exeter after he breached his licence conditions.
2. On 12 January 2016, Mr Khela was transferred to HMP Portland. From 2 to 12 January and from 24 May to 10 June, Mr Khela was supported by Prison Service suicide and self-harm monitoring arrangements (known as ACCT).
3. Mr Khela was popular with other prisoners and appeared to have settled well at Portland. No one reported any concerns about his risk of suicide or self-harm after the ACCT arrangements were closed in June.
4. In July and September, staff suspected that Mr Khela had used illicit drugs, specifically new psychoactive substances (NPS). He declined support from the substance misuse team at Portland.
5. At about 5.55am on 16 September, the night patrol officer carried out a routine check of prisoners and found Mr Khela hanged in his cell. Staff went into Mr Khela's cell and as there were signs that he was clearly dead, they did not attempt resuscitation. At 6.22am, paramedics recorded that Mr Khela had died.

Findings

6. Mr Khela had been in prison for 10 months when he was found hanged in his cell. He had been assessed as at risk of suicide or self-harm on two occasions during that time. We found some deficiencies in the management of ACCT procedures, namely, case reviews were not multidisciplinary and caremap actions, which should be set with the aim of reducing risk, were not properly reviewed.
7. Mr Khela was not being managed under ACCT procedures on the night he died. His actions were unexpected and we found no evidence that staff had missed any indication that his risk had increased or that he needed additional support.
8. Although Mr Khela used NPS on at least two occasions at Portland, we found no evidence that NPS use contributed to his death.

Recommendations

- The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including ensuring that:
 - Case reviews are multidisciplinary and include all relevant people involved in a prisoner's care, including mental health staff where appropriate, and healthcare staff attend all first case reviews.
 - Staff set ACCT caremap actions which are aimed at reducing prisoners' risks to themselves and review them at each case review.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Portland informing them of the investigation and asking anyone with relevant information to contact him.
10. The investigator visited Portland on 21 September. He obtained copies of relevant extracts from Mr Khela's prison and medical records and interviewed two prisoners.
11. NHS England commissioned a clinical reviewer to review Mr Khela's clinical care at the prison.
12. The investigator interviewed 12 members of staff and five prisoners at Portland.
13. We informed HM Coroner for Dorset of the investigation who gave us the results of the post-mortem examination. Our investigation was suspended until the post-mortem and toxicology reports became available in May 2017. We have sent the coroner a copy of this report.
14. One of the Ombudsman's family liaison officers contacted Mr Khela's ex-partner and daughter to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They did not raise any issues.
15. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

Background Information

HMP & YOI Portland

16. HMP & YOI Portland hold up to 530 men. NHS Dorset Community Healthcare Services provides healthcare services. There are no healthcare staff on duty at night at Portland.

HM Inspectorate of Prisons

17. HM Inspectorate of Prisons most recently inspected Portland in July 2014. Inspectors reported that the care and case management of those at risk of suicide and self-harm were inconsistent, particularly on larger wings. Where staff had more time, such as on the Collingwood Unit, good care was more evident. Inspectors were not assured that recommendations from previous Prisons and Probation Ombudsman investigations into deaths at Portland had been properly implemented. Primary mental health services were affected by staff shortages at the time, but inspectors noted that secondary mental health services were very good.

Independent Monitoring Board

18. 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 31 March 2016, the IMB reported that new psychoactive substances (NPS) had continued to be a problem for the prison. A large number of finds during cell and perimeter wall searches had limited but not stemmed the flow of NPS into the prison.

Previous deaths at HMP Portland

19. Mr Khela's death is the second self-inflicted death at Portland since 2014. We have previously raised concerns about emergency response procedures.

Assessment, Care in Custody and Teamwork

20. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multidisciplinary case reviews involving the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

New Psychoactive Substances (NPS)

21. New psychoactive substances, previously known as 'legal highs' are an increasing problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of NPS can present with marked levels of disinhibition, heightened

energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

22. In July 2015, we published a Learning Lessons Bulletin about the use of NPS and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of NPS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.
23. HMPPS now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements. Testing has begun, and HMPPS continue to analyse data about drug use in prison to ensure new versions of NPS are included in the testing process.

Key Events

24. On 13 March 2013, Mr Jaspal Khela was sentenced to five years in prison for wounding with intent to do grievous bodily harm. On 5 October 2015, he was released on licence. Mr Khela had to reside at an approved premises (formerly known as a bail hostel) as part of his licence conditions.
25. On 16 December, probation staff recalled Mr Khela to custody for breach of the good behaviour condition of his licence (he had stolen an item from the approved premises). On 18 December, he was returned to custody at HMP Exeter.
26. During the morning of 2 January 2016, staff began Prison Service suicide and self-harm monitoring arrangements, known as ACCT, after Mr Khela wrote a suicide note. He was frustrated about being recalled to custody and not knowing when he would be re-released.
27. On 4 January, during a case review, Mr Khela was told he would be serving a full standard recall and would be in custody until November 2017. Mr Khela was upset and said he intended to appeal against his recall. Later that day, staff discovered that Mr Khela had tried to cut his throat with a blunt razor. Mr Khela was subject to ACCT monitoring for the remainder of his time at Exeter.

HMP Portland

28. During the afternoon of 12 January, Mr Khela transferred to HMP Portland. A nurse completed Mr Khela's health screen. The nurse recorded that Mr Khela felt depressed while at Exeter but now felt okay. The nurse referred Mr Khela for a mental health assessment.
29. At around 6.50pm, a custodial manager held a case review with Mr Khela and a prison officer. No one from healthcare attended the review or provided a report beforehand. The custodial manager recorded that Mr Khela was happy to be back at Portland as he knew the staff at the prison. He was hoping to move to Beaufort wing and get his old job back in Prison Enterprises. The custodial manager recorded that Mr Khela had accepted his recall and was happy to serve until the end of his sentence. Mr Khela said he had no intention of harming himself and had plenty of support at Portland. Mr Khela's level of risk remained low. The custodial manager reviewed Mr Khela's caremap and added a new action for Mr Khela to have a new cellmate so that he was not alone. She decided to close the ACCT but recorded that observations should continue until the post closure interview. The post closure interview was scheduled to take place on 19 January.
30. On 15 January, Mr Khela saw a nurse for a mental health assessment. The nurse recorded that Mr Khela engaged well during the assessment. His thought processes were clear, he was coherent and organised and his mood appeared bright. Mr Khela told the nurse he had no thoughts of self-harm. He told the nurse he had no current mental health issues or concerns. The nurse asked him to submit an application or talk to wing staff if he needed support from the mental health team in the future.
31. On 19 January, a custodial manager conducted Mr Khela's post closure interview.

32. On 3 May, Mr Khela saw a supervising officer (SO) and told her he was frustrated as he was trying to get his property returned from the approved premises. He asked the SO for the contact details for his offender manager.
33. On 24 May, a member of chaplaincy staff began ACCT arrangements after Mr Khela appeared to be in a very low mood and threatened to end his life. During an assessment as part of the ACCT process, Mr Khela said he felt very frustrated about being recalled to custody and had nothing to look forward to.
34. During the afternoon of 24 May, a SO held the first ACCT review with Mr Khela and a prison officer. No general healthcare or mental health staff were invited to the first case review, even though this is a mandatory requirement. The case review took place in Mr Khela's cell. He told the SO that he did not want to see healthcare staff but was happy to continue speaking to chaplaincy staff. Mr Khela spoke about his recall to custody. The SO gave him the address for the Parole Board and advised him to write to them to express his concerns. Mr Khela said he had no current thoughts of suicide or self-harm. The SO decided that Mr Khela should have one conversation with staff in the morning and one in the afternoon, and be observed hourly at night. Both initial risk of harm to self and current likelihood of further risk behaviours were recorded as raised. The SO recorded two caremap actions. The first was for Mr Khela to liaise with his offender supervisor about his recall to custody, and the second was for the prison officer to refer Mr Khela to the mental health team. The next case review was scheduled for 27 May.
35. On 27 May, a SO held a case review with Mr Khela and a prison officer. Healthcare staff did not attend the case review and did not provide a contribution to the SO beforehand. The SO recorded that Mr Khela admitted that he was in a low mood and that this was due to his recall to custody. Mr Khela said he had no current thoughts of suicide or self-harm. The SO reviewed the level of observations (one conversation in the morning and afternoon and one observation during the night). The SO reviewed the level of risk and changed it to low. The SO reviewed the caremap but added no new actions.
36. At around 5.00pm on 31 May, Mr Khela saw a SO. Mr Khela told him he was very frustrated and depressed at the treatment he received from staff at the approved premises. The SO recorded that he would try to arrange a telephone conference or a video call with Mr Khela's offender manager.
37. On 1 June, the SO spoke to Mr Khela's offender manager and arranged a telephone conference for 10 June at 2.00pm. On the same day, Mr Khela was discussed at the mental health team meeting. They agreed to add Mr Khela to the waiting list and for him to see a nurse.
38. At around 2.00pm on 9 June, Mr Khela told a prison officer that he wanted to cancel the telephone conference with his offender manager as he did not want to talk to him. The officer left a message on the offender manager's answer service. At 4.00pm, the officer received a telephone call from a workshop instructor to say that Mr Khela had now calmed down and wanted to attend the telephone conference. The officer checked and was told that the telephone conference had been cancelled and Mr Khela would need to talk to his offender supervisor to make alternative arrangements.

39. On 10 June, a SO held a case review with Mr Khela, another SO and a prison officer. Healthcare staff did not attend the case review or provide a contribution. The SO recorded that Mr Khela had a telephone conference booked with his offender manager and he had also seen the mental health in-reach team on 8 June. (There is no information recorded on either the ACCT observation record or in the medical record that someone from the mental health team saw Mr Khela.) Mr Khela told the SO he had no thoughts of suicide or self-harm. The SO decided to close the ACCT but that observations should continue until the post closure interview.
40. On 17 June, as planned, the SO conducted Mr Khela's post closure interview.
41. On 22 June, Mr Khela did not attend an appointment with the nurse. She contacted Mr Khela's wing and a prison officer told her that he was "brighter in mood" and engaging with other prisoners. The officer said he had no concerns about Mr Khela's mental health. Another appointment was booked for Mr Khela to see the nurse on 29 June. Mr Khela cancelled the appointment. The mental health referral was then closed. The nurse recorded that Mr Khela could self-refer to the mental health team at any time. He could also ask wing staff to submit a referral to the mental health team on his behalf.
42. On 30 June, Mr Khela saw a recovery worker from the substance misuse team. Mr Khela told her he did not want to see her as he had no substance misuse issues. She provided him with information about new psychoactive substances (NPS) and closed his case.
43. At around 2.10pm on 27 July, it was suspected that Mr Khela had taken NPS as he was unsteady on his feet. A nurse saw Mr Khela and confirmed that he was under the influence of NPS. Mr Khela attended a disciplinary hearing (known as an adjudication) on 4 August, and was found guilty of breaking prison rules. His punishment was to have 18 days added to his sentence. The punishment was suspended for six months. Mr Khela was also referred to the substance misuse team.
44. On 11 August, Mr Khela was invited to attend an NPS group session with the substance misuse team. He did not attend and sent a note to the group leader. Mr Khela wrote that he was not a user of NPS but had in fact bumped his head which made him look like he was under the influence.
45. During the afternoon of 6 September, staff suspected that Mr Khela had taken NPS. His speech was slurred and he was walked back to his cell. A nurse saw Mr Khela and he admitted that he had taken NPS. Mr Khela attended a disciplinary hearing on 7 September, and was found guilty of breaking prison rules. His punishment was to lose his television and the opportunity to mix with other prisoners during association periods (for 14 days) and to be confined to his cell for seven days (but this was suspended for three months).
46. On 14 September, Mr Khela saw a custodial manager, when he returned to the wing from his workplace. He asked her whether she could review his punishment with regard to the loss of his television. She told Mr Khela that when she was back on duty on 16 September she would review whether she could return his television.

Thursday 15 September 2016

47. During the early evening of 15 September, Mr Khela visited a prisoner who lived on the same wing. The prisoner told the investigator that he enjoyed art and Mr Khela would lend him items. This had happened on a few occasions. On the evening before his death, Mr Khela came into the prisoner's cell on three occasions. He initially brought in a box of colouring pencils and felt tips, then a ruler and protractor and then a pencil sharpener and some crisps. Mr Khela told the prisoner he would have his art items back in a couple of days. He then asked if he had any spare cigarette papers. He gave him some and Mr Khela left the cell. The prisoner said that Mr Khela did not seem down or any different from when they had interacted previously.
48. In his statement, a prison officer wrote that he saw Mr Khela talking to another prisoner at association during the evening but did not speak to him.
49. Another prisoner who lived on the same wing, told the investigator that Mr Khela was an older, quiet prisoner who kept his own company. He said the only time he spent any time with Mr Khela was on the night before his death.
50. The prisoner said at the beginning of association, at around 6.00pm, he saw Mr Khela standing at the top of stairs on the three's landing (second floor) of Drake wing. Although Mr Khela was standing motionless his body was shaking. The prisoner assumed he had taken an illicit substance. He went to support him and asked whether Mr Khela wanted any assistance and offered to help Mr Khela back to his cell. Mr Khela robustly refused his assistance and said he was not having a "spice attack". He apologised to Mr Khela if he had upset him. He said it was clear Mr Khela was not under the influence of NPS. Mr Khela started to tell him about his life story. Mr Khela told him his age, that he had three children who he had not seen for nearly ten years and listed a number of other things that had happened to him. The prisoner could not remember all the details but thought the move to prison was one of the issues Mr Khela spoke about. He said Mr Khela was in an extremely distressed state.
51. This was the prisoner's first conversation with Mr Khela but he said he was listening more than talking. When Mr Khela appeared to have calmed down the prisoner gave him a hug and encouraged him to "chill out" and to speak to staff about his concerns. He said there were no warning signs that Mr Khela intended to commit self-harm or suicide.
52. Between 8.30pm and 9.00pm, the night patrol officer, checked all the prisoners on Mr Khela's wing. She told the investigator that she could not recall seeing anything unusual when she checked Mr Khela.

Friday 16 September 2016

53. At about 5.50am on 16 September, the night patrol officer started a routine check of all the prisoners on Mr Khela's wing. When she reached Mr Khela's cell, she saw him hanged with a sheet tied to the light fitting.
54. She radioed for assistance. The control room received the call at 5.55am and immediately requested an ambulance. (The ambulance service received the call at 5.56am.) Two other night patrol officers and a prison officer responded to the

emergency request. They entered the cell while the night patrol officer remained outside. Two of them took Mr Khela's weight while the third cut the ligature. They were joined by the night manager and two other prison officers.

55. According to the prison incident log, at 5.55am, the night manager radioed a code blue emergency (which indicates a prisoner is unconscious, not breathing or having breathing difficulties). Staff in the control room had already called for an ambulance. The officers checked Mr Khela for signs of life and considered that rigor mortis was present, indicating he had been dead for some time. They concluded that they should not try to resuscitate Mr Khela. Paramedics arrived at the cell at 6.22am, checked Mr Khela for signs of life and confirmed that Mr Khela had died.

Contact with Mr Khela's family

56. At around 7.00pm on 16 September, a prison manager and the Governor visited Mr Khela's daughter and told her about Mr Khela's death. In line with national instructions, the prison contributed to the costs of Mr Khela's funeral.

Support for prisoners and staff

57. On the morning of 16 September, the Head of Reoffending debriefed the staff involved in the emergency response to allow them the opportunity to discuss any issues arising. She offered them her support and that of the staff care team.
58. The Governor issued notices to staff and prisoners informing them of Mr Khela's death. Officers and members of the chaplaincy team supported prisoners. Staff reviewed prisoners who had been assessed as at risk of suicide and self-harm in case they had been adversely affected by Mr Khela's death.

Post-mortem report

59. A preliminary cause of death after post-mortem examination found the cause of Mr Khela's death was compression of the neck caused by ligature suspension. The toxicology report showed that Mr Khela was not under the influence of alcohol or drugs at the time of his death.

Findings

Identifying Mr Khela's risk of suicide and self-harm

60. Prison Service Instruction (PSI) 64/2001, which covers safer custody, lists a number of risk factors and potential triggers that might increase a prisoner's risk of suicide and self-harm. Mr Khela had a number of risk factors for suicide including a previous suicide attempt.
61. When Mr Khela was returned to prison, in December 2015, he told staff at Exeter that he had no thoughts of suicide or self-harm. In January 2016, Mr Khela was supported by ACCT procedures after he wrote a suicide note. He told staff he was frustrated at his recall to custody.
62. Following Mr Khela's move to Portland, in May, chaplaincy staff started ACCT procedures after Mr Khela appeared to be in a low mood and was again frustrated about his recall to custody. The ACCT case manager did not invite healthcare staff or chaplaincy staff to attend Mr Khela's case reviews. The case manager identified two actions, the first being that Mr Khela should be referred to the mental health team and the second, that he should liaise with his offender supervisor about his recall to custody.
63. The case manager closed the ACCT procedures but the two caremap actions had not been completed. Mr Khela's offender supervisor had arranged for a telephone conference with his offender manager. Mr Khela told the case manager he had been seen by the mental health team but there is no record that this happened. Mr Khela cancelled the telephone conference with his offender manager and he did not attend his appointments with the mental health team.
64. PSI 64/2011 requires caremaps to reflect the prisoner's needs, level of risk and triggers for their distress. We are concerned that staff did not identify that the caremap actions had not been completed. The mental health team did not assess Mr Khela and he did not attend a meeting with his offender manager. Caremap actions are fundamental to the ACCT process.
65. PSI 64/2011 expects case reviews to be multidisciplinary. Healthcare staff did not attend the case reviews held at Portland and did not give a verbal or written contribution. Chaplaincy staff saw Mr Khela on a regular basis and had started ACCT procedures in May 2016. However, they also did not attend the case reviews and did not give a verbal or written contribution. We make the following recommendation:

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

- **Case reviews are multidisciplinary and include all relevant people involved in a prisoner's care, including mental health staff where appropriate, and healthcare staff attend all first case reviews.**
- **Staff set ACCT caremap actions which are aimed at reducing prisoners' risks to themselves, and review them at each case review.**

66. Staff interviewed during the investigation said they did not think Mr Khela was at risk of suicide or self-harm. On 15 September, Mr Khela gave no indication to staff that he was struggling to cope or contemplating suicide. Both his neighbours and staff said that he had seemed his normal self on the 15 September. However, another prisoner said that Mr Khela appeared to be very upset during the evening of 15 September, The prisoner did not draw this to the attention of staff.
67. We have found no evidence to indicate that staff should have identified that Mr Khela's risk of suicide had increased in the days leading up to his death and we consider they could not have predicted his actions or prevented his death.

Mental health

68. A case manager referred Mr Khela to the mental health team in May 2016 when ACCT support procedures started for a second time. Mr Khela did not attend his two appointments with the mental health team. A nurse from the mental health team checked with wing staff on Mr Khela's wellbeing after he failed to attend his first appointment on 22 June. Wing staff did not raise any concerns. Mr Khela cancelled his second appointment on 29 June. The clinical reviewer was satisfied that Mr Khela's care was equivalent to that which he could have expected to receive in the community.

Substance misuse and new psychoactive substances (NPS)

69. Mr Khela was found to have used NPS on two occasions while at Portland. Staff referred Mr Khela for substance misuse support but he chose not to engage with this service. We note the clear view of the prisoner that Mr Khela had not taken NPS the night before he died and we also note that the toxicology report showed Mr Khela was not under the influence of alcohol or drugs at the time of his death.

Emergency response

70. Prison Service Instruction (PSI) 03/2013 (Medical Emergency Response Codes) requires governors to have a medical emergency response code protocol, which ensures an ambulance is called automatically in a life-threatening emergency. The protocol should give guidance on efficiently communicating the nature of a medical emergency, ensuring that staff take the correct equipment to the incident and that there are no delays in calling an ambulance. It explicitly states that all prison staff must be made aware of, and understand, the protocol and their responsibilities during medical emergencies.
71. The night patrol officer did not radio a code blue medical emergency when she found Mr Khela hanged, but instead asked for assistance. The control room called an ambulance on receipt of the radio message. The night manager radioed a code blue when she arrived at the cell, very shortly afterwards. At interview, the night patrol officer said that she knew she should have radioed a code blue, but she was distressed by what had happened and used her radio to raise the alarm. We consider that there was only a very slight delay in calling the emergency code and that this did not affect the outcome for Mr Khela. We make no recommendation.

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