Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Vilhemas Borketas a prisoner at HMP Pentonville on 21 November 2016.

A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

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*

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 Borketas was found hanged in his cell at HMP Pentonville on 21 November 2016. He was 23 years old. I offer my condolences to Mr Borketas' family and friends.

This was Mr Borketas' first time in prison. He was finding it difficult and was concerned about his family. Mr Borketas was involved in at least three altercations with his cellmate and other prisoners, which were not sufficiently investigated and responded to by the prison.

Mr Borketas was closely monitored by the mental health team who frequently reviewed him and offered good support. Mr Borketas' symptoms were not specific and no diagnosis of serious mental illness was indicated from his presentation, but I am concerned that healthcare staff did not work sufficiently closely with prison staff to share information about his risk factors for suicide and self-harm. Prison staff did not have sufficiently meaningful interactions with Mr Borketas to identify his underlying risk of suicide, reflecting the prison's lack of a functioning personal officer scheme.

This is another case at Pentonville, where staff did not respond promptly to calls from a prisoner's cell bell, something I have made recommendations in previous cases.

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 **August 2017**

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Summary

Events

1. Mr Vilhemas Borketas was born in Lithuania and moved to the UK with his parents at the age of 12. Mr Borketas went to Denmark at the age of 17 and, later to Iceland, returning to the UK in 2014.

2. In April 2016, a GP referred Mr Borketas to the community mental health services because he reported hearing voices and experienced visual hallucinations. He was prescribed antipsychotic medication. The mental heath services were unable to make any contact with Mr Borketas in the community because, although they provided appointments, he did not access their services.

3. On 12 July 2016, Mr Borketas was remanded to HMP Pentonville charged with attempted robbery. On 12 October, he was sentenced to 10 months in prison. It was his first time in prison. Mr Borketas was due to be released on 10 December.

4. Mr Borketas did not have a history of suicide or self-harm. He had a history of drugs and alcohol misuse in the community.

5. On his arrival at Pentonville, a nurse reviewed Mr Borketas. He said that he had been diagnosed with anxiety and depression in the community but did not have current thoughts of suicide and self-harm. The nurse referred Mr Borketas to a GP, who prescribed him medication for alcohol withdrawal and referred him to substance misuse services and the mental heath team. Mr Borketas participated in anxiety group sessions and substance misuse programmes while at Pentonville.

6. Mr Borketas was afraid that people were going to hurt him. He had a fight with his cellmate, was assaulted by other prisoners and appears to have been bullied over a tobacco debt. He was reserved, did not interact with others and stayed in his cell most of the time. The mental health team and a psychiatrist reviewed Mr Borketas frequently. They continued to try to engage with him as his guarded responses and failure to engage might have been signs of underlying mental illness. He did not respond to these approaches and presentation did not lead to a diagnosis of a serious mental illness.

7. At 10.27pm on 21 November, Mr Borketas' cellmate rang his cell bell when he saw Mr Borketas hanging from the window bars. The night patrol officer, responded to the call at 10.48pm and, at 10.56pm, radioed for staff support. He did not use an emergency code. At about 10.57pm, officers arrived and entered the cell, cut the ligature and started cardiopulmonary resuscitation (CPR). At 10.58pm, a unit manager, attended and called an emergency code over the radio. Staff and paramedics tried to resuscitate Mr Borketas but he was pronounced dead at 11.52pm.

Findings

8. Mr Borketas had several factors which indicated he could be at risk of suicide and self harm. It was his first time in prison, he had some involvement with the mental health team at the prison, was possibly being bullied, would not engage or interact with staff or prisoners and was missing his family. Staff did not

recognise the potential significance of these risk factors for suicide and self-harm and did not provide Mr Borketas with the additional support he needed.

9. The allegations of threats by other prisoners and the incident of assault were not formally investigated and the intelligence reports, which were correctly submitted, were not acted on. Mr Borketas was moved following the assault, but otherwise was not supported by any other formal actions.

10. Healthcare staff did not share relevant information about Mr Borketas' risk factors for suicide and self-harm with officers and staff missed several opportunities to provide additional support to him through meaningful contact.

11. There was a long delay of over 20 minutes for the night patrol officer to respond to Mr Borketas' cellmate's cell bell. The officer did not use the emergency response code correctly, which added further delay.

Recommendations

- **The Governor and Head of Healthcare should produce clear local guidance about procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular, this should ensure that staff:**
  - **Are aware of, consider and record all the known risk factors for suicide or self-harm. They should open an ACCT whenever a prisoner has significant risk factors.**
  - **Share information, in particular between healthcare and prison staff about a prisoner's mental health or risk factors for suicide and self-harm to provide collaborative care and treatment;**
- **The Governor should ensure that all information about bullying, intimidation or assault is fully coordinated and investigated; that those suspected of involvement are appropriately challenged and monitored; that staff consider whether victims are at increased risk of suicide or self-harm; and that apparent victims are effectively supported and protected with meaningful, long term solutions, which address their individual situation.**
- **In the absence of and pending the introduction of an effective personal officer scheme, the Governor should ensure all prisoners have meaningful contact with identifiable wing officers who regularly check their wellbeing and record their contact.**
- **The Governor should ensure that all cell bells are answered within five minutes.**
- **The Governor should ensure that all prison and healthcare staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies as outlined in the local Medical Emergency Response Code Protocol so that staff efficiently communicate the nature of a medical emergency, and there is no delay in calling, directing or discharging ambulances.**

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Pentonville informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

13. The investigator visited HMP Pentonville on 21 November 2016 and obtained copies of relevant extracts from Mr Borketas' prison and medical records.

14. The investigator interviewed 13 members of staff and three prisoners between January and April 2017.

15. NHS England commissioned a clinical reviewer to review Mr Borketas' clinical care at the prison. She carried out five interviews jointly with the investigator.

16. We informed HM Coroner for Inner North London of the investigation. We have given the coroner a copy of this report.

17. One of the Ombudsman's family liaison officers contacted Mr Borketas' family, to explain the investigation. Mr Borketas' family did not ask any specific questions.

18. Mr Borketas' family received a copy of the initial report. They did not make any comments.

19. The service also received a copy of the initial report. They responded to our recommendations. They made some accuracy comments, which were addressed.

Background Information

HMP Pentonville

20. HMP Pentonville is a local prison that holds over 1,300 young adult and adult men. The prison primarily serves the courts of north and east London.

21. Healthcare services are provided by Care UK in partnership with Enfield and Haringey Mental Health Trust. There is a large purpose built healthcare centre, which has 22 inpatient beds and a daycare facility for patients with mental health problems who are managed on the wings.

HM Inspectorate of Prisons

22. The most recent inspection of HMP Pentonville to be published was in February 2015. Inspectors reported that the prison was running below its agreed staffing level and staff supervision was often poor. Most prisoners felt unsafe and levels of violence were much higher than in similar prisons. Relatively few prisoners were assessed as at risk of suicide and self-harm and processes to support them needed improvement.

23. Prisoners' views about staff were negative and the poor physical environment was exacerbated by overcrowding. Only around half of prisoners felt that staff treated them respectfully. Prisoners said that they had distant relationships with staff. Inspectors witnessed some indifferent responses to prisoners in need of assistance, and prisoners often expressed their frustrations at their inability to get things done. Inspectors observed long delays in officers answering cell bells and noted that this had also been the case at earlier inspections. Inspectors noted that there was a suitable range of primary healthcare services and some good secondary mental health care and daycare.

Independent Monitoring Board

24. 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 March 2016, the IMB reported that staffing levels remained insufficiently low and temporary regimes had been introduced as a result. The IMB also found that adequate medical care was delivered but that the support of prisoners at risk of suicide and self-harm needed improving. They recognised that cell bells were misused by prisoners and there was often an unacceptable delay in the subsequent staff response.

Previous deaths at HMP Pentonville

25. Mr Borketas was the tenth prisoner to die at Pentonville since June 2014, and the fifth self-inflicted death. In previous investigations, we found that prison staff did not fully consider risk factors for suicide and self-harm and manage this risk accordingly. We have also previously found that staff took too long to answer cell bells.

Key Events

26. Mr Vilhemas Borketas was born in Lithuania. He moved to the UK with his parents at the age of 12. He went to Denmark at the age of 17 and to Iceland a couple of years later, returning to the UK in 2014. He communicated in English well.

27. On 12 April 2016, a GP referred Mr Borketas to the community mental health services because he reported hearing voices and experienced visual hallucinations. He was prescribed antipsychotic medication.

28. The community mental health services informed Mr Borketas' GP that he had not accessed their services. They were unable to make any contact with Mr Borketas in the community. He said that he had engaged with mental health services in the community abroad and there is no evidence that he engaged with them in the UK.

29. On 12 July 2016, Mr Borketas was remanded to HMP Pentonville charged with attempted robbery. On 12 October, he was sentenced to 10 months in prison. This was Mr Borketas' first time in prison. He was due to be released on 10 December 2016.

30. At an initial health screen, Mr Borketas told a nurse that he had a history of mental ill-health but no previous history or current thoughts of self-harm or suicide. Mr Borketas had been a heavy drinker from the age of 14 and used illicit drugs, including crack cocaine and cannabis. He said he had used heroin in the previous month. The nurse referred Mr Borketas to a prison GP, who reviewed him and carried out a urine test for drugs. Results for opiates were negative.

31. The prison GP said Mr Borketas appeared very calm and settled and did not show signs of serious mental health problems. She noted that he was experiencing alcohol withdrawal. She started him on an alcohol detoxification programme and prescribed chlordiazepoxide (which produces a calming effect on the brain and nerves). She referred Mr Borketas to the substance misuse clinic and the mental health in-reach team because he said a doctor had diagnosed him with anxiety and depression in the community. The clinical reviewer found no evidence of this diagnosis in Mr Borketas' community medical records.

32. During a first night interview, Mr Borketas told an officer that he had no thoughts of suicide or self-harm. The officer did not record any concerns. Mr Borketas was located in a shared cell on the drug treatment unit.

33. On 15 July, a psychologist assessed Mr Borketas' mental health. Mr Borketas said that he had received support from his GP for his mental health problems but had not had contact with mental health services in the community. She recorded that Mr Borketas' mood and presentation were fine. However, he was anxious and wanted to speak to his mother and was happy that staff had arranged a welfare call to her for him. She recorded that Mr Borketas said that he had not been hearing voices but she noted that at one stage during the course of the assessment he turned his head to the side and laughed inappropriately. She referred him to a primary care anxiety group and to the substance misuse team.

34. At a multidisciplinary team meeting on 18 July, Mr Borketas was referred to a psychiatrist for an urgent appointment. The same day a substance misuse worker discussed the dangers associated with using drugs with Mr Borketas. He told him that he wanted to study humanities and work when released. He said that he had no debts. He recorded that Mr Borketas was homeless and referred him to drug awareness, mental health and relationship programmes.

35. On 19 July, Mr Borketas spoke to a resettlement worker (who creates resettlement plans during the prisoners last 12 weeks in custody, to address their support needs). She noted that Mr Borketas was quiet and appeared distracted. She did not note any major concerns about his presentation. She recorded that he was homeless and planned to make a referral to St Mungo's, a homelessness charity and housing association. Mr Borketas told her that he was feeling well with his alcohol detoxification programme.

36. Mr Borketas missed two appointments with the specialist forensic psychiatrist on 22 and 26 July. The reason for his non-attendance was not recorded in his medical records.

37. On 27 July, six prisoners assaulted Mr Borketas. A psychiatrist said that Mr Borketas told her that the assault was because he owed tobacco (medical records show that Mr Borketas smoked 20 cigarettes a day). An officer submitted an intelligence report and Mr Borketas was moved to a different residential unit the next day. Staff did not investigate this matter further.

38. On 29 July, the psychiatrist visited Mr Borketas in his cell because he had not attended his clinic appointment in the morning. She conducted a detailed examination and noted that his engagement was limited but he had good eye contact. She reported that there was no evidence that he had an acute mental health problem. She made another appointment for him for 2 August, and noted that officers had not raised any concerns.

39. On 2 August, the psychiatrist examined Mr Borketas (having obtained a copy of his community medical records). Mr Borketas told her that he had had daily mood swings for about a year but his mood was currently fine. He was finding prison difficult because he missed his family. He had had suicidal ideas in the past and sometimes heard voices. She noted that Mr Borketas was pleasant, co-operative and appeared calm. She found no evidence that he had an acute mental disorder but planned to continue to review him due to his lack of engagement. She referred him to daycare (a team of occupational therapists who run a programme of structured daily activity to meet the needs of prisoners with mental, emotional and physical health issues).

40. On 14 August, Mr Borketas had a fight with his cellmate. A custodial manager submitted an intelligence report and an officer conducted an investigation. Mr Borketas told him that the fight started because his cellmate was taking his food and when he confronted him, his cellmate threw a chair at him. The prison did not take any further action. The investigator found no evidence that Mr Borketas was offered support.

41. On 16 August, the psychiatrist reviewed Mr Borketas to explore his experiences of hearing voices and paranoid thoughts. Mr Borketas told her that he was

feeling better. He said he felt scared and feared for his life, that he would get hurt but did not know by whom, how or why but related these thoughts to a difficult childhood. She noted that Mr Borketas was calm, coherent, and co-operative and his mood was fine. She noted that he did not express any thoughts of suicide or self-harm. She concluded that Mr Borketas was not suffering from a psychotic illness but due to his vagueness she planned to continue reviewing him and referred him to Mind Connect, a counselling service to help him manage his childhood memories.

42. On 23 August, an occupational therapist carried out an initial assessment for daycare therapy. Mr Borketas attended five sessions and then disengaged. Mr Borketas told a mental health support worker that he did not want to attend the sessions and was not interested in daycare activities. Mr Borketas continued to not attend daycare activities the reason for his non-attendance was recorded as unknown. Healthcare professionals continued to assess and review Mr Borketas' mental health but reported that he was extremely guarded and it was very difficult to get information from him.

43. On 22 September, Mr Borketas attended daycare for the first time in three weeks. An occupational therapist recorded that Mr Borketas was quiet, but appeared calm.

44. On 28 and 29 September, Mr Borketas attended a psycho-educational group and a substance misuse review. Staff recorded no concerns.

45. On 3 October, Mr Borketas spoke to a Supervising Officer (SO) and told him that other prisoners were threatening him. Mr Borketas did not provide any names or describe the prisoners to him. He said that a note containing threats was passed to him under his cell door. He did not show the SO the note or say what the specific threats were. He said that his cellmate knew who these prisoners were.

46. The SO submitted an intelligence report and made a detailed note in Mr Borketas prison records about this interaction. He told the investigator that he spoke to other members of staff and other prisoners but they did not provide any further information, raise any concerns or confirm Mr Borketas' allegation. He said that Mr Borketas was not using any illicit drugs nor did he have any in his possession. He did not see Mr Borketas dealing drugs or suspect he was in debt and said that Mr Borketas did not raise any further concerns. The Head of Safer Custody told the investigator that this matter never came to the safer custody team's attention.

47. Mr Borketas' cellmate told the investigator that Mr Borketas had upset some prisoners on the wing during a kit change because he was requesting more items than allowed. (Prisoners carry out kit changes on Saturdays and the kits include items the prison issues to a prisoner, such as bedding, towels, blankets or clothing.) Mr Musa said that he intervened so that the situation did not escalate. He described the incident as minor. He said that prisoners did not threaten or bully Mr Borketas on the unit.

48. The cellmate said that when he shared a cell with Mr Borketas, he appeared to be very depressed, did not communicate much with him and did not interact with

other prisoners during association. He said that Mr Borketas was not in debt with anybody and did not take drugs.

49. On 7 October, the psychiatrist reviewed Mr Borketas in his cell. She recorded that he did not want to answer any questions and did not want to come out of his cell. An officer asked Mr Borketas to engage with the psychiatrist, but he did not want to. The officer said that often Mr Borketas did not want to leave his cell or interact with anybody and described him as a very reserved person who kept matters to himself. She said that Mr Borketas did not appear to be sad or depressed and never expressed any concerns about prison life and did not express thoughts of suicide or self-harm.

50. The psychiatrist told the investigator that she felt that something was not right about Mr Borketas because he had stopped engaging with mental health services and was vague and selective with the information he provided to her. She concluded that he did not have an acute mental health problem and did not need medication but thought it possible that he showed early signs of psychosis. She considered moving Mr Borketas to the healthcare in-patient unit for a comprehensive assessment, but Mr Borketas would not agree to move.

51. On 12 October, Mr Borketas attended court. He was convicted of robbery and was sentenced to 10 months in prison.

52. A mental health nurse visited Mr Borketas in his cell to discuss his poor engagement with their services and asked him whether he would agree to move to the healthcare unit for more support. Mr Borketas said that he did not want to move and did not need support because there was nothing wrong with him.

53. On 14 October, a worker from the mental health in-reach team spoke to Mr Borketas in his cell and noted that he was low in mood. Mr Borketas told him that it was because he was in prison and missed his family. Mr Borketas said that he did not have any current thoughts of suicide or self-harm.

54. On 15 October, Mr Borketas spoke to an officer. He was tearful and said that he was concerned that his father might be in danger. The officer said that Mr Borketas was vague and unclear about the reasons for his concern but facilitated a call for him. He said that Mr Borketas did not interact or socialise on the unit and spent most of his time in his cell. He said that he did not find Mr Borketas' behaviour concerning because it was common to see prisoners being quiet and keeping to themselves.

55. On 26 October, a worker from the mental health in-reach team went to see Mr Borketas in his cell but Mr Borketas refused to speak to him. Mr Borketas did not want to go out for association and did not say why. He thought that Mr Borketas' mental health might have deteriorated and asked him whether he wanted to move to the inpatient unit, but Mr Borketas said that he did not want to move. He decided to continue reviewing him. A few days later, Mr Borketas told him that he did not want to attend other activities or education and did not understand why healthcare staff continued to review his mental health. He removed Mr Borketas from daycare therapy but notwithstanding his lack of engagement, he and the psychiatrist continued to review Mr Borketas on his unit.

56. The mental health team continued to engage Mr Borketas and made a concerted effort to ensure he was regularly reviewed.

57. On 10 November, Mr Borketas made a phone call to his mother. The investigator read an English translation of the phone call. Mr Borketas' mother reminded him of his release date; he appeared to be looking forward to his release. Mr Borketas did not mention anything about debts, being threatened or that he had any other concerns. Mr Borketas told his mother that he was fine and that he was keeping to himself and was staying out of trouble.

58. The next day, the psychiatrist and worker from the in-reach team spoke to Mr Borketas in his cell. They also spoke to an officer, who told them that Mr Borketas was taking his meals but otherwise stayed in his cell with limited interaction with others. Mr Borketas told the psychiatrist that he was fine but felt sad sometimes, when he thought about his family. He said he was fine and did not have any thoughts of suicide or self-harm. Mr Borketas told her that once released he was going to live with his parents and wanted to work. The in-reach worker said that Mr Borketas had good eye contact, appeared calm, was not distressed and his speech was coherent.

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59. On the morning of 21 November, the resettlement worker returned to Mr Borketas' cell to talk to him about his housing needs in the community. She was aware that he was going to be released on 10 December and wanted to arrange a referral to St Mungo's. Mr Borketas told her that he did not want to talk to her and did not need help. She said that Mr Borketas appeared very clam and did not raise any particular concerns. She planned to return on another day, before his release, in case he wanted to speak to her.

60. Mr Borketas' cellmate told the investigator that Mr Borketas did not want to associate or communicate with anybody and that they did not talk to each other while they were cellmates (they shared a cell for about 20 days). He said that Mr Borketas received a letter earlier on in the day; he tore it up and flushed it down the toilet. The Head of Safer Custody told the investigator that nobody knew anything about the letter. Mr Borketas' solicitor said that Mr Borketas had no immigration issues and did not know of any official correspondence that was sent to him.

61. The cellmate said that at about 10.00pm he fell asleep. He got up and saw Mr Borketas hanging from the window bars with a ligature made of sheets. He rang the cell bell and waited for assistance. (The police ruled out any involvement of him in Mr Borketas' death.)

62. The cell bell records show that the cellmate rang his cell bell at 10.27pm. The night patrol officer responded at 10.48pm. He said that when he arrived at the cell, he opened the observation panel and saw the cellmate standing behind the door and Mr Borketas hanging by the window bars. At 10.56pm, he called for staff support over his radio. He did not use an emergency code but said that a prisoner had a ligature on his neck by the window frame and required all staff attendance.

63. At 10.57pm, officers arrived and entered the cell. Two officers cut the ligature and placed Mr Borketas on the floor and begun cardiopulmonary resuscitation (CPR). At 10.58pm, a custodial manager arrived and called a code blue over the radio. Two nurses attended and continued with CPR.

64. The ambulance service records show that the prison requested an ambulance at 11.02pm and three ambulances were dispatched. The first team of paramedics arrived at the prison at 11.05pm and arrived at Mr Borketas' cell at 11.09pm. Paramedics took over resuscitation procedures until 11.52pm, when they pronounced that Mr Borketas had died.

Contact with Mr Borketas' family

65. At 11.35pm, the Head of Residence appointed an officer as the family liaison officer. They agreed not to deliver the news of Mr Borketas' death to his father immediately because they would have arrived at his home at 2.00am, which they considered to be inappropriate.

66. On 22 November, at 9.55am two officers informed Mr Borketas' father and brother that Mr Borketas had died in person. The officers answered Mr Borketas' family's questions, offered support and maintained contact with them thereafter.

67. Mr Borketas funeral was held on 30 December. The prison contributed to the funeral costs in line with national policy.

Support for prisoners and staff

68. After Mr Borketas' death, the Head of Residence 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.

69. The prison posted notices informing other prisoners of Mr Borketas death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm, including the cellmate, in case they had been adversely affected by Mr Borketas death.

Post-mortem report

70. The Coroner gave the cause of death as suspension by ligature. The toxicology examination found no alcohol or drugs in his blood.

Findings

Assessment of risk

71. Prison Service Instruction (PSI) 64/2011, which covers safer custody, provides a not exhaustive list of a number of risk factors and potential triggers that might increase the risk of suicide and self-harm and requires staff to take appropriate action, including starting ACCT procedures, if necessary. These risk factors were also listed in our thematic report published in 2014. It was Mr Borketas' first time in prison, he was lonely and was isolated from staff and prisoners, he missed his family, was victim of an assault, and often experienced low mood. He also had some involvement with the mental health team at the prison. His imminent release (being homeless) was also a risk factor for increased risk of suicide or self-harm. Staff were not fully alert to Mr Borketas' risk factors and, as a result, were not able appropriately to address his concerns.

72. (PSI) 64/2011 also outlines the principle that all staff involved with the prisoner must share information on risk of harm to self and others. The PSI stipulates that this can be verbally, in reports, requests for information or emails.

73. We found little evidence that healthcare staff and prison staff shared relevant information about Mr Borketas' risk factors for suicide and self-harm. They, for instance, did not share information about Mr Borketas' mood swings, or when he said that he felt sad, his statements that he was finding prison life difficult, that sometimes he felt scared and feared for his life, that he felt that he would get hurt but did not know by whom or that he missed his family. Healthcare staff did not share relevant information that could have prompted prison staff to make arrangements to monitor him or offer further support.

74. In our thematic review of learning from PPO Investigations on mental health, published in January 2016, we said that it is vital that relevant information is communicated to prison staff, when that information might affect the prisoner's safety or welfare. When prison staff are well informed about a prisoner's safety or welfare issues, this can help them to relate to that prisoner's behaviour, to recognise distress and to respond in the most appropriate manner to support that prisoner. We make the following recommendation:

The Governor and Head of Healthcare should produce clear local guidance about procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular, this should ensure that staff:

- **Are aware of, consider and record all the known risk factors for suicide or self-harm. They should open an ACCT whenever a prisoner has significant risk factors;**
- **Share information, in particular between healthcare and prison staff about a prisoner's mental health or risk factors for suicide and self-harm to provide collaborative care and treatment.**

Safety of prisoners

75. Between July and October 2016, prison staff submitted a number of intelligence reports following a fight Mr Borketas had with his cellmate, after Mr Borketas was

assaulted by other prisoners and in connection with concerns Mr Borketas raised about threats from other prisoners. The fight and the assault were followed up by wing staff but there is no record that anyone investigated these allegations further or took any formal action to support Mr Borketas other than moving him to a different wing, and no evidence that any follow up action to identify and challenge the perpetrators took place.

76. Pentonville's violence reduction strategy says that it operates a zero-tolerance approach to violence and violent assault is not consequence free. The policy says that prisoners involved in violent incidents should be supported through quality follow up actions and more staff/prisoner engagement. We would expect that, where possible, the prison should investigate all incidents of violence and antisocial behaviour. While there was evidence that a SO enquired with other prisoners and staff about Mr Borketas' concerns, there is no evidence that any of the security intelligence reports were referred to the safer custody team or discussed at the safer custody and violence reduction team meetings.

77. Incidents of violence have a clear emotional and psychological impact on prisoners. The PPO has published a range of publications identifying the links between bullying and suicide, but we are concerned that prison staff did not seem to have recognised or considered that the assaults and perceived threats experienced by Mr Borketas might have increased his risk of suicide or self-harm.

78. In a review of self-inflicted deaths, published in June 2011, we found evidence of bullying and intimidation in 20 per cent of the cases we reviewed. In a follow-up report of October 2011, 'Violence reduction, bullying and safety', we identified the importance of implementing local violence reduction strategies, investigating all allegations of bullying and recognising that individuals who have been the victim of bullying are potentially at greater risk of suicide and self-harm.

79. We repeated similar messages in our review of all self-inflicted deaths in prisons in 2013/14 and pointed to the need for all reports or suspicions that a prisoner is being threatened or bullied to be recorded and thoroughly investigated and for the potential impact on the victim's risk of suicide to be considered. We make the following recommendation:

The Governor should ensure that all information about bullying and intimidation or assault is fully coordinated and investigated; that those suspected of involvement are appropriately challenged and monitored; that staff consider whether victims are at increased risk of suicide or self-harm; and that apparent victims are effectively supported and protected with meaningful, long term solutions, which address their individual situation.

Meaningful contact

80. There was no personal officer scheme at Pentonville when Mr Borketas was in prison. Plans for a scheme of that nature were going to be put in place. While staff from the mental health team and substance misuse clearly interacted with Mr Borketas on a number of occasions, he did not have a named point of contact on his wing. For someone like Mr Borketas, who was reserved and isolated, such an approach could have provided him with additional support. We note that

these findings are consistent with those of HM Inspectorate of Prisons and with previous fatal incident investigations and make the following recommendation:

In the absence of and pending the introduction of an effective personal officer scheme, the Governor should ensure all prisoners have meaningful contact with identifiable wing officers who regularly check their wellbeing and record their contact

Clinical care

81. Healthcare staff offered Mr Borketas structured support to deal with his drug and alcohol problems. Mr Borketas was appropriately referred to mental health services on arrival at Pentonville. The mental health team monitored closely Mr Borketas because he was guarded and vague about his history. Healthcare staff considered that such monitoring was appropriate as there was no clear diagnosis of mental health issues but his presentation was somewhat unusual.

82. Mr Borketas declined engagement with mental health services at the prison. Healthcare staff offered him an opportunity to move to the healthcare unit for further review but he declined. Healthcare staff found nothing in his behaviour, which indicated that a process to compel assessment should have been followed.

83. The mental health team made extensive efforts to engage and support Mr Borketas. The clinical reviewer commended the input of the healthcare team on Mr Borketas' care and found good practice in their identification of Mr Borketas as a patient requiring mental health services, and their subsequent persistence, reviewing him, notwithstanding his lack of engagement.

Response to Mr Borketas' cell bell

84. HMIP has an expectation that cell bells should be answered within five minutes. Inspectors have noted at successive inspections that staff at Pentonville do not respond to cell bells as promptly as they should. The issue has also featured in previous fatal incident investigations.

85. It took the night patrol officer 20 minutes to respond to the cellmate's cell bell. He told the investigator that he was answering cell bells on other landings when he noted that Mr Borketas' cell bell went on and then responded to it. Records show that in the hour prior to the cellmate ringing the bell, he answered eight cell bells (on three different landings). There is no record that he answered any cell bells from 10.27pm to 10.48pm.

86. We made recommendations following self-inflicted deaths in 2014 and 2016, that cell bells should be promptly answered. The prison accepted those recommendations and confirmed that cell bell response times would be monitored and staff would be reminded of the need to respond to cell bells within five minutes. We repeat the recommendation that:

The Governor should ensure that all cell bells are answered within five minutes.

Emergency response

87. PSI 03/2013, Medical Emergency Response Codes, contains mandatory instructions for efficiently communicating the nature of a medical emergency, ensuring staff take the relevant 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, this instruction and their responsibilities during medical emergencies.

88. This national instruction required prisons to have a two level code system, which differentiates between a blood injury and all other injuries, usually code red, and code blue. The night patrol officer did not call a code blue and it took around 30 minutes from the time the cellmate pressed the cell bell, to staff entering Mr Borketas' cell. He said that he did not call the code blue because he panicked.

89. Pentonville's local protocol states the control room should call an ambulance automatically as soon as any emergency code is radioed. After the night patrol officer responded to the cellmate's cell bell there was a further delay of at least ten minutes before an ambulance was called. We cannot say how much this delay affected the outcome for Mr Borketas; however, it might be crucial to the outcome in other emergencies in the future. We make the following recommendation:

The Governor should ensure that all prison and healthcare staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies as outlined in the local Medical Emergency Response Code Protocol so that staff efficiently communicate the nature of a medical emergency, and there is no delay in calling, directing or discharging ambulances.

Prisons & Probation Ombudsman
Independent Investigations

PO Box 70769
London, SE1P 4XY

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

T | 020 7633 4100
F | 020 7633 4141