Regulation 28: Prevention of Future Deaths report

Vilhelmas BORKERTAS (died 21.11.16)

	THIS REPORT IS BEING SENT TO: **1. Mr Kevin Reilly** **Governor** **HMP Pentonville** **Caledonian Road** **London N7 8TT**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 25 November 2016, one of my assistant coroners, Richard Brittain, commenced an investigation into the death of Vilhelmas Borkertas, aged 24 years. The investigation concluded at the end of the inquest on 26 October 2017. The jury made a narrative determination, which I attach.
4	**CIRCUMSTANCES OF THE DEATH** Mr Borkertas took his own life on 21 November 2016. His cellmate described waking up in the evening needing to use the toilet, putting on the light and finding Mr Borkertas hanging by a ligature from the window bar. The cellmate rang the cell bell.

	It was answered by an operational support grade 21 minutes later. The OSG then called for assistance and Mr Borkertas was cut down when other members of staff arrived. They attempted resuscitation, but this was unsuccessful.
5	**CORONER'S CONCERNS** During the course of the inquest, the evidence revealed matters giving rise to concern. In my opinion, there is a risk that future deaths will occur unless action is taken. In the circumstances, it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. I gave a great deal of consideration at inquest to the exploration of the time it took staff to attend to Mr Borkertas after his cellmate rang the cell bell. However, I do not write about that now because I know that it is a matter already under scrutiny by the prison, and I do not think there is anything that I can helpfully add. However, there is another matter that I should like to bring to your attention. Mr Borkertas described himself variously as heterosexual and bisexual. The latter was recorded on his cell sharing risk assessment form. His cellmate at the time of death described himself as being homophobic. This was recorded on his cell sharing risk assessment form. However, the two were placed together in a cell and I heard no evidence that consideration was ever given to the potential dangers of this. There is nothing to indicate that this had an impact upon the outcome, but it might be devastating in another case.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 2 January 2018. I, the coroner, may extend the period.

	Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the following. • HHJ Mark Lucraft QC, the Chief Coroner of England & Wales • HM Inspectorate of Prisons • National Offender Management Service • [redacted], Vilhelmas Borkertas's father I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**DATE** **SIGNED BY SENIOR CORONER** 31.10.17