

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Joseph Dybowski a prisoner at HMP Bristol on 31 May 2017

A report by the Prisons and Probation Ombudsman

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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 Joseph Dybowski was found dead in his cell at HMP Bristol on 31 May 2017, having died of electrocution. He was 48 years old. We offer our condolences to Mr Dybowski's family and friends.

Mr Dybowski's death appears to have been an accident, but we note that there are inconsistent accounts of what was found in his cell.

We are concerned that a roll check was not completed the night before Mr Dybowski was found. It is also troubling that, once more, we have to make a recommendation to HMP Bristol about emergency procedures.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman

April 2018

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Summary

Events

1. On 18 May 2017, Mr Joseph Dybowski was recalled to prison on suspicion of theft and was sent to HMP Bristol.
2. At his initial health screen, Mr Dybowski told the nurse he had not previously taken drugs. She did not check his previous record, which would have shown that he had a history of heroin use.
3. On the evening of 30 May, Mr Dybowski seemed well and spoke to other prisoners. At approximately 8.00pm a prisoner, who was in the cell next to Mr Dybowski, said he heard a bang from his cell but did not alert officers.
4. At 8.40pm, an OSG (operational support grade) started the wing's roll check. He did not check the prisoners on Mr Dybowski's landing because the landing gate was locked, and he did not want to disturb the officers who had the key because they were having a 'heated conversation'. Instead, he reported the roll numbers from the wing's roll list.
5. At 5.20am on 31 May, the OSG conducting the morning roll check checked Mr Dybowski's cell and failed to get a response. He did not go into the cell and called over another officer. The second officer did not go into the cell either and asked another officer to attend, then radioed the control room for permission to go into the cell.
6. The officers found Mr Dybowski face down in a pool of vomit and one of them called an emergency code. Nurses attended and decided that resuscitation would not be appropriate as Mr Dybowski had clearly died. Paramedics arrived at 5.50am and confirmed Mr Dybowski's death at 6.00am.
7. The post mortem found that Mr Dybowski died from electrocution and associated vomiting. A kettle with exposed wires was in his cell, in reach of where he was found. The pathologist's report (supported by prison accounts) suggests that scene of crime photographs recorded a scorched cotton bud near the kettle. However, the police dispute this and have no record of any such item.

Findings

8. It seems likely that Mr Dybowski was using his kettle to try to light something and electrocuted himself accidentally, but we cannot be sure. We cannot say what he might have been trying to light, but there is no evidence to suggest it was for the purpose of taking drugs.
9. Failure to complete an effective roll check meant that an opportunity to find Mr Dybowksi earlier may have been missed.
10. Staff inappropriately delayed entering the cell. Although this delay would not have changed the outcome for Mr Dybowski, in other circumstances it could and is clearly inconsistent with Prison Service policy.

Recommendations

- The Governor should ensure that all staff are reminded of the importance of roll checks, how to carry them out and the consequence of not doing so.
- The Governor should ensure that all prison staff are made aware of, and understand their responsibilities during medical emergencies, including entering cells and using emergency codes.

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Bristol informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
12. The investigator obtained copies of relevant extracts from Mr Dybowski's prison and medical records. She interviewed one member of staff and obtained transcripts of a disciplinary investigation conducted by the prison.
13. NHS England commissioned a clinical reviewer to review Mr Dybowski's clinical care at the prison.
14. We informed HM Coroner for Avon of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
15. The investigator contacted Mr Dybowski's daughter to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not raise any concerns.
16. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Bristol

17. HMP Bristol is a local prison, which can hold up to 614 sentenced and remanded men. Bristol Community Health provides primary healthcare and Hanham Health Services provides GP services. Avon and Wiltshire Partnership provides mental health and psychosocial substance misuse services and Bristol Community Health provides clinical substance misuse services.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Bristol was in March 2017. Inspectors reported that most of the residential wings were dilapidated and dirty, that 53% of prisoners said it was easy to get drugs and that violence towards staff and between prisoners was high. Inspectors also reported that staff-prisoner relationships were quite good, with two thirds of prisoners saying staff treated them respectfully (although this was a decrease from the previous inspection).

Independent Monitoring Board

19. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In their latest annual report, for the year to July 2017, the IMB reported that while they were previously extremely concerned by low staffing levels, the headcount had actually improved but there was still a weekly deficit at the prison of approximately 800 prison officer hours. (They also reported that approximately 60% of staff had less than two years' experience.) The board had also previously remarked on the 'defiant' use of drugs and the associated violence and bullying at Bristol and raised these themes again this year.
20. The IMB acknowledged that frontline staff's work can be difficult, dangerous and distressing but noted that there appeared to be a legacy of 'learned helplessness' and 'general malaise' at HMP Bristol.

Previous deaths at HMP Bristol

21. Mr Dybowski's is the fourth death from natural causes in the last two years. We have previously made recommendations about the prison's emergency response procedures.

Key Events

22. On 18 May 2017, Mr Joseph Dybowski was recalled to prison on suspicion of theft and was sent to HMP Bristol.
23. On 18 May, a nurse conducted Mr Dybowski's initial health screen. Mr Dybowski told her that he had not previously used drugs although historical records from 2008 showed he had used heroin. She identified that he had previously misused alcohol. Healthcare staff did not see Mr Dybowski again before his death.
24. Later that day, a nurse sent a task to the prison GPs saying that Mr Dybowski was not registered with a community GP but had been prescribed glycerol trinitrate (GTN) during a previous period in custody. (GTN is used to treat chest pains usually caused by angina.) An unnamed GP responded, noting that as Mr Dybowski did not have a diagnosis of ischaemic heart disease, he should have a doctor's review before a prescription was written. The nurse made an appointment for Mr Dybowski to see a GP on 9 June 2017.
25. On 30 May 2017, at approximately 5.00pm, three prisoners saw Mr Dybowski and had a chat. They reported that Mr Dybowski was in good spirits and they had no concerns about him. Two of the prisoners said they knew he had been waiting some time for his GTN spray.
26. That evening, at approximately 8.00pm, the prisoner who was in the cell next door to Mr Dybowski said he heard banging noises coming from the direction of Mr Dybowski's cell, as if he had banged into something and fallen over. He did not alert staff or hear any further noises coming from Mr Dybowski's cell.
27. Two officers were on duty on Mr Dybowski's wing that evening. In his statement to the police, one officer said that his shift ended at 6.00pm and he could not remember locking Mr Dybowski in his cell. (The other officer has since left the Prison Service.)
28. At 8.40pm, an Operational Support Grade (OSG) started the wing roll check (a headcount of prisoner in their cells). He completed his counts on the first and second landings, but could not access the third landing because the gate was locked as a security measure because there was an issue with the landing's sanitation system. (Prisoners do not have toilets in their cells on this wing. During lock up they use an intercom in their cells to ask the control room to let them out. The automatic let-out system was not working, so officers had to let prisoners out of their cells manually and then unlock the gate manually so they could access the toilet block.)
29. The OSG did not have a key to the gate. He told the investigator that the two officers who were responsible for the sanitation escorts were having a 'heated conversation'. He did not want to interrupt them, so he went elsewhere until the situation calmed. When he returned, the officers were still arguing. He said this went on into the night. When a Custodial Manager phoned for the roll count, he reported the figures he had physically counted for landings one and two, but used figures he had taken from wing office board for the third landing.

30. At approximately 5.20am on 31 May, the OSG was conducting the morning roll check. He looked through the observation panel of Mr Dybowski's cell and saw Mr Dybowski on his bed but with his legs on the floor. He tapped on the cell door window several times, but did not get a response. He called to his colleague for help and she knocked on the window, calling Mr Dybowski's name, but did not get a response. She called to another officer to come over and radioed staff in the control room for permission to open the cell door, telling them that two officers and an OSG were present (which she believed was necessary under prison regulations).
31. Staff in the control room gave permission for the prison staff to enter the cell. They found Mr Dybowski face down on his bed in a pool of vomit. His upper limbs were mottled and rigor mortis had set in. He had a remote control in one hand and his prison identification card in the other.
32. An officer called an emergency code blue (indicating a prisoner is unconscious, not breathing or is having breathing difficulties) over the radio at 5.30am. On receiving the code blue call, staff in the prison control room telephoned for an emergency ambulance at 5.32am (ambulance records show the call was made at 5.34am).
33. Two nurses attended the cell but, as it was clear that Mr Dybowski had been dead for some time, they did not attempt resuscitation. Paramedics arrived at the wing at 5.50am and confirmed Mr Dybowski's death at 6.00am.

Contact with Dybowski's family

34. The prison appointed a family liaison officer. She visited Mr Dybowski's daughter that morning to inform her of Mr Dybowski's death. She continued to offer help and support in the following weeks.
35. Mr Dybowski's funeral was held on 21 June. The prison contributed to the funeral costs in line with national policy.

Support for prisoners and staff

36. After Mr Dybowski'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. The staff care team also offered support. The OSG said that he was not invited to a debrief, although the CM and the Local Care Team did offer him support.
37. The prison posted notices informing other prisoners of Mr Dybowski'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 Dybowski's death.

Post-mortem report

38. The coroner provided a copy of the post-mortem report, which confirmed Mr Dybowski died from electrocution with associated vomiting and a face down position.

39. The toxicology report found the presence of synthetic cannabinoids, but only in the urine and not in the blood, which suggested that any substances present could have been taken in the days leading up to death but not immediately prior to death. No other drugs were detected.
40. There was no suggestion of any significant cardiac disease to suggest that the chest pain Mr Dybowski had previously experienced was disease related.

Findings

The circumstances of Mr Dybowski's death

41. Mr Dybowski's kettle was on the shelf next to his bed, within reach, and had the wires exposed. (This is apparent from police photographs.) The pathologist's report recorded the presence of a short stick-like object, which looked like a cotton bud and was burned at each end, next to the kettle. This was supported by the accounts of prison staff. The investigator made enquiries of the police, but was told they had no record of any such item.
42. A prison manager told the investigator that prisoners sometimes used cotton buds to create a small smoulder by placing them on exposed wires, but did not know of them being used as devices to take drugs.

Clinical care

43. A nurse accepted Mr Dybowski's assertion that he had never used drugs, even though Mr Dybowski's historical record, which included his history of drug abuse, would have been available once she had completed the reception screening tool.
44. The clinical reviewer has made a recommendation, which we do not repeat in this report, but which the Head of Healthcare will wish to address.

Roll checks

45. The OSG did not conduct a proper roll check. A roll check is primarily a security check to count prisoners to ensure that they are present in their cells, but it is also an opportunity for any concerns about prisoners' safety to be identified and addressed.
46. The OSG told us that when the CM phoned for the roll count, he forgot that he had not actually physically conducted a count on the third landing and used the figures that were on the wing office's board. He said that he told the CM the next morning that he had not completed the roll check. The CM said that the OSG did not tell him this.
47. The prison conducted an investigation into the circumstances surrounding the roll check. At the time of writing we have not been notified of the outcome of the investigation.
48. Although we do not know whether an effective roll check would have changed the outcome for Mr Dybowski, we note that the noises that were reported from his cell occurred before the roll check. We also note that when he was found the following morning, Mr Dybowski had been dead for some time. We make the following recommendation.

The Governor should ensure that all staff are reminded of the importance of roll checks, how to carry them out and the consequences of not doing so.

Emergency response

49. PSI 24/2011, which mandates procedures for management and security at nights, says that staff have a duty of care to prisoners, to themselves, and to other staff. The preservation of life must take precedence over usual arrangements for opening cells and where there is, or appears to be, immediate danger to life, then cells may be unlocked without the authority of the night orderly officer and an individual member of staff can enter the cell on their own.
50. The OSG knocked on Mr Dybowski's cell door for some time before summoning an officer. The officer then called another officer and radioed staff in the control room for permission to open the cell door. Mr Dybowski was in a single cell and unresponsive. We see no reason why staff did not enter his cell immediately.
51. Prison Service Instruction (PSI) 03/2013 requires prisons to have a medical emergency response code protocol, which should ensure that an ambulance is called immediately when a medical emergency is called. Its provisions are mirrored in local policies at Bristol. There should be no requirement for control room staff to check with managers, healthcare staff or others at the scene before calling an ambulance, but they should wait for updates and keep the ambulance service informed. The PSI says that it is better to act with caution and request an ambulance that can be cancelled later if it is not needed.
52. Bristol's local policy instructs staff to use a medical code blue to indicate an emergency when a prisoner is unconscious, or having breathing difficulties, and code red when a prisoner is bleeding. Calling an emergency medical code should automatically trigger the control room to call an ambulance, and for healthcare staff to attend with the appropriate emergency equipment.
53. Although in this instance Mr Dybowski had clearly been dead for some time, there was a delay in calling a code blue, and we repeat the recommendation we have made to Bristol previously about its emergency response procedures.

The Governor should ensure that all prison staff are made aware of, and understand, their responsibilities during medical emergencies including entering cells and using emergency codes.

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