Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Henry Benoi-Davies (aka Jimmy Assani), a prisoner at HMP Nottingham, on 23 March 2022

A report by the Prisons and Probation Ombudsman

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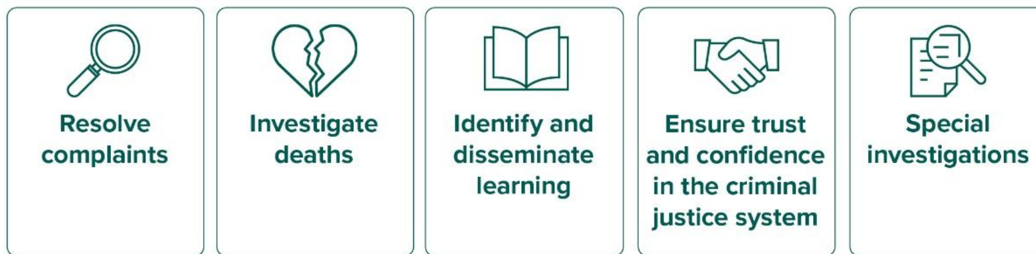
OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

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

Mr Henry Benoi-Davies died from ischaemic heart disease on 23 March 2022 at HMP Nottingham. He was 59 years old. I offer my condolences to Mr Benoi-Davies' family and friends.

When Mr Benoi-Davies arrived at Nottingham on 17 March 2022, he refused to cooperate with staff, and they thought he was under the influence of alcohol or drugs. The reception nurse was unable to carry out his reception health screen due to his behaviour and he was taken straight to the prison's segregation unit. Mr Benoi-Davies' bizarre behaviour continued, and nurses were unable to carry out a health screen over the next six days. On 23 March, he was found unresponsive on his cell floor.

Mr Benoi-Davies' physical health was not assessed at any time during his six days at Nottingham. The lack of reception health screen meant that Mr Benoi-Davies was not referred to a GP nor were his community records checked. I am concerned that after repeated attempts at a reception screen, no one considered alternatives to ensuring that Mr Benoi-Davies received continuity of care. I am also concerned that nurses did not complete a mental capacity assessment on Mr Benoi-Davies to establish whether he had capacity to make decisions about his healthcare.

The clinical reviewer concluded that the care that Mr Benoi-Davies received was only partly equivalent to that which he could have expected to receive in the community.

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

Kimberley Bingham
Acting Prisons and Probation Ombudsman **October 2022**

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Summary

Events

1. On 17 March 2022, Mr Henry Benoi-Davies (also known as Jimmy Assani) was remanded in prison custody, charged with burglary and assaulting a police officer. He was sent to HMP Nottingham.

2. When he arrived at Nottingham, Mr Benoi-Davies refused to leave the van. Officers asked the reception nurse to assess him on the van, but she was unable to carry out the reception health screen due to his disruptive behaviour. Officers moved him to the segregation unit.

3. Each day, nurses tried to complete a reception screen with Mr Benoi-Davies. However, they were unable to because of his bizarre behaviour. He spent most of his time naked in his cell and did not communicate with staff.

4. At around 11.25am on 23 March, while delivering meals to prisoners in the segregation unit, staff saw Mr Benoi-Davies unresponsive on his cell floor. Staff called a medical emergency code, entered the cell and started CPR. Healthcare staff attended quickly and assisted.

5. At 11.46am, paramedics arrived and continued with resuscitation attempts. However, these were unsuccessful and at 12.06pm, the paramedics pronounced that Mr Benoi-Davies was dead.

6. The post-mortem report concluded that Mr Benoi-Davies died of heart disease.

Findings

7. The clinical reviewer found that the care that Mr Benoi-Davies received at Nottingham was only partly equivalent to that which he could have expected to receive in the community.

8. Mr Benoi-Davies' physical health was not assessed by a medical practitioner at any time during his six days at Nottingham. The lack of reception health screen meant that he was not referred to a GP, his community records were not checked and he did not have pulse and blood pressure readings taken. Nurses also failed to carry out a mental capacity assessment.

9. The clinical reviewer also found that the standard of record keeping was poor.

Recommendations

- The Head of Healthcare should ensure that processes are in place to enable reception screening staff to make all reasonable attempts to secure and use past healthcare records to support reception screenings and ongoing care.

- The Head of Healthcare should undertake an immediate review into the actions of nursing staff between 17 and 23 March 2022 in relation to Mr Benoi-Davies' reception screening, assessment and care.

- The Head of Healthcare should review why a GP referral cannot be made until a reception screen has been completed, and implement any potential improvements identified.
- The Head of Healthcare should ensure all healthcare staff receive training and regular updates about the Mental Capacity Act 2005.
- The Head of Healthcare should ensure that all staff make full and accurate SystmOne records of any observations they have, or have not, completed on prisoners, including their rationale for clinical decision-making.

The Investigation Process

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

11. NHS England commissioned an independent clinical reviewer to review Mr Benoi-Davies' clinical care at the prison.

12. The investigator and clinical reviewer interviewed seven members of staff at HMP Nottingham on 10 May and three members of staff by video on 30 May.

13. We informed HM Coroner for Nottingham of the investigation who gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

14. The Ombudsman's family liaison officer contacted Mr Benoi-Davies' next of kin, his son, to explain the investigation and to ask if he had any matters he wanted us to consider. His solicitor responded to our letter. They had no questions but asked for a copy of the report.

15. Mr Benoi-Davies' family received a copy of the draft report. They did not make any comments.

16. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Nottingham

17. HMP Nottingham is a Category B prison, operated by Her Majesty's Prison Service. The prison holds approximately 1000 adult males. Nottinghamshire Healthcare NHS Foundation Trust provides 24-hour healthcare services at the prison.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Nottingham was in January 2020. Inspectors raised that safety of prisoners continued to be an ongoing issue for Nottingham, although noted they were making efforts to address this. They reported that from their previous inspection, healthcare services had improved and noted that staff-prisoner relationships in the segregation unit were positive.

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 its latest annual report for the year to February 2021, the IMB reported that they had concerns that mental health facilities were not meeting prisoners' needs, resulting in some prisoners remaining in the segregation unit longer than necessary. They also noted reduction in violence levels at the prison, suggesting some improvements in safety at Nottingham.

Previous deaths at HMP Nottingham

20. Mr Benoi-Davies was the seventh prisoner to die at Nottingham since March 2020. Of the previous deaths, five were from natural causes and one was self-inflicted. There are no similarities between our findings in the investigation into Mr Benoi-Davies' death and our investigation findings for the previous deaths.

Key Events

21. On 17 March 2022, Mr Henry Benoi-Davies (also known as Jimmy Assani) was remanded in prison custody, charged with burglary and assaulting a police officer. He was sent to HMP Nottingham.

22. When Mr Benoi-Davies arrived at Nottingham, he refused to leave the van. He seemed confused, had been refusing to wear clothes and had urinated in the holding cell. Staff asked the reception nurse to assess him on the van. The nurse said that Mr Benoi-Davies was only half-dressed, was banging on the window of the holding cell and could not communicate properly. She thought he might be under the influence of drugs or alcohol. She asked if a member of substance misuse staff could see him but was told that she would need to make a referral in the usual way. She had just returned from maternity leave and was unsure what to do.

23. Officers moved Mr Benoi-Davies to a cell in the segregation unit due to his behaviour. The reception nurse scheduled a reception health screen for the following day. She also referred him to the mental health team and substance misuse service (SMS).

24. That afternoon, a nurse recorded that Mr Benoi-Davies had failed the segregation algorithm due to ‘no communication and bizarre presentation’. (The segregation algorithm assesses whether a prisoner is fit to remain in segregation.) She noted that he was lying naked on his cell floor, was staring with his eyes wide open and had an odd smile when spoken to. She thought he might be under the influence of drugs. She spoke to SMS and they accepted him onto their stabilisation unit (which means that SMS staff carry out regular checks). SMS staff checked on Mr Benoi-Davies regularly over the next three days. He remained in the segregation unit. (A prison manager authorised that he should remain in segregation as he could not be managed safely elsewhere in the prison.)

25. On 18 March, a nurse recorded that Mr Benoi-Davies was naked in his cell and talking to unseen person/stimuli. She noted that he might be under the influence of an illicit substance or psychotic and that she would continue to monitor him.

26. That day, a nurse recorded that he was unable to see Mr Benoi-Davies for a mental health triage due to time constraints.

27. On 19 March, Mr Benoi-Davies flooded his cell. An officer recorded that he was in a state of confusion and anger. The officer noted that he had been seen every day on the healthcare rounds. However, the only notes in his medical record that day were the ones made by SMS staff.

28. On 20 March, a nurse recorded that she had been to see Mr Benoi-Davies but he was naked, confused and had flooded his cell. She did not carry out a health screen. Staff moved Mr Benoi-Davies to another cell.

29. On the morning of 21 March, two nurses went to assess Mr Benoi-Davies. An officer opened the cell door observation panel and saw Mr Benoi-Davies sitting on his bed naked. The officer asked Mr Benoi-Davies to put some clothes on but he refused. The nurses did not assess him.

30. That afternoon, a nurse went to see Mr Benoi-Davies. She noted that he was sitting on his bed naked and that he turned to look at her when she spoke to him but when he replied, no sound came out. She noted that she would discuss him with the doctor at the complex cases meeting on 24 March.

31. On 22 March, an officer noted that Mr Benoi-Davies had poured his dinner over himself. He also recorded that he continued to misuse his cell bell.

32. That day, a nurse recorded that she had contacted the segregation unit and had been told that Mr Benoi-Davies was in no fit state to be assessed as he was lying on his bed naked. She recorded that she would rebook his health screen for the next day. At interview, she said that it was standard for prisoners to be brought to the healthcare unit for their reception screen (because they had the healthcare computers there) and as Mr Benoi-Davies was naked and uncooperative, officers would not move him.

Events of 23 March

33. At 10.50am on 23 March, a nurse checked on Mr Benoi-Davies in his cell. She saw him conscious, lying on the floor. She did not consider his presentation to be out of the ordinary from her recent interactions with him.

34. At 11.11am, a nurse recorded that she had contacted the segregation unit about doing Mr Benoi-Davies' reception screen but had been told he was disorientated and still naked, as he had been for the past six days. She noted that she had rebooked the health screen for the next day.

35. At 11.24am, two officers and a custodial manager (CM) arrived on the wing and started giving meals to prisoners in their cells. Approximately one minute later, they arrived at Mr Benoi-Davies' cell. The CM opened the cell hatch and saw Mr Benoi-Davies on the floor but could not see him breathing. The CM opened the cell and called a medical emergency code. An officer began CPR. Another officer arrived shortly afterwards and took over.

36. At 11.27, nurses arrived at the cell. An officer continued to give CPR and alternated these duties with a prison nurse.

37. At 11.46am, paramedics arrived and continued to provide emergency first aid. An officer continued to provide CPR despite there being several healthcare colleagues present. Mr Benoi-Davies was pronounced dead at 12.06pm.

Contact with Mr Benoi-Davies' family

38. The prison appointed an officer as the family liaison officer (FLO). Nottingham did not have a listed next of kin for Mr Benoi-Davies. The FLO located Mr Benoi-Davies' brother's details as a previously listed next of kin by reviewing prison records. Mr Benoi-Davies' brother was in another prison. The Deputy Governor rang the prison to arrange for them to notify Mr Benoi-Davies' brother of his death in person. This was done at approximately 1.40pm on 23 March.

39. The following day, Mr Benoi-Davies' son attended court for a hearing due to take place for Mr Benoi-Davies. The court passed this information to Nottingham and at approximately 4:30pm, the FLO rang Mr Benoi-Davies' son to notify him of his death. The court had already made him aware.

40. The prison contributed financially to Mr Benoi-Davies' funeral in line with national instructions.

Support for prisoners and staff

41. After Mr Benoi-Davies' death, the Head of Safety 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.

42. The prison posted notices informing other prisoners of Mr Benoi-Davies' 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 Benoi-Davies' death. Prison staff offered support to a prisoner who witnessed the incident.

Post-mortem report

43. The post-mortem report concluded that Mr Benoi-Davies died from ischaemic heart disease.

Findings

Clinical care

44. The clinical reviewer found that the care that Mr Benoi-Davies received at Nottingham was only partly equivalent to that which he could have expected to receive in the community.

45. Mr Benoi-Davies' physical health was not assessed by a medical practitioner at any time during his six days at Nottingham. The lack of reception health screen meant that he was not referred to a prison GP, he did not have pulse and blood pressure readings taken, there was no medications reconciliation (where community medications are checked and continued if appropriate) and there was no urine testing. The clinical reviewer said it was possible that heart abnormalities may have been identified if pulse and blood pressure readings had been taken.

46. The clinical reviewer noted that healthcare staff were recording notes on Mr Benoi-Davies' prison SystmOne record (electronic medical record) from the day he arrived at Nottingham so would have had access to his past medical history. These records showed that Mr Benoi-Davies displayed similar behaviour at Nottingham in 2010 and he was diagnosed with bipolar affective disorder. There is no evidence that the healthcare staff caring for Mr Benoi-Davies between 17 and 23 March accessed this information. They might have been able to make more informed decisions about Mr Benoi-Davies' care had they done so.

47. We are concerned that after repeated attempts to carry out a reception health screen, no alternatives were considered to ensure continuity of care. We recommend:

    The Head of Healthcare should ensure that processes are in place to enable reception screening staff to make all reasonable attempts to secure and use past healthcare records to support reception screenings and ongoing care.

    The Head of Healthcare should undertake an immediate review into the actions of nursing staff between 17 and 23 March 2022 in relation to Mr Benoi-Davies' reception screening, assessment and care.

    The Head of Healthcare should review why a GP referral cannot be made until a reception screen has been completed, and implement any potential improvements identified.

48. The clinical reviewer was concerned that nurses did not complete a mental capacity assessment on Mr Benoi-Davies. We recommend:

    The Head of Healthcare should ensure all healthcare staff receive training and regular updates about the Mental Capacity Act 2005.

49. The clinical reviewer found that record keeping was of poor quality and not in line with nursing standards. Records about observations made on Mr Benoi-Davies through his observation panel appeared to be copied and repeated. There was no record of how Mr Benoi-Davies appeared physically, only that he was naked. We recommend:

The Head of Healthcare should ensure that all staff make full and accurate SystmOne records of any observations they have, or have not, completed on prisoners, including their rationale for clinical decision-making.

Inquest

50. At the inquest, held from 1 to 9 June 2026, the jury concluded that although evidence suggested there had been multiple failings in the care of Mr Davies, ultimately he had died from natural causes.

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