Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Amos Ndemo, a prisoner at HMP Norwich, on 10 December 2023

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

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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Amos Ndemo was found hanged in his cell on 10 December 2023 at HMP Norwich. He was 26 years old. I offer my condolences to Mr Ndemo's family and friends.

Mr Ndemo's behaviour for the first few months he was at Norwich was unusual, challenging, and unpredictable, but this was managed effectively by staff. From September, it appeared that Mr Ndemo was settling into the prison regime and said he was looking forward to his upcoming release (although the date of this had not been confirmed). There were no obvious triggers to Mr Ndemo taking his own life in December. I am satisfied that staff could not have foreseen his actions.

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

Adrian Usher
Prisons and Probation Ombudsman **August 2024**

Contents

Summary

Events

1. Mr Amos Ndemo was a Kenyan national in the UK on a skilled workers visa, employed as a nurse. On 16 May 2023, Mr Ndemo was arrested for harassment offences and was taken into police custody. The next day, he appeared at court and was remanded to HMP Norwich. It was his first time in prison. On his arrival, Mr Ndemo told a nurse that he did not have any thoughts of suicide or self-harm, but that he had a history of mental health issues. The nurse referred him to the mental health team.

2. On 19 May, a mental health nurse assessed Mr Ndemo. The nurse noted that he was anxious, agitated, confused, and that he had said “life was not worth living”. The nurse started Prison Service suicide and self-harm prevention procedures, known as ACCT. The next morning, Mr Ndemo said that he was missing his friends and family in Kenya and felt like he had lost everything by coming to prison.

3. Mr Ndemo behaved in an unusual, inappropriate, and paranoid manner. Staff were concerned about his mental health, and he was allocated a mental health co-ordinator and referred to a psychiatrist. On 29 May, staff closed Mr Ndemo’s ACCT as they no longer assessed him as a risk to himself.

4. In June, a psychiatrist assessed that Mr Ndemo was suffering from psychosis which was likely to have been drug induced. Over the next few months, Mr Ndemo’s behaviour became increasingly challenging. He continued to make inappropriate sexual remarks towards female members of staff, assaulted a prisoner and a member of staff, damaged prison property, flooded his cell and smeared faeces around it. His behaviour was managed well by prison staff, and he was regularly seen and reviewed by the mental health team.

5. Towards the end of September, Mr Ndemo’s behaviour started to settle. On 14 November, Mr Ndemo was convicted of stalking (several victims) and his case was adjourned until 20 December for sentencing. Mr Ndemo told staff that he was hoping to receive a short custodial sentence or be released.

6. On 21 November, Mr Ndemo spoke to his keyworker about his plans for the future. Mr Ndemo said that he was settled on the wing and was enjoying working in the production workshop. On 4 December, Mr Ndemo said that he would like to speak to the mental health team about his anxiety, so the keyworker requested a GP appointment on his behalf. The GP application was received and processed but did not get to the Mental Health Team until 11 December

7. On 10 December at 11.30am, an officer discovered Mr Ndemo suspended from his window by a ligature. The officer called a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties) and control room staff requested an ambulance immediately.

8. Seconds later, three prison officers responded to the code blue and entered Mr Ndemo’s cell. They cut the ligature, lowered Mr Ndemo to the floor and started chest compressions. Healthcare staff arrived and continued CPR. Mr Ndemo had

signs of rigor mortis. At approximately 11.45am, paramedics arrived at Mr Ndemo's cell and, at 11.46am, the paramedics pronounced that Mr Ndemo had died.

Findings

9. On his arrival at Norwich, staff were concerned about Mr Ndemo's mental wellbeing. His behaviour was challenging and complex, but this was managed well by prison staff and mental health professionals.

10. We found that Mr Ndemo gave no indication to staff that he was at risk of suicide in the weeks leading up to his death and we are satisfied that they could not have foreseen his actions.

11. The clinical reviewer found that the mental health care Mr Ndemo received at Norwich was partially equivalent to that which he could have expected to receive in the community.

12. We make no recommendations.

The Investigation Process

13. HMPPS notified us of Mr Ndemo's death on 11 December 2023.

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

15. The investigator obtained copies of relevant extracts from Mr Ndemo's prison and medical records.

16. The investigator interviewed nine members of staff at HMP Norwich and six members of staff via Microsoft Teams in January and February 2024. In April 2024, the investigation was reallocated to another investigator.

17. NHS England commissioned a clinical reviewer to review Mr Ndemo's clinical care at the prison. The clinical reviewer jointly interviewed staff with the investigator.

18. We informed HM Coroner for Norfolk of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

19. The Ombudsman's office contacted Mr Ndemo's next of kin, a friend, to explain the investigation and to ask if he had any matters he wanted us to consider. He contacted Mr Ndemo's father in Kenya, who asked:

    - How was it possible for Mr Ndemo to take his own life in prison?
    - How did Mr Ndemo die?
    - Was it possible that he was killed by somebody else in prison?
    - Was there any CCTV footage of the events surrounding his death?
    - Why was there a delay in the family being notified of his death?

20. We have answered these questions within this report.

21. Mr Ndemo's next of kin received a copy of the initial report. He did not make any comments.

22. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out one inaccuracy within one of the transcripts, and this report has been amended accordingly.

Background Information

HMP Norwich

23. HMP Norwich is a multifunctional local prison and young offender institution (YOI) which holds remand and sentenced category B, C and D men. The physical health care provider is Health Care Resourcing Group Limited. Mental health services are provided by Norfolk and Suffolk NHS Foundation Trust.

HM Inspectorate of Prisons

24. The most recent inspection of HMP Norwich was in August and September 2022. Inspectors reported that the recorded number of self-harm incidents was higher than in similar prisons and increasing, although repeat self-harmers accounted for around 68% of incidents. Monthly safety meetings analysed a wide range of data, but actions to address and understand the causes of self-harm were too limited. The number of prisoners receiving support through suicide and self-harm prevention procedures (ACCT) for was high, especially on A wing. Most staff inspectors spoke to were knowledgeable about the needs of those on ACCTs in their care, but staff on A wing were overstretched. Good quality assurance processes and consistent case management had improved the quality of ACCTs overall, but ongoing records of meaningful conversations were lacking.

25. Inspectors reported that mental health services were provided by a skilled, experienced, and multidisciplinary team, who were well led. Any immediate mental health needs were identified during the initial reception screening and appropriate information was shared to ensure continuity of care. A duty worker was allocated daily within the team to respond to urgent applications, triage new referrals and attend ACCT case management reviews. Patients with urgent referrals were seen promptly, but there were 47 patients on the waiting list for a routine appointment, with a waiting time of up to four weeks. Managers had put in place an appropriate strategy to reduce the waiting list and patients were being offered assessment appointments.

26. In July 2023, inspectors completed a review of the progress made since the last inspection. In their review, inspectors reported that fewer incidents of self-harm had been recorded since the last inspection. The number of prisoners receiving ACCT support had reduced, and prisoners they spoke to were more positive about the support they received.

Independent Monitoring Board

27. 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 2022 to 2023, the IMB reported that healthcare was broadly equivalent to that available in the community. They noted that the safety team continued to work hard to support men with mental health needs, however that caseloads for the mental health team were very high. Although self-harm had increased, staff acted professionally and with care towards prisoners who self-harmed and managed them through the ACCT process as necessary.

Previous deaths at HMP Norwich

28. Mr Ndemo was the fifteenth prisoner to die at Norwich since 1 December 2020. Eleven of the previous deaths were from natural causes and the other three were self-inflicted. None of these investigations raised issues relevant to the death of Mr Ndemo. Up to May 2024, there had been one further death due to natural causes since that of Mr Ndemo.

Assessment, Care in Custody and Teamwork

29. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner.

30. As part of the process, a care plan (plan of care, support and intervention) is put in place. The ACCT should not be closed until all the actions on the care plan have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison.

Key Events

31. Mr Amos Ndemo was a Kenyan national who was in the UK on a skilled worker visa. Mr Ndemo was a nurse who worked for Norfolk and Suffolk NHS Foundation Trust.

32. On 16 May 2023, Mr Ndemo was arrested for harassment offences and was taken into police custody.

33. On 17 May, Mr Ndemo was taken to court. While at court, escort officers completed a suicide and self-harm (SASH) warning form as Mr Ndemo had self-harmed by scratching and biting his arm. It was noted that the SASH form was added to the digital Person Escort Record (PER – a document for capturing and ensuring the transfer of information that can assist in the management of risk). After his court hearing, Mr Ndemo was remanded into custody and taken to HMP Norwich. It was his first time in prison.

34. Medical records show that Mr Ndemo was under the community mental health team (CMHT) secondary service at the time of his imprisonment. The CMHT secondary service supports adults with a severe mental illness or who have significant mental health concerns. Mr Ndemo was referred to the service after the community crisis team believed he was experiencing psychosis (a mental illness where a person loses contact with reality and feels, hears or sees things that are not there).

HMP Norwich

35. When Mr Ndemo arrived at HMP Norwich on 17 May, a nurse completed his reception health screen. Mr Ndemo said he had no thoughts of suicide or self-harm. He said he had no ongoing health concerns and although he was evasive in the details he provided, he said that he had a mental health history. He said that he had stayed in a psychiatric hospital in Kenya in 2020 and had received treatment from a psychiatrist in the community. The nurse noted that Mr Ndemo had presented with problematic behaviour while being held for court which had included exposing himself and masturbating in front of staff. The self-harm warning from the PER was noted, and she referred him to the mental health team.

36. The next morning, healthcare staff completed Mr Ndemo’s secondary health screen and he raised no issues.

37. Later that day, a Phoenix Futures recovery worker (the prison’s substance misuse service) attempted to see Mr Ndemo as part of his induction. When she arrived on the wing, prison staff were speaking to Mr Ndemo at his cell door. An officer told the recovery worker that it was not appropriate to speak to Mr Ndemo at that time and his appointment should be rebooked. A few hours later, a member of the chaplaincy team saw Mr Ndemo as part of his induction. They noted that Mr Ndemo appeared a little distressed but said he had no thoughts of harming himself. They relayed this to wing staff.

38. The next morning, night duty staff reported that overnight, Mr Ndemo had consistently misused his cell bell for mundane requests, ignored instructions, disturbed the wing by banging the cell window bars and smashed his television.

Wing staff relayed their concerns about Mr Ndemo's mental health to the mental health team who agreed to see him later that day.

39. At 10.40am, a Phoenix Futures recovery worker saw Mr Ndemo to complete his induction. Mr Ndemo did not answer any of her questions relating to substance misuse and refused to sign the associated paperwork. The recovery worker noted that Mr Ndemo was very emotional and appeared to be confused and was asking to see the mental health team. She rescheduled another induction session and noted that he was due to see the mental health team later that morning.

40. At approximately 11.00am, a mental health nurse saw Mr Ndemo to complete an assessment. She noted that Mr Ndemo had a history of drug induced psychosis and said that he had taken psychoactive substances (PS) overnight. She also noted that he was anxious, agitated, confused, and that he had said "life was not worth living". She started Prison Service suicide and self-harm monitoring and support procedures, known as ACCT. Staff set his ACCT observations at one every hour.

41. The next morning, ACCT case co-ordinator and a Supervising Officer (SO) chaired an ACCT review with a mental health nurse and Mr Ndemo. Mr Ndemo said that he was missing his friends and family in Kenya and felt like he had lost everything by coming to prison. They discussed his previous PS use and the nurse reminded Mr Ndemo that PS would have a negative impact on his mental health. The SO explained the support available to him at Norwich including the wellbeing representative, Listeners (prisoners trained by the Samaritans to provide confidential peer-support), staff and Samaritans and they discussed ways he could distract himself when feeling low. Mr Ndemo said that although he felt a bit better that day, he still had thoughts of harming himself. His ACCT remained open with observations set at one per hour.

42. Approximately one hour later, two prisoners assaulted Mr Ndemo after he entered another prisoner's cell and began masturbating. Due to his recent behaviour, Mr Ndemo was downgraded from the standard to the basic prison regime (where a prisoner loses access to certain privileges). A plan was created to help him improve his behaviour.

43. On 22 May, a recovery worker from Phoenix Features attempted to complete Mr Ndemo's substance misuse induction for the third time. As Mr Ndemo was behaving inappropriately and groping his crotch, the recovery worker ended the session and relayed this to the mental health team.

44. Later that day, a nurse was allocated as Mr Ndemo's mental health co-ordinator under the secondary mental health care team. Primary care is usually managed by the prison GP and patients are seen by primary mental health staff as required. Secondary care is usually managed by a mental health specialist and is for those with severe and enduring mental health problems.

45. On 23 May, staff discussed Mr Ndemo at the mental health multi-disciplinary meeting. They agreed that he needed to be assessed by a psychiatrist. Over the next few days, Mr Ndemo continued to act inappropriately towards female staff and misuse his cell bell. Prison management agreed that he should not be seen by lone working females.

46. On 29 May, a SO chaired an ACCT review with Mr Ndemo and a mental health nurse. Mr Ndemo said that he was feeling more settled and that being in prison was giving him a chance to 'collect his thoughts'. He said that he was constantly hungry and that he was not collecting his food. The SO arranged for an officer to assist him in collecting his food from the servery. They discussed Mr Ndemo's hobbies and spoke about education courses he could complete while in prison. Mr Ndemo said he did not have any thoughts of suicide or self-harm and that he would be very content if he had access to more food. The SO reminded him about the servery and canteen processes, and he said he understood. Staff decided to close Mr Ndemo's ACCT (subject to seven days post-closure monitoring) and reminded Mr Ndemo of the support networks available to him.

47. On 1 June, a nurse met Mr Ndemo for a mental health review. She noted that he said he had taken PS two days previously, and he said that this was why he had acted inappropriately towards female members of staff. She said that Mr Ndemo was coherent and appropriate throughout their conversation and his presentation did not raise any cause for concern.

48. The next week, a consultant forensic psychiatrist assessed Mr Ndemo. He concluded that Mr Ndemo's behaviours were consistent with an episode of psychosis, and it was likely that this psychosis was drug induced. He assessed that Mr Ndemo did not need any psychiatric treatment. He noted that Mr Ndemo could be managed under the primary mental health team and recommended that Mr Ndemo engage with Phoenix Futures for substance misuse support. As per the advice of the psychiatrist, on 20 June, Mr Ndemo was transferred from the care of the secondary mental health team to the primary mental health team. It was agreed that he would be seen on a fortnightly basis. However, he was not referred to Phoenix Futures.

49. Over the next few months, Mr Ndemo's behaviour became increasingly challenging. He continued to make inappropriate sexual remarks towards female members of staff, assaulted a prisoner and a member of staff, damaged prison property, flooded his cell and smeared faeces around it. His challenging behaviour meant he was moved to the Care and Separation Unit (CSU) on numerous occasions. A Challenge, Support and Intervention Plan (CSIP) was also opened. (CSIP is a process used to support and manage prisoners who are considered to pose a risk to or be a victim from other prisoners.) Throughout this time, Mr Ndemo was regularly seen and reviewed by the mental health team. Keywork sessions were also facilitated when appropriate.

50. On 14 August, a nurse attended Mr Ndemo's segregation review. As Mr Ndemo was sexually inappropriate towards her, it was agreed that a Healthcare Assistant (HCA) should see Mr Ndemo for all mental health appointments going forward.

51. On 26 September, Mr Ndemo stopped smearing faeces around his cell, had a shower and came out of his cell for association.

52. On 29 September, an HCA saw Mr Ndemo for a mental health review. Mr Ndemo was calm and polite throughout the session and said that he felt his mental health was improving. He told the HCA that he was looking forward to his sentencing date (which was in November) and would feel more settled when he knew his release date. When asked, Mr Ndemo said that he did not have any thoughts of suicide or

self-harm, and that he had no issues to raise with mental health at that time. The HCA reminded Mr Ndemo how to contact the mental health team, should this change.

53. A few hours later, as a result of him showing consistently positive behaviour for the previous seven days, Mr Ndemo was moved from the basic to the standard prison regime. In the regime review, it was noted that Mr Ndemo's behaviour and attitude had improved significantly, and that he was on a waiting list to work in the production workshop.

54. On 26 October, a Custodial Manager (CM) saw Mr Ndemo for a CSIP review. Mr Ndemo said that he was enjoying working in the production workshop and that he was getting on well with staff. The CM noted that he had shown no negative behaviour for the previous four weeks, was engaging well with staff, and had received positive feedback from the workshop instructors. Due to this, he decided to close the CSIP. He reminded Mr Ndemo to contact him if he needed any further support.

55. On 14 November, Mr Ndemo attended Norwich Crown Court and was convicted of stalking (several victims). His sentencing date was adjourned pending a pre-sentence report from the Probation Service. He returned to Norwich later that day. Mental health staff tried to see Mr Ndemo that day, however he did not return from court in time, so they rebooked his appointment.

56. On 16 November, Mr Ndemo told a HCA that he would be returning to court for sentencing on 20 December. He said that he was hoping to receive a short custodial sentence or be released the same day due to the time he had already served. They spoke about his release plans and Mr Ndemo said that he had accommodation to return to, was registered with a GP, and had support from friends in the community. Mr Ndemo said he felt stable and when asked, said there was nothing he needed from the mental health team at that time.

57. On 21 November, an officer introduced himself to Mr Ndemo as his new keyworker. The officer noted that Mr Ndemo was receptive, engaging and pleasant throughout his keywork session. They spoke about Mr Ndemo's life before prison and his plans for the future, which included returning to Kenya, getting back in contact with his family, and continuing his job as a nurse. Mr Ndemo said that he was now very settled on the wing, was enjoying working in the production workshop, and had friends who visited him. He said that he occasionally felt anxious due to it being his first time in prison, and that he sometimes found it difficult to sleep due to the noise on the wing. Mr Ndemo also asked about his immigration status, and the officer assured him that this would be confirmed once he was sentenced. The officer scheduled Mr Ndemo's next keywork session for 4 December but told Mr Ndemo to get in contact should he need anything before then.

58. On 4 December, the keyworker met Mr Ndemo for a keywork session. Mr Ndemo said that he continued to enjoy his job in the production workshop and was looking forward to his upcoming release. He said that he was concerned that he had not been assigned a prison offender manager yet. The keyworker confirmed this was because he was still unsentenced. Mr Ndemo said that he would like to speak to the mental health team about his anxiety, so the keyworker filled in an application requesting a GP appointment on his behalf. The application was received and

processed but did not reach the Mental Health Team until 11 December. At interview, the keyworker explained that Mr Ndemo said he wanted to go back on medication for his anxiety, and the process for that was to request to see a GP who could then discuss treatment options with him. He told us that he was concerned that Mr Ndemo was staying in his cell during association time. He said that he had advised Mr Ndemo to try to spend time out of his cell, get some fresh air and chat to his peers, as this would help to lift his mood. This was the last recorded entry on the prison system before Mr Ndemo's death.

Events of 10 December

59. The investigator watched CCTV footage, body worn video camera (BWVC) footage and listened to prison radio transmissions from 10 December. She also obtained information from the East of England Ambulance Service. The following account has been taken from all sources.

60. At approximately 5.40am, an officer completed a routine check on B-wing. At interview, he said that Mr Ndemo was asleep in his bed and that he saw nothing that caused him to be concerned. Mr Ndemo was locked in a single cell and no other prisoners had access to his cell that morning. He was not required to be checked again until 11:30am.

61. At 11.30am, officers on B-wing began unlocking the cells for lunch. An officer looked through Mr Ndemo's observation panel into his cell. She thought that he was stood still, looking out of his window, so she unlocked his door. She then realised that he was suspended from his window by a ligature made from a torn bedsheet. She radioed a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties) at 11.31am. Control room staff requested an ambulance immediately.

62. Seconds later, three officers responded to the code blue and entered Mr Ndemo's cell. As she was in distress, an officer escorted her out the cell. Another officer saw that Mr Ndemo was unconscious and was not breathing, so he relayed this to the control room.

63. An officer held Mr Ndemo whilst a colleague cut through the ligature. They then lowered Mr Ndemo onto the floor and lay him on his back. At interview, both officers said that they believed Mr Ndemo was already deceased and they thought he had signs of rigor mortis (he was rigid and cold to the touch). One officer said that he did not start resuscitation as it would not have been the right or respectful thing to do. Both officers stayed in the cell and waited for healthcare to arrive.

64. Despite believing that Mr Ndemo was deceased, at 11.34am, an officer started chest compressions. Approximately 10 seconds later, healthcare staff arrived, and a nurse continued giving CPR. They then moved Mr Ndemo onto the wing landing where they applied a defibrillator (a device that gives shocks to the heart to restore a normal heartbeat) and continued resuscitation attempts.

65. At approximately 11.45am, paramedics arrived at Mr Ndemo's cell. Their notes confirm that there were signs of rigor mortis present, with Mr Ndemo's fists clenched in a fixed position. At 11.46am, the paramedics pronounced that Mr Ndemo had died.

Contact with Mr Ndemo's family

66. At 11.50am, the prison appointed a family liaison officer (FLO). The FLO and a member of the chaplaincy team visited Mr Ndemo's listed next of kin, his friend, at his home address. The friend's wife answered the door and said that he was at work. She gave the FLO his mobile telephone number and several attempts were made to contact him. At 3.25pm, the FLO managed to locate Mr Ndemo's friend and they agreed to meet at his workplace.

67. At 4.05pm, the FLO and a senior prison manager met Mr Ndemo's friend and notified him of Mr Ndemo's death. The friend explained that Mr Ndemo's parents lived in Kenya and that he would contact them to inform them of the death of their son.

68. On 12 December, the FLO made multiple attempts to contact Mr Ndemo's parents via telephone, but the prison phone system would not allow him to telephone an international number. He contacted the Head of Security for advice. He tried multiple times to telephone Mr Ndemo's friend in England to inform him of this, but he did not answer. A few days later, Mr Ndemo's friend contacted the FLO and advised him not to attempt to contact Mr Ndemo's parents any longer, as they would find another person contacting them too painful.

69. The prison contributed to the cost of Mr Ndemo's funeral in line with national guidance.

Support for prisoners and staff

70. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoners support following all deaths in custody. Postvention procedures should be initiated immediately after every self-inflicted death and on a case by case basis after all other types of death. Key elements of postvention care include a hot debrief for staff involved in the emergency response and engaging Listeners to identify prisoners most affected by the death.

71. After Mr Ndemo's death, staff held a debrief and those involved in the emergency response were given the opportunity to discuss any issues arising. They were also offered support by the staff care team and signposted to support services available to them. Arrangements were made for the staff who were directly involved in the incident to be taken home and their line managers contacted them the following day to check on their welfare and offer additional support.

72. The prison posted notices informing other prisoners of Mr Ndemo'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 his death.

Post-mortem report

73. The post-mortem concluded that Mr Ndemo died from suspension by ligature (hanging). There were no significant toxicological findings to report.

74. At an inquest held on 25 February 2025, the coroner concluded that Mr Ndemo died by suicide.

Findings

Management of Mr Ndemo's risk of suicide and self-harm

75. Prison Service Instruction (PSI) 64/2011, *Safer Custody*, lists risk factors and potential triggers for suicide and self-harm. It says all staff should be alert to the increased risk of suicide or self-harm posed by prisoners with these risk factors and should act appropriately to address any concerns. Any prisoner identified as at risk of suicide and self-harm must be managed under Assessment, Care in Custody and Teamwork (ACCT) procedures. PSI 64/2011 also states that any information that becomes available which may affect a prisoner's risk of harm to self must be recorded and shared, to inform proper decision making. Mr Ndemo had several risk factors including that it was his first time in prison, he had experienced serious mental health issues, he misused drugs which impacted on his mental health, and he missed his family who lived overseas.

76. On 19 May, Mr Ndemo attended a healthcare appointment and staff correctly identified that he was at risk of suicide and self-harm. They started ACCT procedures, which continued until 29 May. We found these were procedures were managed correctly and closed appropriately.

77. Over the next few months, Mr Ndemo displayed inappropriate sexual behaviours towards female members of staff, smeared faeces around his cell, damaged prison property, flooded his cell and assaulted both a prisoner and a member of staff. His behaviours were described by staff as unusual, erratic and bizarre. Both prison and healthcare staff attempted to explore his behaviour with him, but he gave conflicting and obscure answers. It is still unknown whether Mr Ndemo's behaviour was drug induced or whether he was showing symptoms of an emerging acute mental illness. We recognise that managing Mr Ndemo's complex and difficult behaviour presented staff at Norwich with challenges, but that staff coped well. We are satisfied that there was no evidence to suggest that Mr Ndemo was at risk of suicide or self-harm during this period.

78. From 29 September, Mr Ndemo's behaviour improved significantly. He appeared more settled, was located back on a standard wing, and had no regime restrictions. Mr Ndemo attended work and engaged well with his peers, the mental health team, and his keyworker. We did not find any explanation for the sudden improvement in his behaviour.

79. On 4 December, Mr Ndemo told his keyworker that he would like to speak to the mental health team about anxiety medication. The keyworker filled in an application requesting to see a GP on his behalf, and this was submitted to healthcare the following day. The application was received and processed but did not get to the Mental Health Team until 11 December, the day after Mr Ndemo died. The investigator spoke to the Deputy Service Manager for the Mental Health and Wellbeing Team. She explained that as the application was directed towards the GP, it did not reach the mental health team until 11 December. She said that as there was no urgency within the healthcare application and given the long waiting lists and GP clinic availability, it was unlikely that Mr Ndemo would have been seen prior to 13 December. It is noted however that as Mr Ndemo was open to the

primary mental health team and he was being seen on a fortnightly basis, a review may have occurred in the intervening period.

80. Although records indicate that Mr Ndemo had a vulnerable mental state, we are satisfied that prior to his death he gave no indication to staff that he was at risk of suicide and that they could not have foreseen his actions.

Emergency response

81. We found that when staff found Mr Ndemo unresponsive, they attempted CPR despite noticing clear signs of death. A nurse, who was the first member of healthcare staff on scene, continued CPR because she thought that she had to continue, based on policy. The European Resuscitation Guidelines 2015 state that resuscitation is inappropriate when there is clear evidence that it will be futile.

82. The European Resuscitation national guidance is available to assist staff in this area, but staff were not aware. Healthcare staff have confirmed they are now aware of this guidance and for this reason, we make no recommendation.

83. We consider that an officer provided clear and unambiguous information about Mr Ndemo's condition to colleagues in the control room, which allowed for the local Ambulance Service to dispatch an ambulance with sufficient priority. This is an example of good practice.

Clinical care

84. The clinical reviewer concluded that Mr Ndemo's physical and substance misuse healthcare was of a reasonable standard and equivalent to that he would have received in the community.

85. The clinical reviewer found that the mental health care Mr Ndemo received at Norwich was only partially equivalent to that which he would have received in the wider community. She noted that this was due to missed opportunities for the mental health team to refer Mr Ndemo to substance misuse services and issues with record keeping and care planning. The clinical reviewer made several recommendations around these issues as well as other issues unrelated to Mr Ndemo's death, which the Head of Healthcare will wish to address.

Head of Healthcare to Note

Substance misuse support

86. Mr Ndemo reported using psychoactive substances (PS) prior to coming to custody. The prison's substance misuse service, Phoenix Futures, made significant efforts to engage Mr Ndemo on his arrival at Norwich, however he said that he did not want help from their service. No further referrals to Phoenix Futures were made for substance misuse support to be considered.

87. On 1 June, a nurse noted that Mr Ndemo said that he had taken PS recently. She determined in her clinical notes that this was likely to be the reason for his

challenging and inappropriate behaviour. At interview, she said that she did not consider a referral to Phoenix Futures at this time.

88. Two weeks later, the consultant psychiatrist assessed Mr Ndemo and recommended that he would benefit from substance misuse support from Phoenix Futures. We found that this recommendation was not actioned. The Deputy Service Manager said that she would have expected this recommendation to have been followed up by Mr Ndemo's mental health care co-ordinator. At interview, the nurse said that she was unaware of this recommendation.

89. It would have been good practice for the nurse to refer Mr Ndemo to Phoenix Futures. We recognise, however, that a referral was unlikely to have changed the outcome for Mr Ndemo, given that there was no evidence to suggest that Mr Ndemo was using PS after the dates mentioned above, and he did not test positive for PS post-mortem. Additionally, we acknowledge that his engagement would have been voluntary. For this reason, we make no recommendation, but we bring this to the attention of the Head of Healthcare

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