Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stuart Cordner, a prisoner at HMP Standford Hill, on 1 November 2024

A report by the Prisons and Probation Ombudsman

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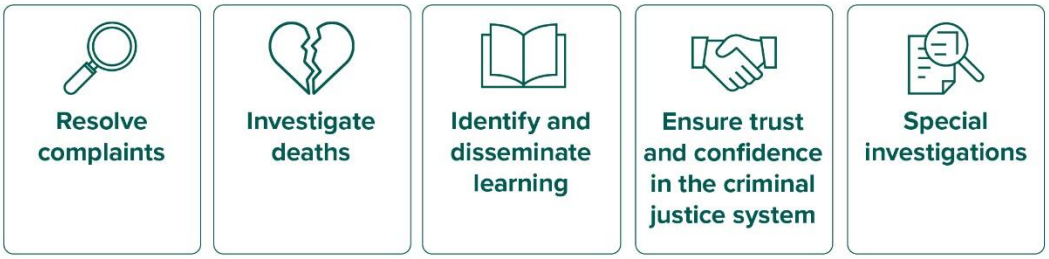
OUR VISION

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 Stuart Cordner died on 1 November 2024, having been found hanged in his pod at HMP Standford Hill. He was 48 years old. I offer my condolences to Mr Cordner's family and friends.

Mr Cordner had been in prison for 19 years and was at Standford Hill preparing for his release in 2025. He had completed several successful periods of release on temporary licence (ROTL) as part of his rehabilitation.

In the hour before Mr Cordner's death, staff suspended his ROTL to attend a narcotics anonymous (NA) group meeting that evening. Security information relating to this ROTL had not been assessed and actioned swiftly, but this was due to short staffing which has since been improved. Although Mr Cordner was upset by the decision that he could not attend NA, my investigation found that staff could not have known that he intended to take his own life.

I make no recommendations.

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 2025**

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Summary

Events

1. In 2007, Mr Stuart Cordner was sentenced to life imprisonment for the murder of his wife, with a minimum time in prison of 19 years. He had a history of anxiety, post-traumatic stress disorder, attention deficit hyperactivity disorder and depression. Mr Cordner was last monitored under prison suicide and self-harm procedures, known as ACCT, in 2017.

2. Mr Cordner was in several prisons before transferring to HMP Standford Hill, an open prison, in December 2023. This was as part of his reintroduction to the community and working towards his release from prison. He completed several escorted and unescorted periods of being released on temporary license (ROTL).

3. On 5 July 2024, Mr Cordner was temporarily moved to the healthcare unit at HMP Elmley due to psychotic symptoms and anxiety. After a week, he returned to Standford Hill and was later allowed to resume periods of ROTL, which included employment and family visits.

4. On 25 October, Mr Cordner attended his first Narcotics Anonymous (NA) meeting in the community as part of his rehabilitation. Prison staff later discovered that Mr Cordner had not fully disclosed a developing relationship he had formed with a young woman and two young men he had met there.

5. Around 3.30pm on 1 November, staff told Mr Cordner that his ROTL was suspended, and he could not attend the NA meeting that evening, pending a risk review. He was unhappy with this decision. At 5.00pm, an officer found Mr Cordner hanging from the window in his pod (individual, ensuite, self-contained residential unit). Prison staff provided emergency care. Paramedics arrived and pronounced Mr Cordner's life extinct at 5.41pm.

Findings

6. We found no evidence that prison staff should reasonably have assessed that Mr Cordner was at risk of suicide on the day he died.

7. The security information which led to the suspension of Mr Cordner's ROTL should have been analysed and actioned quicker. However, the security department was short staffed at the time. This situation has since been improved.

8. The clinical reviewer found that Mr Cordner's healthcare was equivalent to that he could have expected to receive in the community.

9. We make no recommendations.

The Investigation Process

10. HMPPS notified us of Mr Cordner's death on 4 November 2024.

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

12. The investigator visited Standford Hill in November 2024. He obtained copies of relevant extracts from Mr Cordner's prison and medical records.

13. The investigator interviewed six members of staff at Standford Hill in December 2024 and a further three members of staff by MS Teams in January 2025.

14. NHS England commissioned a clinical reviewer to review Mr Cordner's clinical care at the prison. The investigator conducted some joint interviews with the clinical reviewer.

15. We informed HM Senior Coroner for Mid Kent & Medway of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

16. The Ombudsman's office contacted Mr Cordner's family to explain the investigation and to ask if they had any matters they wanted us to consider. Mr Cordner's family wanted to know about the circumstances that led to Mr Cordner's death. We have covered this in our report.

17. Mr Cordner's family received a copy of the initial report. They pointed out some factual inaccuracies. This report has been amended accordingly.

18. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS identified one factual inaccuracy, and the report has been amended accordingly. Their action plan is annexed to this report.

Background Information

HMP Standford Hill

19. HMP Standford Hill is a category D open prison for men on the Isle of Sheppey in Kent and is situated next to HMP Swaleside and HMP Elmley. It holds prisoners nearing the end of their sentences. Open prisons have minimal security and allow eligible prisoners to spend most of their day away from the prison on licence to carry out work, education or for other resettlement purposes. Open prisons only house prisoners who have been risk-assessed and deemed suitable for open conditions. Oxleas NHS Foundation Trust provide healthcare services at Standford Hill. Standford Hill does not have 24-hour healthcare.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Standford Hill was in October 2024. Inspectors reported Standford Hill was a very safe prison. Self-harm and violence were rare and all other safety outcome indicators were low or compared favourably with findings at similar establishments. Prisoners were motivated and incentivised by the quality of life at the prison, the clear opportunities for progression, and in particular, the employment and resettlement opportunities release on temporary licence provided.

Independent Monitoring Board

21. 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 2024, the IMB reported that Standford Hill provided an excellent rehabilitative service to prisoners. It noted that the prison provided education, training and resettlement work of a high standard that gave prisoners the best possibility of leading fulfilling lives on release. The prison continued to release over 100 prisoners every day to paid work.

Previous deaths at HMP Standford Hill

22. Mr Cordner was the third prisoner to die at Standford Hill since November 2021. Of the previous deaths, both were from natural causes. Neither of these cases had any similarities to Mr Cordner's death. Up to the end of May 2025, there have been no further deaths at Standford Hill since that of Mr Cordner.

Pathways Enhanced Resettlement Services (PERS)

23. Pathways Enhanced Resettlement Services (PERS) is a programme in some open prisons (including Standford Hill) that helps prisoners who are at high risk of reoffending or being returned to closed conditions. It encourages successful integration into the prison and then into the community. The length of engagement is approximately three to six months.

Temporary release

24. Release on temporary licence (ROTL) is fundamental to resettlement plans. Each prisoner's needs are considered on an individual basis. They are kept fully informed of their progress and their family members have a vital role in its success. Prisoners are eligible for ROTL on arrival at the prison. Eligibility requires risk assessment before any unaccompanied ROTL takes place. These processes can take up to 12 weeks to make sure each ROTL is both individually appropriate while ensuring public safety. ROTL can be used for resettlement, day release to maintain family ties, work, training and education. Resettlement overnight release is used for getting prisoners back into the community and maintaining their family ties.

Key Events

25. In July 2007, Mr Stuart Cordner was sentenced to life imprisonment for the murder of his wife, with a minimum term of 19 years. This was his first time in prison. He had a history of alcohol abuse and multiple mental health conditions, including anxiety, post-traumatic stress disorder (PTSD – symptoms include flashbacks, nightmares and anxiety), attention deficit hyperactivity disorder (ADHD – characterised by inattention, hyperactivity and impulsivity), depression, and asthma. Mr Cordner formerly served in the army and suffered from chronic lower back pain, due to an injury sustained during service. He was prescribed medication to manage his physical and mental health issues.

26. Mr Cordner spent time in several different prisons. He was monitored under suicide and self-harm procedures, known as ACCT, five times throughout his sentence: in 2007, 2008, March and June 2010, and lastly in September 2017 for three days.

27. As a life-sentenced prisoner, Mr Cordner completed several rehabilitation and treatment programmes, aimed at addressing his alcohol and prescribed medication misuse, traumatic experiences and using cognitive skills to alter how his thoughts affect his feelings and behaviours. Due to his progress and good behaviour, he was on the enhanced level of the prison incentives scheme meaning that he had extra privileges.

28. In October 2023, the Parole Board recommended that Mr Cordner was transferred to an open prison to continue his sentence. His behaviour, compliance, and engagement would continue to be monitored, with the possibility of returning to closed conditions, if concerns arose. His sentence tariff expiry date (date of expected release from prison) was set for October 2025, with another Parole Board review scheduled before that date.

HMP Standford Hill

29. On 8 December 2023, Mr Cordner transferred to HMP Standford Hill, an open prison. An officer completed Mr Cordner's reception screen and first night interview. Mr Cordner said that he was happy but nervous to be at Standford Hill. It was his first time in an open prison. The officer explained the prison and wing rules and ensured Mr Cordner had phone credit to contact his family and friends. Mr Cordner confirmed that his mother, brother and grandma were his main support.

30. A nurse completed Mr Cordner's reception and secondary health screen. She noted that Mr Cordner had a history of asthma, ADHD, PTSD and depression. He was prescribed amitriptyline (to treat nerve pain and depression), gabapentin (to treat seizures and nerve pain), lisdexamfetamine (a treatment for ADHD) and inhalers for his asthma. Mr Cordner denied any thoughts of suicide or self-harm. The nurse noted no concerns. Mr Cordner was located on A Wing.

31. On 11 December, Ms A, a Change Grow Live (CGL) recovery worker, saw Mr Cordner and provided advice to him on substance misuse and harm reduction. The next day, Custodial Manager (CM) A and Ms B, an assistant psychologist, saw Mr Cordner for his initial Pathway Enhanced Resettlement Service (PERS) assessment. CM A was Mr Cordner's PERS key worker.

32. On 18 December, Mr Cordner moved to B Wing and had a PERS session with Supervising Officer (SO) A. By 21 December, Mr Cordner had finished his induction and said he felt settled at Standford Hill. He said that he had improved his coping skills compared to the past. Mr Cordner worked in the chapel, said he wanted to stay busy, and hoped to teach other prisoners how to play musical instruments. He also regularly attended the gym.

33. On 29 December, Mr Cordner told CM A that gaining employment was his priority once he had been risk assessed for ROTL. Mr Cordner also said that he was looking forward progressing onto ROTL and being able to spend time with his family in the future.

2024

34. From January 2024 onwards, Mr Cordner attended several sessions and workshops facilitated by PERS. These included yoga and cooking sessions and theatre workshops.

35. On 7 January, Mr Cordner self-referred to the mental health team. The next day, a mental health nurse saw Mr Cordner. Mr Cordner said that he wanted to see the psychiatrist to review his ADHD medication, with the possibility of reducing the dose. The nurse noted that Mr Cordner was agitated and fidgety and said that he wanted to be referred to psychology for cognitive behavioural therapy. She referred him to the GP and psychiatrist. The GP later saw him and reviewed his medication. No change to his medication was made at this stage.

36. On 23 January, CM A spoke to Mr Cordner about his accommodation prospects at the Royal British Legion village and employment at one of their factory sites. He had discussed this with Mr A from the Care After Combat team. (Care After Combat is a charity that supports veterans in custody in identifying their individual needs and supporting their eventual release into the community.) They agreed to explore this further.

37. On 2 February, Dr A, forensic psychiatrist, assessed Mr Cordner. He noted his diagnosis of ADHD and that Mr Cordner was managing this well. He lowered his medication dose. Two weeks later, he increased this again after Mr Cordner struggled to cope.

38. SO A was reallocated as Mr Cordner's key worker. During February, they discussed that Mr Cordner could progress to ROTL after he had completed the Stear process. (Stear is an escorted period of ROTL where a member of staff takes the prisoner into the community, to provide extra support and familiarise them with life outside prison. It is the first stage of the ROTL process, before a prisoner progresses to unescorted ROTL.)

39. On 3 March, the offender management unit (OMU) assessed that Mr Cordner had progressed well and could start ROTL. On 19 March, SO A and Ms C, Prison Offender Manager (POM), held a key work session with Mr Cordner. They confirmed that his first Stear ROTL was scheduled for 16 April. He expressed positive views about his resettlement, mentioning support from his mother and cousins in Sussex, and his interest in engaging with religious activities, running support clubs, and participating in support groups in the community.

40. On 16 April, Mr Cordner had his first Stear ROTL. This was his first time in the community in 18 years. He was accompanied by SO A. Initially anxious, Mr Cordner became more confident throughout the day, interacted politely with the public, managed financial tasks (including banking), shopped, and set up a mobile phone. (The prison encourages all prisoners to have their own phone, so that they can be contactable when on ROTL and for emergency use. The phones are not allowed on site and are stored in a personal locker at the prison gate lodge. The phone is collected and deposited from the gate lodge when the prisoner departs and returns to the prison, along with other personal items such as money and debit cards.)

41. On 26 April, during his second Stear, Mr Cordner was overwhelmed, particularly with the prison booking in and out process. Mr Cordner planned to use a reminder list to help. SO A recommended support during Mr Cordner's first unescorted resettlement day release (RDR) in the community, noting that PTSD may influence his behaviour and that further support was needed to ensure both public safety and Mr Cordner's well-being.

42. On 17 May, Mr Cordner had a third Stear. SO A noted that Mr Cordner was less anxious and showed a better awareness of his surroundings in the community.

43. On 4 June, SO A noted concerns raised by the Care and Combat Lead and the Chaplaincy Manager regarding Mr Cordner's increasing anxiety and paranoia during group sessions. They observed unusual behaviour and noted that Mr Cordner often misinterpreted supportive comments from peers as negative. In response, SO A referred him to the mental health team and placed him on daily safer custody checks as a precautionary support measure.

44. On 26 June, SO A accompanied Mr Cordner and two other prisoners (also veterans) to the Royal British Legion Village (RBL). The purpose of the visit was to establish future employment and training opportunities for ex-veterans in custody as well as for them to be considered for future accommodation within the village which is overseen by Care after Combat.

45. Also in June, Mr Cordner had his first RDR supported by a representative from Care and Combat team. On his second RDR, Mr Cordner met his mother and grandmother. Mr Cordner said that he had a good time and had started to feel more relaxed when out in the community.

46. On 1 July, CM A noted that Mr Cordner had been accepted to start community work for East Parish Council on 4 July. On 4 July, Mr Cordner told SO A that he thought his anxiety had increased due to an ear infection for which he was being prescribed antibiotics. The next day, Dr A reviewed Mr Cordner, who appeared to be experiencing psychotic symptoms. He reported feeling electric currents in his cell and body and believed someone was using a generator beneath his floor to electrocute him. He exhibited unusual behaviour by lying under a table and refusing to return to his cell, eventually becoming verbally aggressive. Due to his condition, the mental health team arranged for his temporary transfer to the inpatient healthcare wing at HMP Elmley (a closed prison). Healthcare staff stopped his lisdexamfetamine as they suspected it was a possible trigger for the psychosis.

47. On 8 July, a psychiatrist assessed Mr Cordner who was no longer demonstrating any evidence of psychosis. He declined antipsychotic medication. On 12 July, Mr

Cordner returned to Standford Hill. Mr Cordner said he felt much better since he had stopped taking his ADHD medication. Dr A saw Mr Cordner and noted that he appeared well, calm and relaxed. Mr Cordner said he had no thoughts of suicide or self-harm.

48. Due to Mr Cordner's psychotic symptoms, he had to be risked assessed again for ROTL, and any previously arranged dates were cancelled. On 16 July, Mr Cordner attended the PERS office and spoke to SO B who noted that Mr Cordner appeared paranoid. He was also upset that his ROTL had been cancelled and he could not return to his community work placement. He believed it was his ear infection which had caused his psychotic symptoms and was worried that if any concerns were raised about him, staff would send him back to a closed prison.

49. On 19 July, Mr Cordner attended healthcare and said that he thought his ear infection had returned. On 22 July, a GP examined Mr Cordner's ears and prescribed him antibiotics for an infection. The following day, Mental Health Nurse A assessed Mr Cordner. He asked to resume medication to manage his anxiety and continued to report issues related to an ear infection, including hearing noises. The nurse told him that he had been referred to an Ear Nose & Throat (ENT) specialist and was also booked to see the psychiatrist on 26 July to review his medication.

50. On 26 July, Dr A reviewed Mr Cordner, who was agitated and anxious. Although Mr Cordner had no thoughts of self-harm, he continued to believe that electricity was being passed into his cell and onto surfaces. Dr A discussed antipsychotic medication, but Mr Cordner refused this, insisting his anxiety stemmed from ADHD and requested anxiety medication instead. Dr A diagnosed a psychotic condition and prescribed atomoxetine (for ADHD) and promethazine (for anxiety and related symptoms) and planned to review him again in the coming weeks.

51. Over the following days, Mr Cordner's behaviour appeared to settle. On 4 August, PERS staff told Mr Cordner that the OMU would be deciding about his ROTL soon. On 11 August, Mr Cordner told healthcare staff he had felt better since being prescribed atomoxetine but felt that the medication wore off by lunchtime and then he felt agitated and angry. Dr A saw Mr Cordner the next day and increased the dose of his medication. He noted that Mr Cordner had good insight into taking his medication and had no psychotic or suicidal thoughts.

52. For the remainder of August, Mr Cordner attended several key work sessions with SO A. Mr Cordner progressed well and seemed much calmer. He was still keen to restart his ROTL and was disappointed that this had not happened yet. He was told that he would have to have a Stear in the community first.

53. On 29 August, Mental Health Nurse B saw Mr Cordner. Mr Cordner said that he was experiencing anxiety and disappointment related to issues surrounding the prison regime. When asked if he had any thoughts of suicide or self-harm, Mr Cordner denied this and said that he "never" thinks of this and had a very supportive family network.

54. On 6 September, SO A accompanied Mr Cordner on his Stear ROTL. He noted that Mr Cordner was calmer and less anxious than he had been on previous Stears. Later, OMU approved that Mr Cordner could restart his RDR ROTL.

55. On 10 September, Nurse B saw Mr Cordner. Mr Cordner said he was doing well. On this same day, SO A saw Mr Cordner for a key work session. They discussed his upcoming RDR, taking place the following day, when he would be allowed out of the prison, unescorted, for a five-hour period.

56. On 11 September, staff carried out a well-being check upon Mr Cordner's return from his RDR. Mr Cordner said that his RDR had gone well and he had been able to spend time with his family. Staff discussed with Mr Cordner the possibility of him changing jobs and moving to C Wing. C Wing has 80 individual pods (self-contained, ensuite housing units), a servery, and meals are taken into the prisoners' individual pods. Prisoners are located on C Wing because they work outside prison and return there to sleep. Their work hours are often flexible, and some may work through the night.

57. At his key work session on 18 September, SO A agreed that Mr Cordner could start working with the Community Voluntary Service Enterprise work party (CVSE – they complete various jobs in the community such as gardening). This was progress towards Mr Cordner living in a pod on C Wing. Mr Cordner said that he was also keen to engage with Narcotics Anonymous (NA) in the community. CGL had provided him with the necessary ROTL paperwork to apply for this.

58. On 20 September, Mr Cordner met with Mr B from the CVSE work party. He explained more about the role and what was required. Mr Cordner was accepted onto the party. In the meantime, Mr Cordner continued to carry out his job as the prison litter picker.

59. On 24 September, Mr Cordner had another RDR ROTL. Over the next week, staff reported positive interactions with Mr Cordner. He continued to engage with PERS workshops and activities. On 30 September, he started working with CVSE, Monday to Friday, in the community. Mr Cordner told staff that he enjoyed his job.

60. On 8 October Mr Cordner moved to a pod on C Wing which he was pleased about. On 11 October, Mr Cordner attended a drop-in session in the healthcare unit. Healthcare staff noted no concerns. Mr Cordner shared his past experiences of attending fellowship community groups (gatherings to support individuals recovering from addiction) and said he had found them supportive. Staff told him that they were arranging his ROTL so that he could attend NA meetings.

61. On 15 October, Nurse B reviewed Mr Cordner and noted that he had not displayed any symptoms of psychosis for the past two months. The nurse had no concerns about him.

62. Ms A saw Mr Cordner on 17 October for a substance misuse support session. Mr Cordner spoke about his time at Standford Hill and his alcohol issues.

63. On 18 October, during a key work session with SO A, Mr Cordner said that he had settled well in his pod, was enjoying working for CVSE and liked the regular routine this provided. Mr Cordner said that he was aware that the PERS team were available to support him.

25 October – 31 October

64. On Friday 25 October, Mr Cordner attended his first NA meeting in the community. On 27 October, at 6.10 pm, prison staff submitted a Security Intelligence Report (SIR) raising concerns regarding Mr Cordner's potentially inappropriate communication with a young woman he had reportedly met during the NA meeting. During a conversation in the B Wing office, Mr Cordner had told staff that he had been speaking with a young woman who, according to him, "looked 30 but said she was 19." Staff observed that Mr Cordner appeared to be "quite infatuated", speaking about her for five to ten minutes. Mr Cordner disclosed that he had been communicating with the woman via a WhatsApp group chat, as well as through one-to-one messaging. He also mentioned being part of a separate group chat that included the woman and two of her male friends, also NA attendees.

65. In one of the direct messages, Mr Cordner reportedly referred to the woman as "beautiful". Given the nature of Mr Cordner's original offence, staff challenged him regarding the appropriateness of this interaction. Mr Cordner responded and said that he had informed Ms A about the situation. However, staff assessed that Mr Cordner may have said this to mitigate concern, as it appeared that he recognised he had disclosed more than was appropriate. (At interview, Ms A told us that, given the timing of the incident and the unavailability of CGL staff over the weekend, such a conversation did not take place.)

66. At 6.17pm, Mr Cordner phoned his mother. During the call, he said that he had recently begun attending NA meetings and had spoken to a young woman about her personal experiences, while her boyfriend was present. Mr Cordner said that he found the NA meetings beneficial and intended to continue attending. He mentioned exchanging text messages with the woman, including one in which he described her as a "gorgeous, brave young lady" in reference to her openness during the meeting. The woman's boyfriend had questioned the appropriateness of this comment, but Mr Cordner said that he had not meant to cause offence. Mr Cordner also noted that the woman had invited him to go out for a meal following a future NA session. His mother advised him to maintain appropriate boundaries. She cautioned him against becoming involved with the woman or her boyfriend. In response, Mr Cordner described the pair as part of his support network and said he would discuss the situation with the woman at the next meeting. He also said he planned to seek guidance from the CGL team the following day and ask the NA group leader whether socialising with other members outside of meetings was appropriate.

67. On 29 October at 11.00am, Mr Cordner met Ms A. During the meeting, he expressed some anxiety regarding his interactions with members of the NA group. He stated that he had developed a friendship with two young males and a young female, with whom he had exchanged contact details and had begun communicating via text message. Mr Cordner said that he was particularly impressed by the young woman's mature attitude towards substance use. Ms A told us that Mr Cordner did not disclose any information that raised concern about the nature or content of his communication with the group members. Despite the absence of any explicit concerns, Ms A reminded Mr Cordner about the importance of maintaining appropriate friendship boundaries. She advised him to ensure that his interactions remained safe and in line with both prison regulations and the conditions of his licence. She also reminded Mr Cordner that one of his licence conditions required him to inform prison staff of any developing relationships. She

clarified that this requirement applied not only to romantic relationships but also to friendships.

68. At 3.15pm, Mr Cordner phoned his mother. Mr Cordner said that he appreciated the support he was receiving through the NA group and said that staff were aware of his contact with a female group member. Mr Cordner's mother expressed concern about his ongoing text communication with the woman and her boyfriend and reminded him that the woman was in a relationship. In response, Mr Cordner reassured her, and stated that both individuals were "nice people" and that, although they were young, they had "adult minds." He told his mother not to worry.

69. At 3.41pm, Mr Cordner again spoke to Ms A as he was anxious about the friendships he had made at the NA group. Ms A advised Mr Cordner to speak to OMU staff to confirm what information he needed to inform them about regarding his new friendships. She also advised Mr Cordner to speak to his key worker and the NA group lead.

70. On 30 October, Mr Cordner told Ms A that he had spoken to the safer custody officer on A wing, B Wing officers and had returned messages with the NA group members, and said he felt more comfortable about the interactions he was having with them. Mr Cordner provided no further details.

71. On the morning of 31 October, Mr Cordner told Officer A that he was no longer completely happy with his current employment and felt paranoid about the group that he worked with. He said that he was considering other working alternatives. He also said that he was in phone contact with a member of the support group he attended on Fridays, who was supporting him. Mr Cordner provided no further details.

Events on 1 November

72. The investigator watched closed circuit television (CCTV) and body worn video camera (BWVC) footage. He also reviewed information from NHS Southeast Coast Ambulance Service. The following account has been taken from all sources.

73. On the morning of 1 November, Mr Cordner confided in CM A, expressing concern that he may have done something wrong, though not necessarily bad. He explained that he had recently attended a NA meeting, where he met a young woman, her boyfriend, and another male friend. Believing he could offer support due to his maturity, he instead found himself receiving support from the woman. They exchanged phone numbers and texted over several days. Mr Cordner also encountered her outside the NA setting and noted her appearance. CM A grew concerned about the nature of this relationship and the intentions of the young people involved.

74. At interview, CM A said that Mr Cordner seemed flattered by the young woman's appearance, and believed her effort was for his benefit. CM A informed Mr Cordner that his actions suggested he was forming a relationship, which could breach his licence conditions. Mr Cordner claimed he had informed other staff, but not his offender managers, who he said were unavailable at the time. CM A emphasised that he should have told them and expressed concern that the young people might be trying to exploit him.

75. CM A told Ms D, Functional Head of OMU, what Mr Cordner had told him. She suspended Mr Cordner's ROTL for that day's NA meeting until she was able to obtain more information.

76. Worried about his disclosure of information, Mr Cordner returned to see CM A in the office. He insisted that he needed to attend the NA meeting that evening. CM A then accompanied him to the OMU office to speak with Ms D.

77. At 3.25pm, Mr Cordner attended the OMU office with CM A. Also present were Ms D and Ms E, a senior probation officer. Ms D explained that Mr Cordner would not be allowed to attend the NA meeting that evening. The primary reasons included concerns about the safety and appropriateness of the meeting environment, the presence of a young woman accompanied by two men, raising safeguarding concerns, and the potential vulnerability of attendees, including Mr Cordner, to exploitation. Ms D had also tried to contact CGL for their input but they had already left the prison for the day.

78. Ms D noted that Mr Cordner's emotional state fluctuated throughout the conversation. Initially he was calm but became increasingly distressed and began pleading to be allowed to attend the NA meeting. He repeatedly stated, "I need to sort it out," which prompted the staff to question what he meant. Mr Cordner said that he felt let down by CM A and said that he had now lost his external support. Mr Cordner also mentioned that he wanted to inform the young woman involved that they could no longer communicate and that he had already identified a female sponsor in the group. (A sponsor is usually someone who has been in recovery for a significant period, who mentors and supports someone newer to the recovery process). These statements raised further concerns with staff, as NA sponsors are typically of the same gender, and the woman in question, was not qualified to be a sponsor.

79. Ms D reiterated that the suspension was temporary and only applied to that evening. She assured Mr Cordner that further inquiries would be made with CGL and that he could potentially resume attendance at the NA meeting the following Friday. She emphasised that the decision was based on safeguarding concerns and was not of a punitive nature. CM A addressed Mr Cordner's feelings of betrayal and explained that he had a duty to report the situation. Mr Cordner then left the room.

80. Ms D phoned C Wing, spoke to Officer A and updated him that Mr Cordner's ROTL had been temporarily suspended. She told Officer A that Mr Cordner was not happy with the decision and asked staff to "keep an eye" on him.

81. At 3.57pm, Mr Cordner got to C Wing. He stopped in the C Wing office and spoke to Officer A. Officer A noted that Mr Cordner was slightly agitated and told him about his ROTL being suspended that evening. He stated that he would no longer talk to staff, as he now felt let down by them. Mr Cordner then left the office. At 3.59pm, Mr Cordner walked back to his pod. Officer A recorded what had happened in the C Wing observation book.

82. At interview, Officer A said that at no point during his conversation with Mr Cordner did he indicate or present as if he intended to take his own life. Officer A said that he also asked Officer B, who started his evening shift at 4.30pm, to check Mr

Cordner given his disappointment at not being able to attend the NA group. Officer A's shift ended around 4.30pm and he left C Wing at 4.40pm

Emergency response

83. Shortly before 5.00pm, Officer C and Officer B started carrying out the routine roll checks on the C Wing pods. At 5.00pm, Officer B checked Mr Cordner's pod. When he knocked on his door, Mr Cordner did not respond. Officer B opened the door and went in. He saw Mr Cordner suspended by a ligature (made from string that is used to close/open shutters) attached to the window. Mr Cordner's knees were laying to one side and his body was resting on a plastic container. Officer B radioed a code blue (an emergency code indicating that a prisoner has either stopped or is having difficulty breathing) at 5.00pm and staff in the control room called an ambulance immediately. Officer B supported Mr Cordner's body to alleviate the tension of the ligature. Officer C arrived at this point, cut the ligature and they laid Mr Cordner on the floor.

84. Mr Cordner showed no signs of life. Officer B started cardiopulmonary resuscitation (CPR). Officer D and CM E arrived with a defibrillator which staff attached and followed its instructions. Paramedics arrived at 5.14pm and took over Mr Cordner's care. A second ambulance crew and doctor arrived at 5.22pm. At 5.42pm, paramedics declared Mr Cordner's life extinct.

Contact with Mr Cordner's family

85. Mr Cordner had named his mother as his next of kin but had only provided her telephone number. Staff then discover that Mr Cordner had been in contact with his mother and that her address had been approved as his ROTL address. They decided to inform her at her home address. Officer B was Standford Hill's duty family liaison officer (FLO) and given his role in the emergency response Ms F, the on-call manger, contacted neighbouring prisons for support. Due to their closer proximity to Mr Cordner's mother's address, HMP Ford assisted and deployed a family liaison officer. They went to Mr Cordner's mother's house at 10.30pm and broke the news of his death and offered support.

86. Standford Hill appointed Mr C as the FLO, who remained in contact with Mr Cordner's family over the following days, offering support and advice. The prison contributed to the cost of Mr Cordner's funeral in line with national policy.

Support for prisoners and staff

87. 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. Standford Hill followed postvention procedures including holding a hot debrief, chaired by a prison manager, for staff involved in the emergency response and Listeners (prisoners trained by the Samaritans to provide confidential peer-support) being engaged to identify prisoners most affected by Mr Cordner's death.

Post-mortem report

88. The post-mortem report concluded that Mr Cordner's cause of death was multiorgan system failure and cerebral hypoxia (when the brain does not get enough oxygen) caused by ligature neck strangulation.

After Mr Cordner's death

89. Following Mr Cordner's death, Standford Hill suspended all fellowship meetings in the community, due to security intelligence issues. Fellowship meetings have since resumed but now take place at Standford Hill and are either face to face or online.

Inquest

90. The Coroner's inquest held on 16 February 2026 determined the medical cause of death to be cerebral hypoxia with multiorgan system failure, due to mechanical asphyxiation, due to ligature neck strangulation, due to hanging, with pulmonary congestion and oedema, congested liver with fatty change, hypertensive heart disease, congestive cardiac failure, chronic obstructive pulmonary disease, and polydrug misuse listed as contributory conditions.

91. The jury returned a narrative conclusion, stating that Mr Cordney died as a consequent of his own action, with his intention unclear.

Findings

Assessment of Mr Cordner's risk to himself

92. Prison Service Instruction (PSI) 64/2011, Safer Custody, was in place at the time of Mr Cordner's death (replaced in January 2025 by the Prison Safety Policy Framework), sets out the risk factors and triggers that might increase a prisoner's risk of suicide and self-harm and the procedures (known as ACCT) that staff must follow when they identify a prisoner at risk. Mr Cordner had a number of these risk factors: he had had been convicted of a violent offence against a family member, had a history of alcohol abuse, anxiety, PTSD, ADHD, depression, and suffered from chronic lower back pain.

93. However, Mr Cordner had no recent history of attempted suicide or self-harm and in the weeks leading up to his death, displayed no overt signs of distress or anxiety that gave staff concerns that he may harm himself.

94. In the week preceding his death, Mr Cordner appeared to be experiencing internal conflict regarding the extent of information he should disclose to staff. He seemed aware that his actions were likely to be considered inappropriate and potentially in breach of his licence conditions. Of particular concern was his apparent decision to withhold, and possibly downplay, the nature of developing relationships, especially one involving a young female.

95. When staff discovered the nature of the developing relationships at the NA group Mr Cordner attended, they were concerned about both the appropriateness of the relationships, Mr Cordner's capacity for sound judgement and his own vulnerability. We consider the decision to suspend Mr Cordner's ROTL was appropriate.

96. Staff were aware that Mr Cordner was not happy following this decision. In response, wing staff were advised to maintain appropriate monitoring. They also tried to reassure Mr Cordner that it was only a temporary suspension, he could hopefully attend the following week, and it was not intended as a punitive measure. We found no evidence that staff should have assessed Mr Cordner as being at imminent risk of suicide when he died.

Intelligence Report Handling and Risk Communication

97. Concerns regarding Mr Cordner's potentially inappropriate behaviour were formally raised one week before he died when staff submitted a SIR. We found that Mr Cordner appeared to have selectively shared versions of the situation with various staff members. Despite the seriousness of the concerns, no further action was taken to investigate the matter, nor was the information shared with the OMU, who are responsible for assessing and managing prisoners' risk. Although OMU staff eventually became aware of the information through an alternative source, the initial failure to act on and communicate the intelligence undermined the prison's risk management processes.

98. Following Mr Cordner's death, Ms D discussed the SIR with Ms G, Head of Security. Ms G explained that, at the time, the security team was experiencing significant staff shortages, with only one analyst available due to sickness absence.

This resulted in delays in reviewing, disseminating, and actioning SIRs. Since then, additional custodial managers have been recruited to the security department. We also note that prisoners are no longer allowed to attend fellowship meetings in the community.

99. While we make no recommendation on this matter, the Governor will wish to ensure all staff are aware of their risk-related responsibilities. This should include that a clear, consistent protocol is in place, to ensure that any information with potential implications for prisoner or public safety, is promptly communicated to the appropriate departments.

Clinical care

100. The clinical reviewer concluded that the clinical care Mr Cordner received was of a good standard and was equivalent to that which he would have received in the community.

Good practice

101. Mr Cordner spent 16 years in closed prisons before his transfer to Standford Hill, an open prison. This transition represented a significant shift in his prison experience, bringing with it challenges that were both complex and, at times, overwhelming. The adjustment required was considerable. It is noteworthy that Standford Hill provided Mr Cordner with consistent and meaningful support through their healthcare services, regular key work and resettlement sessions. These interventions were instrumental in facilitating his adaptation to the new environment and contributed significantly to him experiencing successful reintegration during his ROTL periods. Staff should be commended for the consistent efforts they made with Mr Cordner.

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