Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Alexander Corbett, a resident of Fleming House Approved Premises

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 Alexander Corbett was found hanged at an address in the community on 23 August 2024, six days after absconding from Fleming House Approved Premises. He was 46 years old. I offer my condolences to Mr Corbett's family and friends.

While Mr Corbett had some risk factors for suicide and self-harm, there was little to indicate in the time before he left Fleming House that he was at heightened risk. Nevertheless, there were missed opportunities that might have helped to prevent his death. A GPS monitoring tag, which was required in his licence conditions, was not ordered or fitted, which meant that probation staff and police could not identify his location for the six days before he died.

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 February 2024, Mr Alexander Corbett was remanded in custody for offences of stalking involving fear of violence and making threats to kill. He was later sentenced to 16 months in prison. Mr Corbett had a history of substance misuse, primarily alcohol, which influenced his offending behaviour, and reported a history of post-traumatic stress disorder (PTSD) and that he had been diagnosed with anti-social personality disorder (ASPD). Mr Corbett had attempted suicide at least once before (in 2017), and was admitted to hospital around the time of his arrest after expressing suicidal ideation.

2. Mr Corbett spent his time in prison at HMP Elmley. He progressed well, engaged in activities to support other prisoners, and raised few concerns. Prison staff did not order GPS tracking and alcohol monitoring tags ahead of his release, which Mr Corbett's licence required him to wear on release, and the tags were never fitted.

3. On 6 August, Mr Corbett was released to Fleming House Approved Premises (AP). On arrival at Fleming House, Mr Corbett was inducted, and staff completed his Support and Safety Plan (SaSP).

4. Mr Corbett complied with his curfew, participated in AP activities and had an appointment to engage with a community personality disorder programme.

5. On 17 August, Mr Corbett left Fleming House and did not return for his curfew. AP staff attempted to call Mr Corbett, but there was no answer. At around 9.00pm, after further efforts to locate Mr Corbett were unsuccessful, the head of service authorised his recall to prison.

6. On 20 August, a friend of Mr Corbett's contacted the on-duty probation practitioner and said that Mr Corbett had struggled at the AP and had mental health issues. Mr Corbett's community offender manager contacted him and attempted to obtain address information. Mr Corbett agreed that he would report to a police station, but did not.

7. On 23 August, Mr Corbett's friend found him hanged and called paramedics, who confirmed life extinct.

Findings

8. While Mr Corbett had some risk factors for suicide and self-harm, his time in prison was largely uneventful and – until he absconded – there was little to indicate to staff at Fleming House that he was at increased risk.

9. Important monitoring equipment was not fitted, which meant that probation staff and police could not track Mr Corbett's location when he did not return to Fleming House.

10. Support for staff and residents, and contact with Mr Corbett's family, was poorly managed in the time following his death.

Recommendations

- The Governor of HMP Elmley should review procedures for ordering monitoring tags for prisoners awaiting release, identify whether the error with Mr Corbett's licence is a systemic issue and implement any necessary changes to mitigate this.

- The Probation Service should ensure that AP staff conduct daily alcohol tests for residents awaiting alcohol tags to be fitted.

- The Probation Service should ensure that AP staff are aware of their responsibilities regarding managing tagging requirements and that a clear process is in place for staff to escalate tag fitting.

- The AP area manager should ensure that all staff at Fleming House AP are clear in respect of the death in AP process, as set out on EQuiP.

The Investigation Process

11. HMPPS notified us of Mr Corbett's death on 29 August 2024.

12. The investigator issued notices to staff and residents at Fleming House informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

13. The investigator obtained copies of relevant extracts from Mr Corbett's prison, probation and medical records.

14. The investigator interviewed two members of staff at Fleming House on 11 October and three members of staff via Microsoft Teams on 8, 10 and 17 October.

15. We informed HM Coroner for Kent and 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 Corbett's family to explain the investigation and to ask if they had any matters, they wanted us to consider. Mr Corbett's mother asked why Mr Corbett was found at another address and not the approved premises (AP). Mr Corbett's ex-partner asked why probation services did not track him by his GPS tag when he absconded.

17. Mr Corbett's parents received a copy of the draft report. They did not make any comments on the factual accuracy of the report however they provided a statement detailing additional information regarding Mr Corbett's personal life and requested that we share this with the Coroner. The Ombudsman's office shared this statement with the Coroner on their behalf.

18. We also shared the initial report with HMPPS and agreed to amend the wording of the recommendations 2-4 to ensure they were more effective.

Background Information

Fleming House Approved Premises (AP)

19. Approved Premises (AP - formerly known as probation and bail hostels) mostly accommodate offenders released from prison on licence and those directed there by courts as a condition of bail. Their purpose is to provide a supportive and structured environment. Residents are responsible for their own healthcare and are expected to register with a GP.

20. Fleming House is in Maidstone, Kent and managed by the Probation Service. It has 27 single rooms (and will soon have four shared rooms). Breakfast and evening meals are provided and there is a communal area for eating and socialising. Each resident has a key worker to oversee their progress and wellbeing and see that they adhere to their individual licence conditions and the premises' rules. Staff are on duty at Fleming House 24 hours a day.

21. Fleming House is a psychologically informed planned environment (PIPE) AP where staff members have additional training to help them develop an increased psychosocial understanding of individuals. PIPEs aim to support the progression of offenders with complex needs and personality related difficulties, with a particular focus on the local environment and recognising the importance and quality of relationships and interactions.

Previous deaths at Fleming House

22. Mr Corbett was the second resident of Fleming House to die since August 2021. The other resident died of natural causes, around a month before Mr Corbett. Both deaths occurred away from the AP.

Recall

23. Recall refers to the process of returning to prison an individual who does not follow their licence conditions. It is the responsibility of the Probation Service to initiate recall of individuals on licensed supervision through the Public Protection Casework Section (PPCS).

24. The recall process is set out in the Recall, Review and Re-Release of Recalled Prisoners Policy Framework. In addition to breaching a licence condition, probation practitioners must consider whether the recall threshold has been made, based on an individual's behaviour or circumstances presented whilst on licence. At the point of initiating recall, it is the responsibility of the police to attend a known address and arrest the individual.

Support and Safety Plan (SaSP) and Collaborative Approach to Risk and Emotion (CARE)

25. The full SaSP aims to provide individualised information and includes an opportunity to assess the types of risks, triggers and needs for residents, how staff can help to prevent issues, and provide residents with a support structure including

for supporting themselves in the event of distress. Staff are required to complete this within the second stage of induction.

26. CARE is the AP system used to support residents at risk of suicide or self-harm. The purpose of a CARE plan is to prevent escalation of self-harm, a suicide attempt and reduce risk-related behaviour. After an initial assessment of the resident's main concerns, levels of interactions, staff actions and interventions are set according to their perceived risk of harm.

Key Events

Background

27. Mr Alexander Corbett had a history of violent offences, substance misuse, had reported struggling with post-traumatic stress disorder (PTSD) and had been diagnosed with anti-social personality disorder (ASPD). Mr Corbett had spent time in prison and had been supervised by probation staff several times throughout his adulthood. He had a history of self-harm and had attempted suicide by overdose in prison in 2017, and was monitored under prison service suicide and self-harm prevention procedures (known as ACCT) as a result.

28. Mr Corbett was prescribed propranolol (beta-blocker medication used to treat anxiety and cardio issues) and quetiapine (medication used to treat depression, mania symptoms, schizophrenia, and bipolar disorder).

29. On 15 February 2024, Mr Corbett was convicted of offences of stalking involving fear of violence and making threats to kill. At the time he was under a period of post-sentence supervision (PSS) for an offence of possession of an offensive weapon, racially aggravated harassment, assault and actual bodily harm. Mr Corbett was remanded in custody at HMP Elmley pending sentence.

30. Mr Corbett's Crown Prosecution Service (CPS) papers detailed that around the time of these offences, he was admitted to hospital after "displaying suicide intent". Mr Corbett's community offender manager (COM) explained that Mr Corbett reported hearing loud thoughts in his head especially about harming others, and having suicidal ideation. The COM had worked with Mr Corbett in the community since 2020, and reported to have built a good rapport with him.

HMP Elmley

31. On 15 February, Mr Corbett was inducted by prison staff and referred to the mental health in-reach team (MHIRT). The MHIRT were aware of Mr Corbett's 2017 overdose attempt and his self-reported attempt on his life. Mr Corbett's self-report of PTSD, ASPD and childhood trauma were also recorded in his medical record.

32. On 22 February, Mr Corbett had a mental health assessment. The MHIRT found that there were no signs to suggest that Mr Corbett presented a risk of harm to himself and that he possessed no delusional or paranoid beliefs. A mental health nurse concluded that Mr Corbett presented as having no acute mental health symptoms or signs of enduring mental illness. Mr Corbett's medication was continued, and he was advised how to self-refer to the MHIRT in the future.

33. On 18 April, Mr Corbett had a substance misuse assessment and explained that accommodation was a big concern for him. He said that he had used substances since he was 14 years old and that he experienced PTSD from childhood trauma. Mr Corbett said that had previously taken an overdose of his prescribed medication, but he said he did not have any current thoughts of suicide.

34. On 21 May, Mr Corbett was sentenced to 16 months in prison. Staff conducted a well-being check and offered Mr Corbett an appointment with the MHIRT, which he declined.

35. On 29 May, Mr Corbett had a keyworker session with an officer. Mr Corbett reported no issues with his mental health and the officer noted that he appeared to be in high spirits as he had expected to receive a longer sentence. The officer explained to him that he would serve another four months in custody and asked Mr Corbett for family contact information. Mr Corbett said that he had no contact with his family.

36. On 4 June, Mr Corbett's prison offender manager (POM) contacted the COM to provide a handover of Mr Corbett's time at Elmley. The COM explained that the POM informed him that Mr Corbett had been doing well in prison, had become a trained Listener and that there was nothing to suggest that he was at risk of suicide or self-harm during that period. (Listeners are prisoners who are trained and supported by the Samaritans to provide confidential, emotional support to their peers.)

37. On 6 June, the COM submitted Mr Corbett's AP referral. This contained the following information about Mr Corbett's risk and history of suicide and self-harm:

> "As observed within the CPS packs, Mr Corbett has made various threats of harm to self. He denies experiencing suicidal ideation within the custodial environment which he described as containing. However, due to his experiences and trauma, it is assessed that the risk to self is present. He is encouraged to engage with the in-reach mental health services and PIPE units in custody."

38. The COM highlighted that Mr Corbett's risk to self and others would likely be increased by alcohol and drug misuse, homelessness, and difficulty in managing his thoughts and feelings.

39. Mr Corbett's AP referral mirrored the CPS summary of his offence. However, information about the February 2024 hospital admission was not included. The COM noted that, "actions prior to remand include suicidal ideation and actions" with no further information. In interview, when asked whether the events of February 2024 were passed onto AP staff, the COM said that he did not know.

40. The COM told us that although he thought Mr Corbett might struggle at Fleming House, as it was not in his home area, he thought that Fleming House being a PIPE AP would provide Mr Corbett with the right support. He said that Mr Corbett appeared positive about the move. To assist in monitoring Mr Corbett's risk at the AP, he requested additional measures such as additional daily sign ins (at 12.00pm and 5.00pm) and at least weekly substance tests.

41. On 17 June, Fleming House accepted the referral.

42. Mr Corbett's licence conditions included a curfew requirement between 9.00pm-6.00am, additional reporting requirements at 12.00pm and 5.00pm, and a prohibition from drinking alcohol. Mr Corbett was also required to be monitored by a GPS tag (to monitor location retrospectively) and an alcohol monitoring tag (which

uses sweat to determine whether alcohol has been consumed and to what level. If a tag detects alcohol or is tampered with, an alert is sent to the Probation Service).

43. On 15 July, staff from the Apollo programme emailed Mr Corbett. (Apollo is a community programme developed for individuals with personality disorder or with personality disorder traits, which Mr Corbett had been assessed as suitable for in December 2023.) The Apollo team advised Mr Corbett that he could join their late 2024 programme, after his release. Mr Corbett did not respond to their email.

44. On 16 July, Mr Corbett had a video-call with the COM, in which the COM explained the AP placement and Mr Corbett's licence conditions. He told us that Mr Corbett was pleased that he had accommodation and support around him, and that he accepted his licence conditions.

45. On 18 July, Mr Corbett was discussed at an interdepartmental risk management meeting (IRMM). The POM attended along with healthcare and mental health staff and social workers. In interview, she explained that Mr Corbett was discussed due to his upcoming release, to identify any pending action. She told us that during Mr Corbett's time in prison, he raised no concerns and there was no evidence to suggest that he presented a high risk of suicide and self-harm. She said that Mr Corbett was a neurodiversity representative and that he often worked on different wings at Elmley, supporting other prisoners.

46. Prior to Mr Corbett's release a keyworker at Fleming House completed Mr Corbett's pre arrival risk assessment. (Despite requests, Fleming House did not provide a copy of the assessment. We therefore cannot confirm if accurate suicide and self-harm risk information was captured within this assessment.)

47. On 6 August, Mr Corbett was released from Elmley under the end of custody supervised licence (ECSL) scheme (an early release scheme).

48. Neither of Mr Corbett's tags were fitted following his release from prison. The electronic monitoring service (EMS) told us that, at the point of Mr Corbett's release, they did not receive his licence and were therefore unaware of the tagging requirements. The service manager for electronic monitoring operations for HMPPS, told us that it is the responsibility of the Offender Management Unit (OMU) team at the releasing prison to share licence paperwork prior to a prisoner being released. She confirmed that once this is shared, a first attempt to fit the monitoring equipment should be made by midnight on the day following release.

49. The investigator asked Elmley why an order to fit Mr Corbett's tags had not been sent to the EMS. The Head of Offender Management Services, advised that both Mr Corbett's alcohol tag and GPS tag were missed due to human error. Fleming House were unaware that Mr Corbett's tagging requests had not been submitted.

Fleming House AP

50. On 6 August, Mr Corbett arrived at Fleming House and was inducted by a residential worker. The induction included an explanation of AP rules, and the completion of a medication contract and GP consent to liaise form. Mr Corbett told staff that he had no next of kin and handed over his medication. (Residents'

medication is stored in a staff office and they collect and sign for it at their prescribed medication times.) The residential worker told us that when he asked Mr Corbett about whether he had any learning difficulties or mental health concerns, he said, "I've just got mental health issues". He said that Mr Corbett provided no further information, and he raised no issues.

51. Later that day, staff conducted a routine urine test for drugs and alcohol. Mr Corbett tested negative for all substances.

52. On 7 August, Mr Corbett had two appointments with staff.

- Mr Corbett attended an induction appointment with a probation officer to discuss his licence conditions. The probation officer explained to Mr Corbett what was expected of him and the consequences of failing to comply. Mr Corbett reported that alcohol was his main area of concern and that, should he relapse, it "tend(s) to spiral". Mr Corbett also explained that he was engaged with social services to seek contact with his son. The probation officer agreed on several actions to support Mr Corbett, including liaising with the local services to assess and identify any alcohol support needs. The probation officer was not aware that the OMU had not sent tagging requests to EMS.

- Mr Corbett received his second stage induction with his keyworker. She completed Mr Corbett's support and safety plan (SaSP) and noted that Mr Corbett had disclosed that his medication made him feel "quite flat" at times, so staff would need to regularly check his mood. Mr Corbett's SaSP detailed that his main concerns were accommodation after his AP placement (of 12 weeks), that he had taken an overdose one year ago, and that he was not sure if he would tell AP staff if he was struggling. Mr Corbett also told her that he had no family contact.

53. His keyworker said in interview that she was not aware of Mr Corbett's recent (February 2024) stay in hospital. She said that Mr Corbett was prescribed quetiapine, which would have helped him with managing voices and therefore, had she known of this event, her assessment of Mr Corbett would not have changed.

54. Also on 7 August, the COM contacted the keyworker to ask if Mr Corbett's tags had been fitted. We do not know whether the COM received a response.

55. Over the following days, staff reported that Mr Corbett responded to all welfare checks, attended a resident's brunch and that no concerns were raised.

56. On 12 August, Mr Corbett had a keywork session with his keyworker. Mr Corbett said that he had joined the local gym as he had felt bored. He also said that he was concerned about accommodation following his AP placement and that this was at the front of his mind. The keyworker encouraged Mr Corbett to participate in AP activities and Mr Corbett expressed an interest in cooking for the AP brunch. She discussed the Apollo Group and the creating future opportunities (CFO) activities hub. Mr Corbett requested more information about Apollo and appeared open to the activities suggested by her. She reported in interview that she had no concerns, that Mr Corbett felt settled and that he was taking his medication.

57. On 13 August, Mr Corbett had several interactions with staff:

- He attended a PIPE induction session with a member of staff, where staff explained the expectations of the PIPE AP. She discussed the support available within the Apollo Group, and Mr Corbett agreed to an appointment on 19 August.

- Mr Corbett had an appointment with the COM by video-link. The COM said that Mr Corbett was well engaged and felt that he had settled in well to the AP. Mr Corbett confirmed that he had registered with a GP and reported no temptations regarding drugs or alcohol. The COM said that Mr Corbett was concerned about being at Fleming House and ease of access to travel to Folkestone to see his son. He explained to Mr Corbett that, although he wished to live in the Folkestone area, due to exclusions on his licence he would not be able to. He reassured him that a referral to a Canterbury housing organisation had been completed.

- Mr Corbett was breathalysed for alcohol. This test gave a negative reading.

58. The investigator asked the COM whether he had considered a community mental health referral to support Mr Corbett. He said that Mr Corbett's mental health had been unstable at the beginning of the year, but that he had been doing well in prison. He said that Mr Corbett reported that he was "pretty comfortable" at Fleming House. He said that he wanted to assess how Mr Corbett was self-reporting and how he engaged with the Apollo Group before completing a mental health referral.

59. Over the following days, staff recorded that Mr Corbett responded to welfare checks and complied with his medication. There were no records of staff observing any changes in behaviour and no concerns regarding Mr Corbett being under the influence of alcohol or drugs.

Events of 17 – 22 August

60. At 9.00am on 17 August, Mr Corbett responded to a welfare check. He signed out of the AP at 12.02pm and returned at 12.28pm.

61. At 1.43pm, Mr Corbett signed out of Fleming House. He did not tell AP staff where he was going.

62. By 5.00pm, Mr Corbett had not returned to the AP and missed his sign in time. A residential worker attempted to phone Mr Corbett's mobile, but she received no response. She reported to the on-call manager that Mr Corbett had not returned and that staff had been unable to reach him by phone. The on-call manager advised AP staff to wait until Mr Corbett's 9.00pm curfew before initiating recall.

63. At 9.07pm, the residential worker attempted to call Mr Corbett's mobile again. After no answer, she initiated an out of hours recall, which was agreed by the head of service.

64. At 9.28pm, staff sent Mr Corbett's recall notification to Kent Police and his licence was revoked.

65. At 11.00pm, Mr Corbett had not returned for his second curfew check. A residential worker went to Mr Corbett's room and found two bottles of vodka hidden behind the bed.

66. On 19 August, his probation officer and the COM completed Mr Corbett's recall paperwork. This detailed that Mr Corbett had no fixed abode, was considered to present a high risk of serious harm to others and had a history of failing to comply with probation. The COM also documented that Mr Corbett had made previous suicide attempts and had ASPD. He also recorded that Mr Corbett had a history of alcohol and drug misuse.

67. On 20 August, Mr Corbett sent a text message to the COM and said that he was "struggling with social services". At around 3.00pm, the duty probation practitioner received a call from a friend of Mr Corbett's, who said that he had been staying with her. His friend said that Mr Corbett was "a mess" and felt let down by both probation and social services. She asked Mr Corbett's friend for her address, however she declined to share this information. During this call, Mr Corbett's friend said that Mr Corbett would like contact with the COM.

68. At 4.10pm, the COM phoned Mr Corbett's friend to speak with Mr Corbett. He reported that Mr Corbett's friend answered the phone and said that she had known him for many years, and that he had experienced mental health problems. Mr Corbett was handed the phone and told the COM that he had struggled at Fleming House due to "the people there" and was also frustrated at being unable to see his son. In interview, the COM said that he attempted to obtain address information from Mr Corbett, but Mr Corbett was worried that the police would attend and arrest him for recall. The COM explained that he advised Mr Corbett that a warrant had not yet been authorised, but recall was still being considered. (Although his recall paperwork had been completed, the court had not yet issued an arrest warrant and therefore he was unable to confirm recall with certainty.) The COM told us that Mr Corbett said that he would prefer to surrender to a police station. He advised him that if his recall was agreed, he would be expected to surrender immediately, which Mr Corbett agreed to.

69. The COM told us that he discussed the approach with his manager, who advised that Mr Corbett's action in reaching out was positive and that once a warrant had been received, they would ask him to attend a local police station.

70. On 21 August, the COM called Mr Corbett and informed him that his recall had been processed. He said that Mr Corbett asked him if he would receive a 28-day fixed term recall. He explained to Mr Corbett that although he might not remain in custody until the end of his sentence, because he was high-risk and had absconded from the AP, his recall would not be solely for a fixed-term. He told us that Mr Corbett appeared to accept this, and he apologised for letting him down. The COM reassured him. He said that Mr Corbett agreed to report to a police station by no later than 2.00pm.

71. On 22 August, the COM contacted the police and was told that Mr Corbett had not handed himself in. He provided the police with contact details for Mr Corbett's friend.

Events of 23 August

72. The following account is based on police and ambulance records from the date of Mr Corbett's death.

73. Police records state that Mr Corbett had been staying at his friend's address since he absconded from Fleming House on 17 August. Police recorded that Mr Corbett's friend last saw Mr Corbett at around 4.00am on 23 August.

74. At 6.50am, Mr Corbett's friend called for an ambulance after she found Mr Corbett hanging from her front door.

75. At 7.05am, paramedics arrived and commenced cardiopulmonary resuscitation. At 7.36am, they pronounced life extinct.

76. Police reported that Mr Corbett's friend said that the previous night they had smoked crack cocaine and had a couple of cans of beer.

Events following Mr Corbett's death

77. At 10.38am, the COM was notified of Mr Corbett's death by a social worker.

78. At 11.34am, the COM shared the news of Mr Corbett's death with AP staff.

Contact with Mr Corbett's family

79. Mr Corbett's ex-partner, his last recorded next of kin, was notified of Mr Corbett's death by the police. Fleming House did not have any next of kin contact details recorded on file. We are unsure when and how Mr Corbett's mother was notified of his death.

80. On 2 October, the AP manager, confirmed that AP staff had not made any contact with Mr Corbett's ex-partner due to concerns of domestic abuse and a no-contact licence condition between Mr Corbett and his ex-partner. The AP manager asked the investigator for advice on approaching family liaison with her. We directed them to the HMPPS national instructions following a death under supervision and sought assistance from the Coroner to determine who they had liaised with regarding Mr Corbett's funeral.

81. On 10 October, the Coroner told us that Mr Corbett's funeral had taken place and that Mr Corbett's parents did not wish to have any contact with AP staff.

82. On 11 October the AP area manager told us that in the AP manager's absence, he had contacted Mr Corbett's ex-partner.

83. As a result of the no contact request from Mr Corbett's mother, HMPPS did not provide contributions towards Mr Corbett's funeral costs in line with national instructions.

Support for residents and staff

84. Although staff were informed of Mr Corbett's death on 23 August, a staff debrief was not held until 29 August. Staff were signposted to relevant support services.

85. On 28 August, the AP posted notices informing other residents of Mr Corbett's death and held a resident meeting.

Post-mortem report

86. A post-mortem examination found that Mr Corbett died from pressure on the neck due to hanging. Toxicology tests identified alcohol (at a level higher than the national drink-driving limit), cocaine and benzoylecgonine (a chemical compound produced when cocaine is metabolised in the body).

Findings

Identifying risk of suicide and self-harm

87. Mr Corbett had several risk factors for suicide and self-harm. He had previously attempted suicide by overdose and had been admitted to hospital in February 2024, after disclosing suicidal intent. Mr Corbett had a history of abusing alcohol and reported that he experienced PTSD and ASPD. He was prescribed quetiapine in hospital in February 2024. Mr Corbett was also unemployed, reported that he had no family contact (but was clearly anxious to regain contact with his son) and had been homeless in the community.

88. In preparation for Mr Corbett's release both his POM and COM liaised about Mr Corbett's time in custody and no concerns regarding his mental health or suicidal ideation were raised. Mr Corbett had positively engaged in prison, fulfilling the role of neurodiversity representative and training as a Listener, and appeared to be motivated to progress in the community. The COM captured Mr Corbett's history of self-harm and risk factors such as alcohol within Mr Corbett's AP referral. However, details of the events of February 2024 were not documented within the self-harm section. Nonetheless, this information was included within Mr Corbett's AP referral which was shared with AP staff and therefore we assess that they had sufficient information about Mr Corbett's risk of suicide and self-harm.

89. When he arrived at Fleming House, staff carried out a mandatory SaSP assessment. SaSP guidance states that if there is a current risk of self-harm or suicide, then consideration must be given to activate the self-harm prevention approach. Mr Corbett denied any current thoughts of suicide and self-harm and staff did not assess Mr Corbett as presenting with an increased risk. His keyworker was aware of Mr Corbett's historic suicide attempt (2017) however, said that she was unaware of the events of February 2024. The keyworker reported that if she had been aware of this, due to Mr Corbett being supported by medication, she would not have changed her assessment of his risk of self-harm.

90. SaSP guidance states that staff should explore actions that other people can do to help support the resident with a particular concern. Mr Corbett reported that his medication caused him to feel "flat" and that he was not sure that he would tell staff if he was struggling. The only support action set for Mr Corbett was for staff to conduct regular check ins and to encourage him to attend activities. SaSP guidance lists examples of distraction tools and activities that can support residents in reducing their negative feelings, however there was no evidence that these had been suggested.

91. Mr Corbett did not report needing any support with his mental health during his time at Fleming House. He was compliant with his medication, did not display any overt signs of deteriorating mental health and had planned to engage with the Apollo community mental health service.

92. We assess that staff had a good understanding of Mr Corbett's risk factors and triggers and that it was reasonable not to start CARE procedures during the time Mr Corbett lived at the AP. During his time at Fleming House, there was little to indicate that he was at increased risk of suicide and self-harm or entering a period of crisis.

Licence conditions - tagging

93. Mr Corbett's tagging requirements formed a key part of his licence, to aid probation staff in monitoring his risk. Mr Corbett's alcohol misuse was recognised to contribute towards his offending behaviour and without both of his tags (alcohol monitoring and GPS trail monitoring), probation staff were not sufficiently equipped to accurately monitor Mr Corbett's risk of harm to himself or others. Had Mr Corbett's tags been fitted, these would have provided staff with a method of assessing any increase in alcohol consumption and of locating Mr Corbett after he absconded from the AP.

94. We understand that the referral to EMS for Mr Corbett's tags was missed by staff at Elmley when he was released and were told that this was due to human error. As a result, the EMS provider did not receive an order to fit the tags. Mr Corbett's release was one of the releases under the early release scheme (a government measure to alleviate overcrowding in prisons) but we are satisfied that staff had sufficient notice. The Head of Offender Management Delivery at Elmley, explained that staff had managed the early releases to the best of their ability, but that pre-release planning and licence arrangement had been impacted. He said that following Mr Corbett's death, additional checks were now being carried out on all licences.

95. The AP area manager told us that where a resident is awaiting an alcohol tag, AP staff should carry out daily alcohol tests. This was not done for Mr Corbett.

96. Although it is the responsibility of the releasing prison to instruct EMS providers to fit tags, it is the responsibility of the Probation Service to ensure that there is opportunity for such tags to be fitted and to chase EMS if this does not happen. EMS guidance to HMPPS states that, "If your person on probation has not had their tag fitted within one week of release, this is chased with EMS at the earliest opportunity". The COM did not contact the EMS provider until after Mr Corbett's death to ask if his tags had been fitted. Staff at Fleming House also did not identify that Mr Corbett had not had tags fitted.

97. As a result, Mr Corbett was not monitored in the community in line with his licence conditions. Had he been properly monitored, his GPS tag might have enabled police or probation staff to locate him at an earlier stage, which might have led to a different outcome. We make the following recommendations.

The Governor of HMP Elmley should review procedures for ordering monitoring tags for prisoners awaiting release, identify whether the error with Mr Corbett's licence is a systemic issue and implement any necessary changes to mitigate this.

The Probation Service should ensure that AP staff conduct daily alcohol tests for residents awaiting alcohol tags to be fitted.

The Probation Service should ensure that AP staff are aware of their responsibilities regarding managing tagging requirements and that a clear process is in place for staff to escalate tag fitting.

Events following Mr Corbett's death

Family Liaison

98. The AP Manual sets out standards for family liaison following the death of a resident. This requires the AP to appoint a family liaison officer who will offer ongoing contact, explaining the purpose of any investigations, and including offering assistance with funeral costs in line with HMPPS policy.

99. While Mr Corbett had not provided an updated next of kin contact at Fleming House, his prison records listed his ex-partner as next of kin. Due to concerns of domestic abuse and a no-contact licence condition between Mr Corbett and his ex-partner, the AP manager was hesitant to contact next of kin. While we understand the concerns AP staff had in contacting Mr Corbett's ex-partner, as the most recently recorded next of kin, reasonable steps should have been taken to offer support and an opportunity to engage.

100. In the event where no next of kin is provided, the AP Manual says that the AP must take reasonable steps to trace them (e.g. by consulting the Coroner). No further attempts were taken by AP staff to identify another next of kin. By the time Mr Corbett's ex-partner was contacted, the investigator had been informed by the Coroner that Mr Corbett's funeral had taken place and that his parents had said that they did not wish to be contacted.

Funerals

101. HMPPS policy for APs includes an obligation for the service to offer contributions towards the cost of the funeral. The AP manager was unfamiliar with this policy and sought advice from the PPO investigator regarding the scope of this responsibility. At the request of Mr Corbett's mother, AP staff made no contact and no contribution to the cost of Mr Corbett's funeral was made. While we appreciate that these were difficult circumstances, an offer of a contribution to funeral expenses might have been made through other means, such as via the Coroner.

Informing staff and residents

102. The AP Manual requires the AP to inform staff and residents and provide support following the news of a resident's death. Despite AP staff receiving notification of Mr Corbett's death on 23 August, residents were not informed for five days and a staff debrief did not take place for six days. Although the AP Manual does not specify a time limit in offering support and information to staff and residents, we consider this was too long to wait. When residents are not told of a death at the earliest opportunity, staff risk them learning through other means which might have implications for the accuracy of information they are given or on support needs.

103. The AP area manager explained that the policy following a death of a resident was not followed and that in both the recent deaths at Fleming House, problems with this process have been highlighted. He said that he was not made aware of Mr Corbett's death until 28 August. He explained that at the time of Mr Corbett's death, although AP staff were informed, the notification was sent to the AP manager who was on annual leave. The AP area manager said that staff have not received any

training in how to manage actions following the death of a resident and that learning has since been identified.

104. The AP area manager shared Fleming House's Action Plan, prepared earlier in 2024, which details the following actions relating to deaths in the AP:

- Review recent deaths in Fleming House.
- Brief all staff on the process for dealing with a death in an AP.
- Look at the induction process to ensure correct and up to date next of kin details are recorded.
- Brief AP manager on the process and policy for dealing with a death in an approved premises.

105. In another recent death at Fleming House, we have identified similar issues in relation to family liaison. We think this area requires particular focus and make the following recommendation:

The AP area manager should ensure that all staff at Fleming House AP are clear in respect of the death in AP process, as set out on EQuiP.

Inquest

106. The inquest into Mr Corbett's death concluded on 11 April 2025, and recorded a verdict of suicide.

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