Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Ms Jamie Perfect, a prisoner at HMP Peterborough, on 14 October 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.

Ms Jamie Perfect died on 14 October 2024, after taking multiple medications, one of which had been obtained illicitly, at HMP Peterborough. She was 29 years old. I offer my condolences to Ms Perfect's family and friends.

Ms Perfect, who had a history of substance misuse and tested positive for drugs when she arrived at Peterborough, was appropriately monitored and supported by substance misuse staff during her ten days there. The clinical reviewer found that her care was of a good standard and equivalent to that which she could have expected to receive in the community.

We 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. Ms Jamie Perfect was remanded to HMP Peterborough on 4 October 2024, charged with assaulting an emergency worker.

2. Ms Perfect had a history of substance misuse and when she arrived at Peterborough, she tested positive for opiates, cocaine, cannabis and benzodiazepines (prescription medication used to treat anxiety but also widely abused). She was placed on the drug stabilisation unit for assessment and monitoring and was prescribed medication to help with drug withdrawal.

3. On 10 October, during a routine check of Ms Perfect's cell, an officer found an improvised vape which contained an unknown substance. The officer placed Ms Perfect on a disciplinary charge. At the adjudication hearing the next day, Ms Perfect denied the charge. The hearing was adjourned to allow her to obtain legal advice.

4. At around 7.20am on 14 October, an officer unlocked Ms Perfect's cell and found Ms Perfect unresponsive on her bed. The officer radioed a medical emergency code and staff started CPR. When ambulance paramedics arrived at 7.42am, they assessed that Ms Perfect was dead and pronounced life extinct.

5. The post-mortem report concluded that Ms Perfect died from aspiration pneumonia (when saliva, food or stomach contents enter the lungs leading to infection) caused by polypharmacy (multiple drug use).

Findings

6. One of the drugs found in Ms Perfect's system, tapentadol (an opioid), is not prescribed at the prison and so it must have been brought into the prison illegally. We do not know how Ms Perfect obtained it.

7. The last HMIP report found that Peterborough had taken important steps to limit drug supply but like all women's prisons, had no body scanner to detect secreted items, which was a risk. It also found that the prison's drugs strategy covered both the men's and women's prison so issues more specific to female prisoners, such as trading medications, were not addressed. In December 2024, Peterborough issued an updated drugs strategy for the women's prison. While it says that diversion of medication is the most significant drug-related issue among female prisoners, it does not say how that will be tackled. We bring this to the Director's attention.

8. Ms Perfect was referred for SMS support when she arrived at Peterborough and received daily SMS monitoring. The clinical reviewer concluded that Ms Perfect's clinical care was of a good standard and equivalent to that which she could have expected to receive in the community.

9. We make no recommendations.

The Investigation Process

10. HMPPS notified us of Ms Perfect's death on 14 October 2024.

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

12. The investigator visited Peterborough on 22 October. She obtained copies of relevant extracts from Ms Perfect's prison and medical records.

13. The investigator interviewed four members of staff at Peterborough on 28 November and a prisoner by telephone on 27 March 2025.

14. NHS England commissioned an independent clinical reviewer to review Ms Perfect's clinical care at the prison and she conducted joint interviews with the investigator.

15. We informed HM Coroner for Cambridgeshire & Peterborough of the investigation. The investigation was suspended from 20 January until 18 March 2025 as we waited for the post-mortem and toxicology reports. 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 Ms Perfect's mother to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond.

17. We shared our initial report with HMPPS and the prison's healthcare provider, Northamptonshire Healthcare NHS Foundation Trust. They found no factual inaccuracies.

18. We sent a copy of our initial report to Ms Perfect's mother. She did not notify us of any factual inaccuracies but raised some queries which we have addressed in separate correspondence.

Background Information

HMP Peterborough

19. HMP Peterborough is operated by Sodexo Justice Services. It holds men and women in separate sides of the prison. The women's side of the prison holds almost 400 women. There is 24-hour healthcare provision. Northampton Healthcare Foundation Trust provides healthcare services.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Peterborough (Women) was in November 2023. The Chief Inspector noted that overall, the prison had supportive relationships between staff and prisoners.

21. Inspectors noted that from their survey, 27% of prisoners said it was easy to obtain illicit drugs, which was in line with other women's prisons. Some important steps had been taken to reduce the supply of illicit items. For example, all social mail was now photocopied, CCTV had been upgraded and there was now a dedicated team of dog handlers. Enhanced gate security had been introduced, which was not seen in other women's prisons. Like all other women's prisons, there was no body scanner to detect secreted items, which was a risk. The proportion of drug test results proving positive was one of the lowest among women's prisons at 5.95%. All suspicion testing was completed and only a small number came back positive.

22. Inspectors noted that the prison's drug supply action plan was the same across the men's and women's prisons and did not focus on supply and demand specific to the women's population, such as the increased likelihood of prescribed medication being traded.

23. Inspectors noted that the substance misuse services were well led and delivered by a skilled team. Women needing substance misuse treatment and alcohol detoxification were identified at reception and received appropriate care.

Independent Monitoring Board

24. 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 31 March 2024, the IMB reported that life for prisoners at Peterborough was generally calm and well-ordered, with little violence. IMB members observed positive working relationships between staff and prisoners. The Board noted that prisoners very seldom raised concerns about the drug and alcohol rehabilitation service.

Previous deaths at HMP Peterborough

25. Ms Perfect was the third female prisoner to die at Peterborough in three years. Of the previous deaths, one was drug related and one was from natural causes.

Key Events

26. Ms Jamie Perfect was remanded in prison, charged with assaulting an emergency worker, on 4 October 2024. She was sent to HMP Peterborough. She had been at Peterborough several times before.

27. Ms Perfect had a history of alcohol and drug misuse, including heroin, crack cocaine, cannabis, and illicit prescription medication. When she arrived at Peterborough, she tested positive for opiates, tetrahydrocannabinol (THC – found in cannabis), cocaine and benzodiazepines (prescription medication used to treat anxiety but also widely abused).

28. On 5 October, a nurse from the substance misuse service (SMS) completed a medication review. She noted that Ms Perfect had not collected her ADHD medication since June 2024. She prescribed standard methadone titration (starting at 10mls and increasing to 30mls over three days) and supportive medications to help with the symptoms of drug withdrawal. Ms Perfect asked to start with Buvidal injections (used to treat opiate dependence as it blocks the feel-good effects of opiates) so she was added to the clinic waiting list to start.

29. Ms Perfect was allocated a single cell on the upper landing of B2 of the induction integrated drug treatment service (IDTS) wing for assessment and monitoring.

30. The remote SMS team GP completed a monitoring review. She noted that methadone stabilisation had already begun so she prescribed diazepam for the benzodiazepine withdrawal to cover from 5 October until 14 October.

31. The SMS team assessed Ms Perfect daily. Ms Perfect told SMS staff that she smoked £200 - £300 of cocaine a day and an unlimited amount of cannabis. She had been taking illicit diazepam (a benzodiazepine) and buprenorphine (an opiate) when she could.

32. During a meeting with SMS staff on 9 October, Ms Perfect told a GP she was not managing on her methadone and asked for an increase. She told the GP that she wanted to stabilise on methadone and then receive the Buvidal injection. The GP increased her methadone dose to 35mls and then from 11 October, 40mls. SMS nurses administered the methadone in accordance with the prescription.

33. On the morning of 10 October, during a routine cell check, an officer found a bag containing an improvised vape containing an unknown substance. (Vapes are often modified and used to smoke illicit substances.) Prison staff issued her with a notice that she would have an adjudication (disciplinary hearing) the next day. At the adjudication hearing on 11 October, Ms Perfect pleaded “not guilty” and the matter was adjourned for her to obtain legal advice.

34. On 13 October, Ms Perfect was on her wing, interacting with staff and prisoners throughout the day. (Intelligence reports submitted after Ms Perfect’s death say that Ms Perfect had been asking other prisoners for foil from their chocolate wrappers.)

Events of 14 October 2024

35. The investigator watched CCTV footage and body worn video camera (BWVC) footage from 14 October. She also obtained information from the East of England Ambulance Service. The following account has been taken from all sources.

36. At 4.09am, an operational support officer completed a roll check (a visual check into all cells to check that all prisoners are accounted for) and reported no issues.

37. At 7.23am, Prison Custody Officer (PCO) A unlocked Ms Perfect's cell door. In her written statement, she said that she called "Good morning" and got no response. She saw that Ms Perfect was lying on her bed on her right-hand side but could not see her face as her hair was covering it. She could not see any movement so she entered the cell. She touched Ms Perfect's leg which was cold and stiff so she radioed a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties that alerts healthcare staff and tells the control room to call an ambulance immediately). She turned Ms Perfect onto her back, which was difficult as she was so stiff, and shouted to PCO B for help. When PCO B arrived, they moved Ms Perfect to the floor and began CPR.

38. Nurse A was the first nurse to arrive. She shouted for more nurses to attend and for someone to bring the medical bag. She noted that Ms Perfect had rigor mortis (stiffening of the body after death). Three nurses and a healthcare assistant joined her. They attached a defibrillator which advised no shock. Nurse A tried to insert an airway but was unable to as Ms Perfect's jaw was stiff.

39. Staff moved Ms Perfect out of the cell and onto the landing for more space. For privacy they placed screens and continued with the resuscitation attempts.

40. The ambulance log noted that the telephone call was received at 7.25am. Paramedics arrived at the gate at 7.37am. Paramedics noted in their log that they were delayed in getting to Ms Perfect due to prison protocols of "getting through numerous locked gates and escorts". Ambulance staff were with Ms Perfect at 7.42am and noted that rigor mortis was present. They stopped CPR and pronounced life extinct at 7.43am.

Contact with Ms Perfect's family

41. The prison appointed a supervising officer (SO) as the family liaison officer on 14 October. She and a member of the chaplaincy team visited Ms Perfect's mother that day. She was not at home. A few hours later, they returned to Ms Perfect's mother's address after she phoned the prison having already heard her daughter had died, and confirmed the news and offered support. (We do not know who phoned Ms Perfect's mother.)

42. The prison contributed to the cost of Ms Perfect's funeral, in line with national guidelines.

Support for prisoners and staff

43. 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 (prisoners trained by the Samaritans to provide confidential peer-support) to identify prisoners most affected by the death.

44. After Ms Perfect's death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support. Listeners visited the wing to offer support and inform prisoners of the support available.

45. The prison posted notices informing other prisoners of Ms Perfect'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 Ms Perfect's death.

Post-mortem report

46. The post-mortem report concluded that Ms Perfect's death was due to aspiration pneumonia (when saliva, food or stomach contents enter the lungs leading to infection) caused by polypharmacy (multiple drug use).

47. The toxicology report found there had likely been therapeutic range use of amitriptyline, diazepam, promethazine, propranolol, methadone and tapentadol. (All had been prescribed to Ms Perfect apart from tapentadol (an opioid pain killer).) The report concluded that the combination of drugs present could increase sedation and therefore the risk of aspiration pneumonia.

Findings

Drugs strategy

48. Ms Perfect's toxicology report noted that she had tapentadol in her system. The prison does not prescribe tapentadol and therefore, it must have been smuggled in from outside. It is unclear how Ms Perfect obtained it.

49. HMIP's last inspection of Peterborough (Women) found that the availability of illicit drugs was comparable to other women's prisons, but the positive drug test rate was low at 5.95%. Inspectors noted that some important steps had been taken to reduce supply, including photocopying of mail and enhanced gate security, but that like all women's prisons, there was no body scanner to detect secreted items which was a risk.

50. At the time of the HMIP inspection, the prison's drug supply action plan was the same across the men's and women's prisons and did not focus on supply specific to the female population, such as the trading of medication. Peterborough has since published a drug strategy for the women's prison in December 2024. While it says that diversion of medication is the most significant drug-related issue among female prisoners, it does not say how this issue will be tackled. We would expect this to be addressed within the drugs strategy, especially given its significance within the women's prison. We bring this to the Director's attention.

Clinical care

51. The clinical reviewer considered that the clinical care Ms Perfect received was of a good standard and was equivalent to that which she could have expected to receive in the community. She found that Ms Perfect was monitored in line with the SMS process, prescribed appropriate detoxification medications and assessed regularly for withdrawal. She made no recommendations.

52. The clinical reviewer was satisfied that the prescribing of Ms Perfect's medications was in line with guidance. Ms Perfect had not been prescribed tapentadol, which she had taken alongside her other medications.

Director to Note

53. Ambulance staff noted that they were delayed in getting to Ms Perfect due to having to go through numerous locked gates. It made no difference in this case as Ms Perfect was dead when found but delays could make a difference in a future medical emergency. We bring this issue to the Director's attention as it is the prison's responsibility to ensure swift access of emergency vehicles.

Inquest

54. At the inquest, held on 29 June 2026, the jury concluded that Ms Perfect's death was drug related.

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