Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Ms Fallon Adams, a prisoner at HMP Peterborough, on 9 February 2023

A report by the Prisons and Probation Ombudsman

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OUR VISION

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

WHAT WE DO

WHAT WE VALUE

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

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

Ms Fallon Adams died from mixed drug intoxication involving methadone, chlordiazepoxide and diazepam, on 9 February 2023 at HMP Peterborough. She was 37 years old. I offer my condolences to Ms Adams' family and friends.

Ms Adams arrived in Peterborough on 2 February and after providing a positive urine sample for benzodiazepines, opiates and cocaine, she was prescribed methadone and chlordiazepoxide.

In addition to her prescribed medication, Ms Adams was able to obtain diazepam. We do not know the source of the diazepam, but Peterborough will need to remain vigilant in limiting the misuse of medication by prisoners.

There was a slight delay in discovering Ms Adams' death and when staff responded, they tried to resuscitate her, even though there were clear signs that she was already dead.

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 **December 2024**

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Summary

Events

1. On 2 February 2023, Ms Fallon Adams arrived in HMP Peterborough after being sentenced to four months in prison for breaching a no-contact restraining order.

2. During reception screening, Ms Adams said that she misused drugs and alcohol, and she provided a urine sample that was positive for benzodiazepines, opiates and cocaine. She was prescribed methadone for opiate substitution and chlordiazepoxide for alcohol detoxification.

3. In the following days, Ms Adams' symptoms were checked, with no concerns raised.

4. At 6.53am on 9 February, an officer unlocked Ms Adams' cell for her morning medication. Ms Adams was in bed and the officer asked her cellmate to wake her and she then continued unlocking other cells. A minute later, Ms Adams' cellmate shouted to staff that Ms Adams would not wake. The officer returned to the cell and after checking on Ms Adams, she called for assistance and also radioed a medical emergency code blue (to indicate a prisoner is unconscious or having breathing difficulties). To avoid wasting time, the officer began cardiopulmonary resuscitation (CPR) with Ms Adams still in the top bunk of her bed but when more staff arrived, they moved Ms Adams to the floor and continued CPR. A nurse arrived a minute later and they continued with CPR. Both officers and nurses noted that Ms Adams had signs of rigor mortis. Ambulance paramedics arrived at 7.10am and instructed staff to stop CPR as Ms Adams had died.

5. Post-mortem examination found that Ms Adams' cause of death was mixed drug toxicity involving methadone, chlordiazepoxide and diazepam.

Findings

6. Ms Adams was appropriately prescribed methadone and chlordiazepoxide but was also able to obtain diazepam, which she had not been prescribed.

7. There is no evidence that Ms Adams intended to harm herself.

8. The officer who unlocked Ms Adams on the morning of 9 February did not check on her welfare as she should have done.

9. Staff should not have continued giving CPR once they recognised that she had rigor mortis and had died.

Recommendation

- The Director of HMP Peterborough should identify an effective means to ensure all staff understand their responsibilities to check the welfare of prisoners when unlocking cells.

The Investigation Process

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

11. The investigator obtained copies of relevant extracts from Ms Adams' prison and medical records.

12. The investigator interviewed seven members of staff at HMP Peterborough on 11 and 12 April. He interviewed four other members of staff by video link.

13. NHS England commissioned a clinical reviewer to review Ms Adams' clinical care at the prison. The investigator and clinical reviewer conducted joint interviews with clinical staff.

14. We informed HM Coroner for Cambridgeshire and Peterborough of the investigation. He gave us the results of the post-mortem examination. We have sent him a copy of this report.

15. The Ombudsman's family liaison officer contacted Ms Adams' mother to explain the investigation and to ask if she had any matters she wanted us to consider. She said that:

- Her daughter used alcohol but had never used drugs so wanted to know why her daughter was prescribed methadone.
- Another prisoner told her that her daughter had fallen off the top of the bunk bed and she questioned why her daughter was placed in the top bunk initially and why she remained in the top bunk after her fall.

16. These questions have been answered in this report. Ms Adams' mother raised several other matters which we have addressed in separate correspondence.

17. We shared our initial report with HMPPS and with Ms Adams' mother via her solicitor. Ms Adams' solicitors identified that we had used an incorrect personal pronoun for Ms Adams at paragraph 47 (now paragraph 48). We have corrected this error.

Background Information

HMP Peterborough

18. 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. At the time of Ms Adams' death, Sodexo provided healthcare under the provisions of their contract with the Ministry of Justice. However, Northampton Healthcare Foundation Trust now provide healthcare.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Peterborough was in March 2021. The Chief Inspector noted that overall, the prison treated women respectfully, though there was more to do to embed an approach that considered more fully the trauma many women had experienced and which was so often linked to their offending. Inspectors found that relationships between staff and prisoners were generally good, staff were knowledgeable about the women in their care and were available on the landings to talk to women during their time out of cell.

20. Inspectors noted that women needing substance misuse treatment and alcohol detoxification were identified at reception and received appropriate care. Inspectors found that observations were made for those who needed monitoring during their first five days and that prescribing was flexible, with regular reviews taking place. Inspectors found that the great majority of women receiving opiate substitution therapy were on a maintenance dose, and only a minority were on a reducing regime.

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 2022, the IMB reported that life for prisoners in Peterborough was generally calm and well-ordered, with little violence. IMB members observed positive working relationships between staff and prisoners.

Previous deaths at HMP Peterborough

22. There were no deaths of female prisoners at Peterborough in the three years before Ms Adams' death.

Key Events

23. On 2 February 2023, Ms Fallon Adams was sentenced to four months in prison for breaching a no-contact restraining order and she arrived at HMP Peterborough that day. This was her first time in prison.

24. A nurse saw Ms Adams for a reception health screen. The nurse noted that Ms Adams appeared calm and settled and had no thoughts of suicide or self-harm. Ms Adams said that she had problems with substance misuse, both drugs and alcohol, and she provided a urine sample that was positive for benzodiazepines, opiates and cocaine.

25. A nurse then saw Ms Adams for a detailed substance misuse assessment. Ms Adams said that she used heroin, cocaine and cannabis. She also said that she used alcohol daily, drinking one bottle of vodka and eight cans of lager each day. The nurse assessed Ms Adams for withdrawal symptoms and identified that she had mild withdrawal symptoms for opiates and alcohol dependence.

26. Following her assessment, Ms Adams was prescribed methadone for opiate substitution: she received a standard prescription of 10 millilitres (ml) for the first day, 20ml for the second day and 30ml from the third day onwards. Ms Adams was also prescribed chlordiazepoxide for alcohol detoxification and several other medications to deal with the physical effects of withdrawal and associated vitamin deficiencies commonly found in people with drug and alcohol dependence.

27. A reception officer noted that Ms Adams was not concerned that she was in prison, apart from wanting to contact her family to let them know where she was. The officer told her that she could have a reception phone call and noted that Ms Adams had a history of self-harm but had no present thoughts of suicide or self-harm. The officer noted that Ms Adams was in good spirits and was polite and compliant while in reception.

28. Ms Adams was then moved to a cell in Wing B1, sharing with Prisoner A. Prisoner A had already occupied the bottom bunk, so Ms Adams took the top bunk. The investigator was told that if a prisoner was elderly or had a physical disability, they would be allocated a single cell or given the bottom bunk. However, there was no reason why Ms Adams could not take the top bunk. Wing B1 holds prisoners needing support for substance misuse.

29. On the morning of 3 February, a nurse assessed Ms Adams for withdrawal symptoms and noted she had some withdrawal symptoms for opiates and alcohol.

30. Also on 3 February, a Prison Custody Officer (PCO) saw Ms Adams for a key work meeting. The PCO noted that Ms Adams was calm and relaxed. She spoke about having family and friends for support, but also said that most of her current friends were bad influences and encouraged her to use drugs. The PCO told her that while she was in Peterborough, it would be a good time for her to think about making positive decisions about her future. Ms Adams spoke about an uncle she trusted and said that she intended to engage with the prison's substance misuse team.

31. On 6 February, a substance misuse worker saw Ms Adams to explore her substance misuse history and what future support she may need. Ms Adams spoke

about a past abusive relationship that had led to her using drugs. She said that she was looking forward to recovery as it was her last hope.

32. In a statement to the police Prisoner A, said that she believed that Ms Adams had been over-medicated because she was very drowsy and kept falling over. The CCTV footage for 8 February showed that Ms Adams appeared to walk reasonably slowly but did not appear unsteady on her feet at any time.

33. A PCO told the investigator that she had unlocked cells between around 4.30pm to 5.00pm on 8 February for women to collect their evening meal. Prisoner A told her that Ms Adams had just fallen. The PCO said that Ms Adams was sitting on the floor but said that she was okay and declined an offer to see a nurse. Ms Adams then went to collect her food. The PCO said that she would tell a nurse if she thought a prisoner appeared to be over-medicated and she had not needed to do that for Ms Adams.

34. Ms Adams' records show that her withdrawal symptoms were assessed every day at Peterborough. All the staff who gave Ms Adams her morning, midday and evening medication on 8 February said that they would withhold giving medication if a prisoner appeared sedated. They also explained that the process for giving medication was that the prisoner would drink a cup of water after taking their medication and an officer would check their mouth to ensure they had swallowed it. None of the staff identified any concerns with Ms Adams.

35. Prisoner A also told the police that Ms Adams had fallen from the top of their shared bunk bed at some time on the evening of 8 February. She said that she checked that Ms Adams had no injury and then helped her back into bed. She said that they had both gone to bed early that evening and she recalled Ms Adams snoring loudly at about 8.00pm. There is no record to indicate that staff were told about this fall. Prisoner A was released from Peterborough before the investigator had the opportunity to speak to her, and she did not respond to a letter he sent her asking her to contact him.

Events of 9 February

36. At 5.47am on 9 February, a Healthcare Assistant (HCA) checked on Ms Adams and all the other women who were within their first days of drug or alcohol withdrawal, using a torch. At interview, the HCA explained that he was not expected to wake the women at that time in the morning but instead had to check that they appeared to be well. He did not notice anything of concern with Ms Adams but acknowledged that it was difficult to see her clearly.

37. At 6.53am, PCO A unlocked Ms Adams' cell for morning medication. Ms Adams was in bed, but Prisoner A was out of bed and ready for the morning. The PCO asked Prisoner A to wake Ms Adams, and she then continued down the wing unlocking cells. A little over a minute later, Prisoner A came out of the cell and shouted to staff that Ms Adams would not wake. The PCO ran to the cell and found that Ms Adams had no pulse. She tried to radio a medical emergency code blue, but her call was not acknowledged as a lot of day staff were arriving for work and were radioing to join the network. However, PCO B came into the cell and PCO A told him to call the nurses as Ms Adams was possibly dead. PCO A radioed again and was able to make a code blue call. She said that as she would not have been

able to move Ms Adams to the floor alone and as she did not want to waste any time, she climbed to the top bunk and started CPR.

38. At 6.56am, a Senior Prison Custody Officer (SPCO) and PCO C arrived in the cell. The officers moved Ms Adams to the floor and the SPCO began CPR. The SPCO said that Ms Adams' body was stiff, but she said that she was not medically trained, and she had been told to carry out CPR until told to stop. Two nurses arrived in the cell one minute later. One nurse noted that Ms Adams' jaw was locked through rigor mortis, so it was not possible to insert an airway. The nurses and the SPCO continued with CPR. The nurse said that she understood that if officers had already started CPR, nurses had to continue with it on their arrival.

39. An emergency ambulance was called when the code blue was radioed. Ambulance paramedics arrived at 7.10am and instructed that resuscitation efforts should stop as Ms Adams had died.

Contact with Ms Adams' family

40. Peterborough appointed a family liaison officer (FLO). Ms Adams had named a friend as her next of kin and the FLO and a colleague visited him. They arrived at 10.50am but found that he was unknown at the address. After seeking clarity from managers, the FLO telephoned him to ask where he was and if she could visit him. He said that he wanted to know why so she told him that Ms Adams had died. The FLO then drove to a neutral location, where she arrived at midday. She spoke further to him and obtained information about Ms Adams' family. Ms Adams' mother telephoned the prison that afternoon to say that she had heard from her son that her daughter had died.

41. Peterborough contributed to the cost of Ms Adams' funeral in line with national instructions.

Support for prisoners and staff

42. After Ms Adams' death, the Director 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.

43. The prison posted notices informing other prisoners of Ms Adams' 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 Adams' death.

Post-mortem report

44. Toxicology tests showed that Ms Adams had methadone and chlordiazepoxide in her blood at a level consistent with her prescription. Tests also found a therapeutic level of unprescribed diazepam. (Therapeutic means a level prescribed to treat an illness effectively.)

45. The pathologist explained that while the concentration of methadone was within therapeutic range, it also fell within the range associated with fatalities. She explained that how the methadone affected Ms Adams depended on her tolerance

to opioids. The pathologist found no significant natural disease to explain Ms Adams' death and gave her cause of death as mixed drug intoxication involving methadone, chlordiazepoxide and diazepam. The pathologist also noted that her skin had features that indicated that she died while lying face down with her neck against a relatively firm surface. The pathologist noted that her position in bed might have contributed to her death in the form of positional asphyxiation while intoxicated.

Findings

Unlock procedures and wellbeing checks

46. Prison Service Instruction (PSI) 75/2011 on residential services says that it is unacceptable that the PPO has identified cases where prisoners had died overnight but staff unlocking them had not noticed that they had died.

47. A local operating procedure issued at Peterborough in February 2020, reminded staff that they were expected to conduct welfare checks when unlocking residents, including receiving a positive response from them. It says that if staff fail to get a response, they should investigate further until they get a response to ensure the prisoner is safe and well.

48. PCO A unlocked Ms Adams' cell at 6.53am on 9 February. She was in bed and the PCO asked Prisoner A to wake her and then continued with her duties. Around a minute later, Prisoner A discovered that Ms Adams was dead.

49. It is clear from both PSI 75/2011 and Peterborough's local operating procedure that PCO A should have obtained a response from Ms Adams. The delay in Ms Adams' discovery made no difference to the outcome for her, but clearly staff do not understand their responsibilities, despite the local operating procedure being issued in 2020. We make the following recommendation:

    The Director of HMP Peterborough should identify an effective means to ensure all staff understand their responsibilities to check the welfare of prisoners when unlocking cells.

Clinical care

50. The clinical reviewer found that Ms Adams' care at Peterborough was of a reasonable standard and at least equivalent to what she could have expected to receive in the community. The clinical reviewer noted that Ms Adams had comprehensive and thorough screening and support from the substance misuse team and received frequent checks for withdrawal symptoms.

    However, the clinical reviewer also identified a number of areas for improvement. For instance, the clinical reviewer questioned the purpose of the regular night-time checks on Ms Adams given the report from staff that it was very difficult to observe prisoners properly from outside the cell. The clinical reviewer also commented on the emergency response which we also consider in our findings in this report.

Director to note

Ms Adams' cause of death

51. Ms Adams' cause of death was given as mixed drug intoxication involving methadone, diazepam and chlordiazepoxide. Ms Adams had been prescribed methadone and chlordiazepoxide. However, she had not been prescribed diazepam.

52. Prisoners at Peterborough are not given diazepam to keep and administer themselves. Instead, they are dispensed tablets daily by healthcare staff and under the close supervision of an officer. It is possible that the diazepam had been smuggled into the prison, either by Ms Adams or another prisoner. Alternatively, it is possible that a prisoner in receipt of prescribed diazepam might have concealed a tablet in her mouth without detection and subsequently gave or sold it to Ms Adams.

53. Nothing emerged during this investigation to indicate that Ms Adams had any intention to deliberately harm herself but had instead indicated that being in prison gave her the opportunity to deal with her addictions. We also note the pathologist's comment that Ms Adams' position in bed might have contributed to her death in the form of positional asphyxiation while intoxicated.

54. As we cannot be certain of the source of the diazepam, we make no recommendation. However, the Director will wish to note the dangers closely associated with prisoners obtaining and using non-prescribed medication.

Director and Head of Healthcare to note

Emergency response

55. European Resuscitation Council Guidelines for Resuscitation 2015, which were shared with prison managers in September 2016, introduced new staff guidance about when not to perform CPR. It states: "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile". The guidelines define examples of futility as including the presence of rigor mortis.

56. Both PCO A and the SPCO recognised that Ms Adams was almost certainly dead, and they both recognised the presence of rigor mortis. However, both said that they had been instructed to carry out CPR until told by a qualified person that they should stop. A nurse said that she would not have started CPR if she had been the first person to find Ms Adams, but she understood that the instruction to nurses was that they should continue giving CPR if it was already underway when they reached the prisoner.

57. While we understand the wish to start and then continue resuscitation until death has been formally recognised, staff are not expected to carry out CPR in circumstances such as those with Ms Adams. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased.

Inquest

58. An inquest into Ms Adams' death held between 24 and 27 November 2025 concluded that her death was caused through the combined effects of prescribed and non-prescribed medication. The inquest jury found that inadequate welfare checks and observations resulted in missed opportunities for staff to intervene at an earlier stage.

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