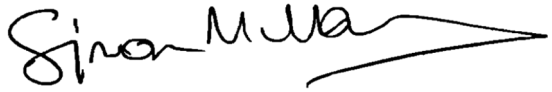
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: **1 Northamptonshire Healthcare NHS Foundation Trust**
1	**CORONER** I am Simon MILBURN, Area Coroner for the coroner area of Cambridgeshire and Peterborough
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 10 February 2023 I commenced an investigation into the death of Fallon Leanne ADAMS aged 37. The investigation concluded at the end of the inquest on 28 November 2025. The conclusion of the inquest was that: Fallon came to her death by intoxication of mixed drugs where the illicit obtaining of diazepan had a high probability of causing her death. Failure to conduct adequate welfare checks and observations allowed for missed opportunities to intervine. Evidence of this was staff admitting to not being able to confirm respiratory movement observations, observations of movement and general observations of inmate. Unsatisfactory training was also highlighted in the evidence however this did not cause or minimally contribute to Fallon's death. Fallon came to her death between 18:33 on the 8/2/23 and 7am on the 9/2/23. She came to her death on the top bunk of cell 8, wing B1 of HMP Peterborough.
4	**CIRCUMSTANCES OF THE DEATH** On Thursday 9th of February 2023 at approximately 0657hours, the alarm was raised by the cell mate of Ms ADAMS in her cell at HMP Peterborough. Staff arrived on scene and found Ms ADAMS unresponsive and cold to the touch,

	they called for an ambulance and an ambulance crew arrived and declared Ms ADAMS deceased at 0715hours after a negative heart trace. CPR had been attempted by Prison staff. Ms ADAMS had arrived at HMP Peterborough 8 days prior to her death and had been sharing a cell for the entirety of her time at the prison. Ms ADAM's cell mate describes that during the days prior to her death, Ms ADAMS was heavily medicated on methadone and described her has "BEING OFF HER FACE MOST OF THE TIME". Onthe day before her death, 8th of February 2023, Ms ADAMS' states that during the evening, Ms ADAMS was lying on the top bunk and she was slouching over the top, she then fell off the bunk and hit her head. Ms ADAMS' cell mate states that she then put Ms ADAMS to bed and tucked her in, she checked her head for injuries or lumps but could not see any. She last spoke to ADAMS at 1930hours when Ms ADAMS asked her if another prisoner had dropped off the laundry. Ms ADMA's could be heard snoring until 2000hours when the cell mate herself fell asleep. Staff checked on the cell at 0559hours it was a visual check through the cell hatch, the officer recorded that he could see Ms ADAMS moving. Ms ADAMS' cell mate woke at 0625hours and confirmed this was the time by turning on the TV in the cell. She shouted to Ms ADAMS to wake up but got no reply. She then went to check on her and touched her neck, she states it was cold, she then lifted her leg and describes it as a dead weight, she then raised the alarm and staff arrived on scene and began CPR. According to prison medical records , Ms ADAMS was on the following medications: • Chlordiazepoxide 10mg • Ibuprofen 400mg • Mebeveine 135mg • Methadone 1mg • Metoclopramide 10mg • Thiamine 100mg • Sertraline 50mg
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern)

	• Whilst an inmate at HMP Peterborough Fallon ADAMS was prescribed methadone (for opiate withdrawal) and chlordiazepoxide (for alcohol withdrawal). She also took non-prescribed diazepam apparently obtained from an illicit source within the prison. All of these medications have a sedative effect which in combination have the potential to cause over sedation and death. • The evidence seemed to show that at no stage was Ms ADAMS given a specific warning or advice stating that taking additional non-prescribed medication/diazepam could result in over sedation and death. • I also heard evidence in relation to Regulation 28 issues. Whilst it is clear that a number of relevant changes were being made it was not clear that a specific warning in relation to the risks of over sedation was being implemented.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely **by February 23, 2026**. I, the Coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons **Megan PHILLIPS – Legal representative for Ms ADAMS' family** **India MOORE – Legal representative for Sodexo** **Liz HACKETT – Legal representative for Northamptonshire Health Care** I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest.

	You may make representations to me, the coroner, at the time of your response about the release or the publication of your response by the Chief Coroner.
9	**Dated: 29/12/2025**  **Simon MILBURN** **Area Coroner for** **Cambridgeshire and Peterborough**