Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Gavin Wheale, a prisoner at HMP Birmingham, on 8 August 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 Gavin Wheale died in his cell on 8 August 2024 at HMP Birmingham. He was 47 years old. I offer my condolences to Mr Wheale's family and friends. The pathologist gave the cause of death as mixed drug interactions (morphine, cocaine and diazepam).

In my investigation into a death at Birmingham in May 2024, I identified a number of weaknesses in reception procedures including the failure to examine all available information about risk. These findings echoed some of the former Ombudsman's findings in a death there in February 2022. I am deeply concerned to find the same issues in this case.

Mr Wheale arrived at Birmingham with a significant amount of evidence from the police that he was concealing drugs on his person and had threatened to consume them. The reception manager and the reception nurse did not examine all of the information about Mr Wheale's risk, and the nurse was unaware that Mr Wheale was concealing drugs. An officer saw Mr Wheale conceal an item internally during a search and shortly afterwards Mr Wheale self-reported that he had taken diazepam in a holding room. The officer did not tell healthcare staff. Mr Wheale was taken to the care and separation unit (CSU – segregation unit) in line with local policy. The CSU staff were unaware of the prison's secreted item policy and Mr Wheale was not made subject to extra monitoring. Neither the nurse who assessed his fitness for segregation nor the one that checked him for a routine night check considered the risks or potential consequences of Mr Wheale having concealed drugs. He was found dead early the following afternoon.

The investigation identified a number of systemic and endemic failures by staff to follow national and local guidance for the risk assessment of prisoners in reception and the management of prisoners deemed to be concealing items. Overall, most seriously, there was a complete and collective failure to recognise that prisoners concealing items are at serious risk of harm. This meant that there was no effective oversight to prevent Mr Wheale's death.

At the time of writing in May 2025, two prison staff are facing disciplinary hearings into their actions on 7 August 2024, as would a nurse had he not left employment there. The prison has already put in place several measures as a result of learning from Mr Wheale's death and previous investigations. I welcome these and make fewer recommendations of my own as a result.

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 **July 2025**

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Summary

Events

1. Mr Gavin Wheale had a significant history of poly-substance abuse and had served several sentences for crimes relating to his addictions. He also had a history of anxiety, depression, self-harm, concealing drugs, and accidental overdose.

2. On 12 December 2023, Mr Wheale was sentenced to 16 months imprisonment for threatening a person with a bladed article in a public place. On 11 July 2024, he was released on licence from HMP Doncaster. He was recalled to prison the following day, but he remained unlawfully at large.

3. On 6 August 2024, West Midlands police arrested Mr Wheale for shoplifting. During a strip search in police custody, officers noticed plastic packaging protruding from his anus. They took him to hospital as they suspected he had drugs secreted in his body. Mr Wheale was seen by a doctor but refused all other treatment. He was returned to police custody, put under constant observation and kept handcuffed overnight after he said he would retrieve the package as soon as he was able to.

4. On 7 August, Mr Wheale was taken to HMP Birmingham. In addition to risk information contained in his escort records, a member of the escort service staff told reception staff that Mr Wheale was concealing a package and required monitoring.

5. The custodial manager (CM) in charge of reception did not examine the escort records and did not properly consider all of Mr Wheale's risk factors as required by local and national policy. Neither did he inform the reception nurse that Mr Wheale was concealing a package. The reception nurse also did not read the escort records. Mr Wheale gave a urine sample that tested positive for opiates, benzodiazepines, cocaine and cannabinoids.

6. During a search, an officer saw a package fall out of Mr Wheale's shoe. Mr Wheale refused to give it to the officer and appeared to conceal it in his anus. A subsequent X-ray body scan was inconclusive. Shortly afterwards, Mr Wheale showed the same officer a plastic bag and told him that he had taken a single tablet of prescribed diazepam. The officer told senior managers but did not tell healthcare staff.

7. Mr Wheale was segregated in line with local policy on secreted items. No one in the CSU was aware of the prison's secreted item policy and Mr Wheale was not risk assessed or monitored more closely as he should have been. The nurse that assessed whether Mr Wheale was physically and mentally fit enough to be segregated did not consider the risks and potential consequences of Mr Wheale concealing drugs.

8. Mr Wheale pressed his cell bell several times during the night and told the night patrol officer that he was withdrawing from drugs. He also told the nurse that visited him for a standard first night welfare check that he was in pain. She did not explore why he was in pain or where his pain was and told him he was not allowed any type of medication as he had a concealed item. She too did not consider the risks and potential consequences of Mr Wheale concealing drugs.

9. The next morning, several members of staff saw Mr Wheale and he came out of his cell for a shower. Staff last saw him alive at about midday. At about 2.25pm, two officers unlocked his cell to take him for another body scan and found him unresponsive on his bed. Officers and nurses gave Mr Wheale cardiopulmonary resuscitation (CPR) and naloxone (to reverse opiate overdose) but at 2.39pm the prison GP pronounced life extinct.

Findings

10. There were a number of systemic and endemic failures by staff to follow national and local guidance for the risk assessment of prisoners in reception and the management of prisoners deemed to be concealing items.

- The reception CM did not consider all of the available information on Mr Wheale's risk in line with national guidance. He did not inform the reception nurse that Mr Wheale was suspected of concealing an item as he should have done.

- The reception nurse also did not look at the escort records in line with local and national guidance and therefore failed to consider all of the available information on Mr Wheale's risk.

- The officer operating the body scanner did not tell healthcare staff that he had seen Mr Wheale conceal a package internally and that he had reported taking a tablet of diazepam. He made a serious error of judgement by not considering this represented a significant increase in Mr Wheale's risk.

- The officer operating the body scanner did not attempt to retrieve and secure the bag Mr Wheale showed him as evidence for trace testing as he should have done.

- The nurse that assessed Mr Wheale in the CSU and the nurse that completed the night welfare check did not consider the risks and potential consequences for Mr Wheale of concealing an item.

- The duty governor authorising segregation and none of the staff in the CSU were aware of the prison's secreted item policy and Mr Wheale was not subject to extra monitoring as he should have been.

11. There was a complete and collective failure among all staff to recognise that prisoners concealing items are at serious risk of harm. This resulted in a lack of clinical assessment and monitoring and meant that there was no effective oversight to prevent Mr Wheale's death.

12. The clinical reviewer concluded that the clinical care offered to Mr Wheale was not of the required standard and therefore not equivalent to that which would have been received in the wider community.

Recommendations

- The Governor and Head of Healthcare should deliver training to staff emphasising the potential risk of harm to a prisoner suspected of secreting items and introduce a robust assurance process to satisfy themselves that this learning has been embedded.

The Investigation Process

13. HMPPS notified us of Mr Wheale's death on 8 August 2024.

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

15. The investigator obtained copies of relevant extracts from Mr Wheale's prison and medical records, CCTV, body worn video camera (BWVC) footage and staff radio communications. Despite several requests, including to senior prison managers, we were not provided with the cell bell records from the CSU. Further information was provided by West Midlands police and West Midlands Ambulance Service. West Midlands police investigated Mr Wheale's death for the Coroner but did not consider any criminal charges. The prison provided the investigator with a copy of their local investigation into the actions of two members of staff on 7 August 2024.

16. The investigator interviewed 15 members of staff at Birmingham in November 2024. Two members of staff were absent on sick leave and did not wish to be interviewed.

17. NHS England commissioned a clinical reviewer to review Mr Wheale's clinical care at the prison. The clinical reviewer interviewed seven healthcare staff together with the investigator.

18. We informed HM Coroner for Birmingham of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

19. The Ombudsman's office contacted Mr Wheale's mother to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Wheale's mother had no specific questions but asked for a copy of our report, which we have sent to her.

Background Information

HMP Birmingham

20. HMP Birmingham is a category B reception prison. Birmingham and Solihull Mental Health Foundation Trust provides 24-hour healthcare services at the prison and sub-contracts Birmingham Community Healthcare NHS Trust to provide primary care services. Substance misuse services are delivered by an integrated service known as the Birmingham Recovery Team (BRT).

HM Inspectorate of Prisons

21. The most recent inspection of HMP Birmingham was in January and February 2023. Inspectors noted significant improvements at the prison since the previous inspection. They found that the leadership team, which was well motivated and supportive of the Governor's priorities, had helped to improve stability. Healthcare services were well led by knowledgeable managers with a clear vision for providing better outcomes for prisoners.

22. Inspectors found reception and induction arrangements were appropriate. The segregation unit was in a temporary location due to the refurbishment project which meant that three wings were out of use. Cells were clean and adequately equipped but the regime was limited and there was little to stimulate or motivate prisoners.

23. There had been significant investment in physical and procedural security arrangements to prevent the ingress of drugs. This included the body scanner, enhanced gate security and better netting. Far fewer prisoners than at the previous inspection said it was very or quite easy to get hold of drugs.

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 June 2023, the IMB reported that the prison had continued to build on the earlier successes and improvements.

25. The Board's main concerns were centred on the recruitment and retention of suitable staff and the negative impact of staffing issues on the regime and availability of support for prisoners. The body scanner had proved effective in detecting and deterring the ingress of drugs. The number of prisoners placed in segregation following a positive scanner reading had steadily reduced between 2021 and 2023.

Previous deaths at HMP Birmingham

26. Mr Wheale was the thirteenth prisoner to die at Birmingham since August 2021. Of the 12 previous deaths, seven were from natural causes, three were self-inflicted, one was drug related and one was a homicide.

27. In a self-inflicted death in 2022, we recommended that the Governor should review the Person Escort Record (PER) system to ensure that reception staff had access to all relevant information. The two deaths immediately before Mr Wheale's in May and June 2024 were both of prisoners in their early days in custody. In the first of these, we recommended that the Governor and Head of Healthcare should review the training for reception and induction staff to ensure they examine and share all relevant information about risk including information in the PER. We also recommended that the Head of Healthcare review the quality and compliance with policy of reception health screens.

Segregation

28. Segregation units are used to keep prisoners apart from other prisoners. Segregation is authorised by an operational manager at the prison who must be satisfied that the prisoner is fit for segregation after an assessment by a member of healthcare staff. The unit at HMP Birmingham is known as the care and separation unit (CSU) and comprises 15 cells.

29. Regimes are usually restricted and prisoners are permitted to leave their cells only to collect meals, shower, make phone calls and have a daily period in the open air. A doctor should visit at least every three days and a registered nurse on the other days to assess the physical, emotional and mental wellbeing of the prisoners and whether there are any apparent clinical reasons to advise against continuing segregation.

30. Segregation policy is contained in Prison Service Order (PSO) 1700.

X-ray body scanner

31. An X-ray body scanner uses ionising radiation to provide high resolution and real time body view images. Guidance on operating the body scanner is contained in the Use of X-Ray Body Scanners (adult male prisons) Policy Framework. Scans should only be undertaken when deemed necessary and proportionate in order to prevent, detect or investigate crime, to maintain prison security, good order and discipline and there is intelligence or reasonable suspicion that the person is internally concealing an item.

32. If an X-ray body scan of a prisoner shows a negative scan image but the prisoner has been seen by staff or another person to internally conceal an item, the prison may manage the prisoner as if they do have an internally concealed item on grounds of reasonable suspicion. If the image indicates that the prisoner is internally concealing an item, healthcare must be told as soon as possible in case there is a risk to the prisoner. Positive detection of an illicit or unauthorised item must also be recorded on the Incident Reporting System (IRS).

33. In all cases the prison must consider the location and observation requirements of the prisoner. This could include use of segregation and/or suicide and self-harm monitoring procedures, if applicable, locating the prisoner in healthcare, or sending the prisoner for outside medical intervention. This decision should be made in conjunction with the advice from healthcare.

34. If the prisoner has an unknown internally concealed item, an operational manager must ensure that a defensible decision is made on any actions taken or not taken and recorded on the prisoner's record.

Digital Person Escort Record (DPER)

35. A person escort record (PER) must be completed every time a person in custody is escorted between police stations, courts and prisons. It provides relevant information on a prisoner and highlights risks they may pose to themselves and to others during and after the movement. A paper PER is used for all escorts undertaken by HMPPS. All escorts undertaken by private escort companies (GEOAmey and Serco) are booked via the Book a Secure Move (BaSM) system. PERs for moves booked on this system are referred to as digital PERs or DPERs because the record is online. BaSM is a web-based platform that can be accessed by all prison staff. Healthcare staff are also able to access the system if they have been provided with a Prison Service (NOMIS) user account.

Key Events

36. Mr Gavin Wheale had a significant history of poly-substance abuse and had served several sentences for crimes relating to his addictions. He also had a history of anxiety, depression, self-harm, concealing drugs, and accidental overdose.

37. On 12 December 2023, Mr Wheale was sentenced to 16 months imprisonment for threatening a person with a bladed article in a public place. In February 2024, he was supported by Prison Service suicide and self-harm monitoring procedures (known as ACCT) after he overdosed on illicit drugs. He told staff that it was not a deliberate overdose.

38. On 11 July 2024, Mr Wheale was released on licence from HMP Doncaster. His licence was revoked the next day after he failed to go to the accommodation arranged for him and to attend a pre-arranged appointment with the Probation Service. He was recalled to prison for a fixed term of 28 days.

39. Mr Wheale remained unlawfully at large until 6 August when West Midlands police arrested him for shoplifting. During the arrest, a member of the public told officers that Mr Wheale had concealed an item in his mouth. At the police station, Mr Wheale said the item he had concealed was ibuprofen. A strip search was authorised to confirm Mr Wheale did not have a quantity of drugs with which he could harm himself. During the search officers noticed plastic packaging protruding from his anus. They took Mr Wheale to Sandwell Hospital as they suspected he had drugs secreted inside his body.

40. Mr Wheale was seen by a doctor and given an electrocardiogram (ECG - a scan of the heart) but refused all other treatment and was returned to police custody. He was put under constant observation and kept handcuffed overnight due to telling officers that he had concealed drugs to retrieve in prison.

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Escort to and reception at HMP Birmingham

41. Mr Wheale arrived at HMP Birmingham at 12.20pm. The investigator asked for CCTV of the reception area for this period but was told it was not working. A custodial manager (CM) was in charge of Birmingham reception that day and an officer was responsible for operating the X-ray body scanner. Both the CM and officer were on sick leave during the investigation and did not wish to be interviewed. However, both made written statements immediately after Mr Wheale's death which the prison provided to us. We were also provided with evidence from a subsequent prison investigation into the events of 7 August. The following account has been taken from these sources, prison documents and from police custody records and police statements from GEO Amey staff provided to us by West Midlands police.

42. The police completed a digital person escort record (DPER) on the web-based Book a Secure Move (BaSM) system. The DPER showed Mr Wheale:

- Had a history of overdose and concealing class A drugs internally ('plugging').

- Had currently got something concealed in his anus.
- Had said he would remove the item as soon as he was able to and take it.
- Had refused hospital treatment.
- Was under constant observation and required constant observation.
- Was detoxifying.

43. The paper PER completed by the police for Mr Wheale's escort from police custody to Sandwell Hospital the previous night also arrived with him. The front of the PER was blank. The risk indicator page showed Mr Wheale:

- Had a history of self-harm and had previously attempted to hang himself.
- Had overdosed in 2017.
- Had a history of concealing drugs.
- Had been strip-searched and a package was seen in his anus on 6 August.

The medical information section also showed Mr Wheale was suspected of having a package in his anus.

44. A prisoner custody officer (PCO) from GEO Amey escorted Mr Wheale to the prison. She said it was hot in the van and they wanted to move Mr Wheale into the prison as soon as possible to avoid distressing him (we understand there was a queue to enter the prison because some prisoners had arrived from another prison after an incident). She telephoned reception to try and expedite the move. She said she told an officer that Mr Wheale was handcuffed and suspected of concealing something, possibly drugs.

45. The PCO said she saw the "duty governor" in reception when they brought Mr Wheale in and told him that the police believed Mr Wheale was concealing drugs. The duty governor that day said he was in reception along with two other senior managers dealing with the arrival of the prisoners from another prison and did not speak to anyone from the escort service. He said nobody in reception said anything to him about Mr Wheale. Escort records showed Mr Wheale was transferred to prison custody at 12.45pm. The PCO said she also handed over the paper PER that had been started when Mr Wheale was taken to Sandwell Hospital and Mr Wheale's hospital discharge letter.

46. An officer said the GEO Amey escort telephoned before they brought Mr Wheale in and told her that he was being constantly supervised as he had concealed something and would need to be monitored. She said she read the DPER when Mr Wheale arrived and was aware that Mr Wheale had been under constant observation in police custody and had been handcuffed to prevent him retrieving the item. She said she told the CM before he started the reception process with Mr Wheale that he was potentially concealing drugs and had previously refused treatment. She also said she told the officer who was operating the body scanner that Mr Wheale might have been concealing drugs.

47. The CM said he attended a meeting at about 1.30pm. He returned to reception at about 3.00pm and Mr Wheale and several other prisoners were waiting to be processed. The CM said reception staff informed him that Mr Wheale had concealed something while in police custody and had arrived in handcuffs to prevent him from retrieving the item. He said the staff told him that the duty governor had advised them to process Mr Wheale in the normal way and the handcuffs had been removed. The CM said he was aware that the prison had a secreted items policy but he was unaware whose responsibility it was to initiate the process and had never read it.

48. The CM said Mr Wheale showed signs of withdrawing from drugs and asked to be 'rushed through'. The CM said this was usually a sign that the person was concealing something. He explained to Mr Wheale that he would follow the normal process, which was an interview with the reception CM, an initial health assessment with a nurse, an X-ray body scan and then a search.

49. The CM said he looked at the front of the DPER and could see there were alerts but he did not read the detail because he had known Mr Wheale for years, he knew that Mr Wheale might have something concealed, he knew his self-harm history and he had not arrived with a suicide and self-harm (SASH) warning form. He completed the initial interview with Mr Wheale and the first section of the cell sharing risk assessment (CSRA). Mr Wheale denied that he had concealed something. The CM informed Mr Wheale that he would be scanned and that any secreted items would show up. He said Mr Wheale did not reply but walked away from the desk.

50. A healthcare assistant saw Mr Wheale next and completed a set of physical observations. Mr Wheale's blood pressure was significantly elevated. The healthcare assistant asked for a urine sample and Mr Wheale told them he was unable to pass urine at that time.

51. A nurse then completed an initial health assessment. The nurse said he was given Mr Wheale's file containing the first part of his CSRA and his custodial document file. He said the DPER was online and he did not have access to it from his computer terminal. There was no PER or extra information about risk in Mr Wheale's paper file and he did not see the hospital discharge letter. He said no one told him that Mr Wheale was suspected of concealing an item or gave him any other information about Mr Wheale before he saw him.

52. The nurse said Mr Wheale told him that he had a bad back because the police had hit him but did not want to show him his injuries. Mr Wheale denied any current thoughts of suicide or self-harm but said he had last self-harmed and had attempted suicide in June 2024. He gave a history of poly-drug misuse and post-traumatic stress disorder (PTSD – symptoms can include flashbacks and changes in mood).

53. The nurse said he did not make a plan to review Mr Wheale's blood pressure because he had no history of high blood pressure. He said he told Mr Wheale that he needed to give a urine sample so that the correct medication could be prescribed to manage his withdrawal symptoms.

54. Mr Wheale was given some water and about 45 minutes after the initial health assessment he provided a urine sample that tested positive for opiates, benzodiazepines (sedatives), cocaine and cannabinoids. A GP subsequently

reviewed Mr Wheale's clinical record and prescribed methadone for opiate withdrawal. However, his first dose due that evening was withheld in the light of the urine screen results to avoid risk of opiate overdose. The only other medications he had been prescribed in the community were for asthma and acid reflux.

55. After he completed the health assessment the nurse handed Mr Wheale's file to an officer so that he could scan him. The officer said he did not get a handover from the nurse, and he did not read Mr Wheale's file.

56. The officer said he asked Mr Wheale to remove his shoes and a small bag fell out of one of them. He asked Mr Wheale to give him the bag but Mr Wheale refused and then concealed the package in his anus. He scanned Mr Wheale and the results of the scan were inconclusive. The officer put Mr Wheale into one of the holding rooms pending a second scan in line with local policy. A short while afterwards, he said Mr Wheale held up a small plastic bag at the window of the room. The officer opened the door asked him what it was. Mr Wheale said, "it was a tablet". The officer said he asked Mr Wheale what sort of tablet it was, and Mr Wheale replied, "It's diazepam, it's my medication and I took it". (Diazepam is used to treat anxiety and has sedative effects. Mr Wheale was not prescribed it.) The officer said he did not see Mr Wheale swallow anything.

57. The officer said he told the reception CM and another CM (who was in reception to take over). Both CMs denied this when interviewed for the prison's internal investigation.

58. The officer said he did not consider initiating Prison Service suicide and self-harm monitoring procedures (known as ACCT) because Mr Wheale told him he had only taken one tablet and that it was medication and he did not appear to be suicidal. He did not inform healthcare staff that Mr Wheale had said he had taken a tablet because he did not consider one tablet to be an overdose. The officer said he was not aware of the prison's secreted items policy.

59. Mr Wheale refused to take a second scan and the CM asked staff to take him to the care and separation unit (CSU – segregation unit) in line with the prison's local policy for managing prisoners suspected of concealing items.

60. The officer subsequently submitted a security information report (IR), made an entry on Mr Wheale's prison record (NOMIS) and informed the orderly officer (the most senior uniformed grade responsible for ensuring the running of the regime and managing incidents) that Mr Wheale had allegedly taken a tablet. The officer did not secure the bag as evidence and we do not know what happened to it. Mr Wheale was escorted to the CSU.

Care and separation unit (CSU)

61. The investigator watched CCTV of Mr Wheale's journey to the CSU and for the duration of Mr Wheale's stay there. Based on other documentary evidence, later body worn video camera (BWVC) footage and staff radio communications, the CCTV clock is about 23 minutes behind the correct time. We have adjusted the times accordingly in the account of events below.

62. Mr Wheale arrived at the CSU at about 4.13pm. An officer said he remembered Mr Wheale arriving from reception and being told that he had given a positive indication on the body scanner and was suspected of secreting an item. He said he was not made aware that Mr Wheale might have taken a substance in reception. Mr Wheale was given a full search (a strip search) and then given a clean set of prison clothes. The officer said that Mr Wheale was held in the CSU for reasons of good order and discipline (GOOD). This meant that, during the day, he would be checked during the daily routine roll counts but would not be checked more often.

63. The officer recorded the reason for segregation as "body scan protocol". He said he was not aware at the time of any requirement to check prisoners suspected of concealing items internally any more frequently than any other prisoner and he had never been made aware that such prisoners might be at increased risk of harm. He was not aware of the prison's secreted items policy. The officer had worked in the CSU for four years.

64. At about 5.35pm, a nurse assessed whether Mr Wheale was medically fit to be segregated. She said she looked at Mr Wheale's clinical record before going to the CSU but did not notice the results of his urine screen. The nurse said Mr Wheale looked physically well. She understood that as long as the prisoner was not suicidal, appeared fine and was talking, it was safe to segregate them. She was unable to complete a set of physical observations because there was no medical equipment in the CSU.

65. The nurse said Mr Wheale denied any suicidal thoughts, asked her for methadone and walked off when she told him he could not have any. She completed the segregation safety algorithm and answered no to the question of whether Mr Wheale was within four weeks of detoxification or stabilisation from opiates, which was incorrect. She said she would have been unable to complete a clinical opiate withdrawal screen (COWS) assessment as she was not trained to do so.

66. The duty governor signed the Authority for Initial Segregation at 5.49pm. He did not complete the form as he should have done and was unable to say why he had not done so when interviewed during the prison's investigation. In his PPO interview, the duty governor said that he would not normally go and speak to the person being segregated because they would be spoken to the next day. He said he signed the paperwork once he was satisfied that a nurse had confirmed that Mr Wheale was fit to be segregated. He said no one told him that Mr Wheale was suspected of concealing an item or that he might have taken an unknown substance in reception.

Overnight checks 7 – 8 August 2024

67. The night duty officer in the CSU that night said she was told in the handover at the beginning of her shift that Mr Wheale had arrived in the CSU that day because he had 'failed' the body scanner and was suspected of concealing a package. She said that all prisoners in the CSU are checked hourly overnight. The checks are not recorded but night staff are required to write a summary of the night on each prisoner's record before they go off duty at the end of their shift. The officer said she was not aware of the prison's secreted items policy.

68. She said Mr Wheale pressed his cell bell several times during the night and told her he was "rattling" (withdrawing from drugs) and asked for paracetamol. She said she

explained that the night nurse would not be able to give him any medication until they were satisfied that he did not have any drugs concealed on him. She said Mr Wheale appeared to accept this and went to sleep.

69. He woke again later and pressed his cell bell. This time she said he asked her if he could go on the body scanner again and what would happen the next day. The officer said she explained that he would be scanned the following day and told him what regime he could expect on the CSU. She said she had seen prisoners in withdrawal from drugs and Mr Wheale did not appear to have any of those symptoms and neither did he appear to be under the influence of drugs.

70. At about 11.10pm, a nurse spoke to Mr Wheale through the observation panel in his cell door for the overnight welfare check on prisoners with substance misuse issues. She said the purpose of the visit was to check Mr Wheale for symptoms of withdrawal although she was not required to use the COWS tool as part of this. She was aware that Mr Wheale was in the CSU because he had not given a clear body scan in reception. She said she was not made aware that Mr Wheale might have taken a substance in reception.

71. The nurse said Mr Wheale sat up in bed, told her he was in pain and asked for paracetamol. She told him that he was not allowed any medication at all because he was suspected of concealing a package. She said she did not question Mr Wheale about where his pain was because she knew she could not give him any medication.

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72. Between 8.36am and 9.11am, a nurse, Imam, and duty governor checked Mr Wheale for the required daily check of every prisoner in the CSU. No one raised any concerns about Mr Wheale.

73. An officer unlocked Mr Wheale at 9.28am. She said she knew Mr Wheale as a familiar face and knew from the CSU whiteboard that he was in the CSU because he had not given a clear body scan in reception the day before. She said in her experience such prisoners were treated the same as every prisoner segregated for GOOD and were not subject to additional checks. She was not aware of the prison's secreted items policy. The officer said Mr Wheale asked for a shower and to use the phone and kiosk (a terminal that prisoners can use to order items from the prison shop and submit applications).

74. At 9.45am, a psychosocial worker from the substance misuse recovery team completed Mr Wheale's initial assessment at his cell door. She said she looked at Mr Wheale's clinical record to check what medication he was on before she visited him and remembered seeing that he had not given a clear body scan and would therefore not be given any medication until he did so. Mr Wheale answered her questions and then asked when he could have some medication. The psychosocial worker said she explained that he would not have any until he could provide a clear scan. She said Mr Wheale looked a bit dishevelled but appeared to walk steadily and his speech was not slurred. Nothing in his appearance gave her any cause for concern.

75. At 9.59am, a probation service officer completed Mr Wheale's basic custody screening (a routine assessment to identify the prisoner's key needs). He said the CSU staff were unwilling to open the cell as they did not have time so he spoke to Mr Wheale through his observation panel. He said Mr Wheale sat on the edge of his bed and did not respond to any of his questions. He did not look ill or in pain, but the probation service officer assumed he was withdrawing from drugs. As it became apparent that Mr Wheale was not going to respond to him, he told him he would come back and speak to him another time.

76. An officer said Mr Wheale pressed his cell bell more than once that morning to ask when he would be let out for his shower and she explained that they had to do each prisoner in turn. She said Mr Wheale appeared fine.

77. At 11.40am, Mr Wheale left his cell to use the shower. He returned to his cell at 11.53am and staff gave him his lunch. There was no indication that Mr Wheale was in any physical difficulty at this point. An officer said Mr Wheale was sitting up smiling on his bed when he gave him his lunch and caught an orange he threw to him.

78. At 12.01pm, a Reverend looked through Mr Wheale's observation panel and put something under his door. The Reverend provided information about his visit to the investigator by email. He said he was visiting all new prisoners registered as Church of England to give them a welcome booklet and Christian Diary. When he looked through the observation panel, Mr Wheale was lying on his bed apparently asleep. He decided not to try to wake him as he knew Mr Wheale had already been visited by the duty chaplain on the CSU round. He pushed the welcome booklet and diary under Mr Wheale's door and left.

79. According to CCTV, Mr Wheale did not press his cell bell after this point.

Emergency response

80. As well as CCTV footage, the investigator watched body worn video camera (BWVC) footage and listened to staff radio communications from 8 August. She also obtained information from the West Midlands Ambulance Service. The following account has been taken from these sources and staff interviews and statements.

81. At about 2.25pm, two officers went to Mr Wheale's cell to collect him for a second body scan in reception. One officer said he tried to wake Mr Wheale, but when he looked more closely, he realised he was not breathing and started chest compressions immediately while he remained on the bed.

82. An officer radioed a code blue emergency (indicating that a prisoner had either stopped or was having difficulty breathing). Her initial radio transmissions were indistinct (possibly due to her location in the cell) and there was a delay of about a minute and a half before the control room officer was able to understand what she was saying. The control room officer asked the orderly officer and the emergency response nurse to acknowledge and made all staff aware there was a code blue. Another officer in the control room called an ambulance within a minute. Once control room staff told the call handler that there was a code blue emergency, they did not ask for any further details. The handler dispatched an ambulance as a

category two but did not tell prison staff this (meaning the situation was serious but not immediately life threatening) with an estimated response time of 17 minutes.

83. The emergency response nurse arrived at Mr Wheale's cell at 2.32pm, followed shortly by other healthcare staff. At 2.33pm, the control room officer rang the ambulance service back to tell them Mr Wheale was not breathing and the ambulance response was upgraded to a category one (a life threatening emergency).

84. The nurse asked the officers to bring Mr Wheale out on to the landing to allow more space to perform CPR which they did. The nurse said Mr Wheale was cold and his pupils were fixed and dilated but rigor mortis had not set in and his limbs were still flexible. He was able to insert an i-gel airway to give Mr Wheale oxygen without difficulty. The nurse said that as soon as the defibrillator was attached it advised it was going to deliver an electric shock to Mr Wheale which was unusual because it had not gone through the analysis process first.

85. The defibrillator continued to analyse Mr Wheale's cardiac output but did not advise any further shocks. Healthcare staff administered naloxone (to reverse opiate overdose) but it had no effect. The dose they gave him was not recorded.

86. A GP said he arrived after the initial shock from the defibrillator and after staff had administered naloxone. He said he was surprised that the defibrillator had advised a shock as soon as it was attached to Mr Wheale because there were signs that he had died, including fixed dilated pupils and absence of respiratory and cardiac output. He thought the defibrillator had likely malfunctioned. The GP said he discussed the situation with the emergency response nurse and the other healthcare staff present and they agreed to stop CPR. He pronounced life extinct at 2.39pm. The first ambulance arrived at the prison at about 2.40pm.

Contact with Mr Wheale's family

87. The prison appointed two family liaison officers. They drove to Mr Wheale's mother's home and broke the news of his death and offered their condolences that afternoon. The prison offered a financial contribution to Mr Wheale's funeral in line with national policy.

Support for prisoners and staff

88. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoner 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.

89. After Mr Wheale's death, a senior 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.

90. The prison posted notices informing other prisoners of Mr Wheale's death and offering support. The prison delivered postvention support to the other prisoners on the CSU that afternoon. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Wheale's death.

Actions taken by the prison following Mr Wheale's death

91. New assessment and monitoring procedures were immediately brought in for all prisoners moved to the CSU after a positive body scan. The Head of Security re-wrote and re-issued the prison's secreted items policy. The prison subsequently 'dip tested' compliance with the document and amended it to ensure that new prisoners managed under the policy also received a first night interview in the same way as every other prisoner.

92. On 9 August, the Head of Healthcare issued a notice to all healthcare staff reminding them of the requirement to read the DPER before beginning the initial reception health assessment and reiterating that if they had issues accessing the DPER they must ask officers to show them the document. He said that if staff were not working that way, they would be liable to disciplinary investigation.

93. On 28 August, the Head of Healthcare wrote to the reception nurse under the disciplinary policy requiring him not to return to work after the end of his leave until the Trust had completed a fact-finding investigation into his actions on 7 August. On 6 September, he wrote to the nurse again advising him that it might be necessary for the Trust to conduct an investigation. In December, the Head of Healthcare told the clinical reviewer that the Trust had discussed the nurse in a Decision Making Group (DMG) meeting and decided not to pursue further investigation as he had left their employment and no longer worked in prisons. They passed on their concerns to his new employers.

94. The Deputy Governor issued terms of reference for a local investigation to determine the actions taken by the reception CM and officer responsible for operating the x-ray body scanner on 7 August. Both men were suspended from duty pending the outcome. The local investigation was also asked to consider Mr Wheale's care in the CSU. The investigation was undertaken by the Head of Security and his final report was submitted on 17 March 2025 with a recommendation that the CM and officer should face disciplinary hearings.

95. The Head of Security also made a number of other recommendations which resulted in the following actions:

- A quality assurance check was introduced to ensure that the 'record handover' button in the DPER is completed. (Which by our understanding means that in completing it, staff are confirming that they have read the contents of the PER. This does not mean, of course, that anyone can be sure that they have.)

- A list of all staff drawing BWVC are reported to the Governor's briefing each morning and any staff not drawing a camera are challenged. (This was because Officer Webster was not wearing one when he did Mr Wheale's body scan.)

- Training on handling evidence was included in security awareness days in January and March and guidance has been provided to staff.

- Staff have been briefed on ensuring that all incidents that may impact on a prisoner's risk are communicated appropriately. Further measures and testing of this are planned.

- The Senior Leadership Team have received a verbal briefing on completing the authority to segregate including making defensible decisions.

- The fault with the CCTV in reception has been reported but had not been resolved at the time of writing in April 2025.

Post-mortem report

96. The pathologist gave the cause of death as mixed drug interactions (morphine, cocaine and diazepam).

97. No drugs were found concealed inside Mr Wheale's body.

Coroner's inquest

98. The Coroner's inquest held between 30 June and 9 July 2025 gave the medical cause of death as: mixed drug interactions (morphine, cocaine and diazepam).

99. The jury concluded that Mr Wheale's death was drug related and identified shortcomings in the following areas at the time of Mr Wheale's death:

    - The training of custodial and medical staff at HMP Birmingham in he implementation of policies and procedures designed to facilitate the arrival, processing and housing of prisoners considered 'at risk' or vulnerable.

    - The lines of communication across custodial staff at HMP Birmingham concerning the effective transfer of information pertinent to the health and wellbeing of incoming prisoners.

    - The lines of communication between medical and custodial staff at HMP Birmingham concerning the effective transfer of information pertinent to the health and wellbeing of incoming prisoners.

    - The facilities and resources in the reception area at HMP Birmingham pertaining to custodial staff's ability to monitor and supervise incoming prisoners, particularly those considered 'at risk' or vulnerable.

    The jury did not find that these shortcomings impacted on Mr Wheale's death.

100. The Coroner issued a Prevention of Future Deaths (regulation 28) report at the conclusion of the inquest outlining his concerns, including that Birmingham's secreted items policy did not provide clear guidance to staff on how to manage prisoners entering the prison with concealed items who then claim to have removed or ingested the item.

Findings

Assessment of Mr Wheale's risk

Risk assessment in reception

The reception CM's assessment

101. Prison Service Instruction (PSI) 7/2015 Early Days in Custody requires reception staff to examine the PER and any other available documentation to identify immediate needs and risks already recorded. Staff are required to be aware that particular groups are at a higher risk of suicide/self-harm. Annex D of PSI 07/2015 lists the categories of prisoners who may be especially vulnerable to suicide or self-harm.

102. Mr Wheale arrived at Birmingham with a significant amount of information about his risk factors in his PER and his DPER. In addition, GEO Amey escort staff provided a verbal handover to reception staff by telephone and in person. When he arrived at Birmingham, Mr Wheale had a number of risk factors that indicated a risk of serious harm: he had a history of self-harm and attempted suicide, he was on licence recall, he had a history of concealing class A drugs and overdose, he was detoxifying from drugs and he had concealed a package internally and stated his intention was to take the contents as soon as he could.

103. The reception CM acknowledged that he did not read all of the information in the PER and DPER because he was familiar with Mr Wheale from previous sentences. In his statement, and from what we know of his interview for the prison's investigation, the CM said he considered Mr Wheale's risk of suicide and self-harm based on his knowledge of Mr Wheale's history, the fact that Mr Wheale was adamant he was not suicidal, and that Mr Wheale had always been honest with him.

104. Staff judgement is important and there is a place for using experience and skills in determining risk. However, knowledge and past experience of a person should not replace the consideration of all available risk information. Risk fluctuates according to a combination of factors including current circumstances. The CM does not appear to have considered that Mr Wheale was at risk of harm due to having an item concealed or the potential consequences should he retrieve and consume the contents or if it leaked internally. Neither does he seem to have considered the importance of making sure that the reception nurse was aware of the information that Mr Wheale had drugs concealed on him.

105. The prison's secreted item policy in operation at the time of Mr Wheale's death required all staff who suspected a prisoner of having secreted items to inform the duty governor or orderly officer, CSU, security department, safer custody and healthcare. In common with every other member of staff involved in this investigation, the CM was unaware of the requirements of this policy.

106. We raised similar concerns about risk assessment in Birmingham reception in our investigation into a self-inflicted death there in May 2024. We recommended that the Governor and Head of Healthcare should review the training for reception and

induction staff to ensure they understand how to identify prisoners at risk of suicide and self-harm, including that all relevant risk information, including the PER, is properly shared and examined as part of the reception/first night process.

107. In January 2025, the prison responded that they had:

"Reviewed and amended the training provided to reception and induction staff. Guidance detailing how to identify risk of self-harm and suicide, particularly in reception, has been distributed to all custodial managers and has been relayed to all reception and induction staff. All reception staff have now received demonstrations from the reception custodial managers on how to check and record information on the digital PER. These demonstrations are also delivered to all custodial managers during morning briefings."

108. In the light of this we make no further recommendation. However, experience tells us that proper risk assessment in reception requires maintained focus if genuine cultural change is to happen, and so we urge the Governor to continue to focus on this vital area.

109. We are satisfied that the prison has appropriately investigated the actions of the CM on 7 August and that the Governor will be holding a disciplinary hearing in due course.

Reception health assessment

110. Although reception staff should have informed the reception nurse that Mr Wheale was concealing an item, it was his also responsibility to examine the PER and DPER. He failed to do this and claimed to the investigator that he did not have access to the DPER. After the interview, the investigator queried this with the Head of Healthcare, who confirmed that all healthcare staff had access to the BaSM system for use during the initial health assessment in reception. The Head of Healthcare said that, as access issues were common, staff had been instructed to ask officers to show them the DPER if they could not see it. The Head of Healthcare added that after Mr Wheale died, he had asked the nurse why he did not look at the DPER and the nurse had said that he had been too busy and had not had time.

111. This was a serious omission. The nurse was aware from the results of his urine sample that Mr Wheale had a number of other drugs in his system and this was a significant opportunity to consider necessary measures to mitigate his risk of overdose.

112. In response to the recommendation referenced above from our investigation into the death in May 2024, The Head of Healthcare responded in January 2025 that healthcare staff now had more robust training before being allowed to complete reception health assessments and were supervised for an initial period. He had also updated the reception operating procedures for healthcare staff.

113. In the same investigation, we also recommended that the Head of Healthcare should review the quality and compliance with policy of reception and secondary health screens in the previous 12 months, ensure that prisoners are referred to the mental health team when appropriate, and identify any improvements required. In January 2025, the Head of Healthcare responded:

"Dip-testing was completed and those that had not referred correctly were taken off screening. Retraining and competency skills were re-assessed until fully competent and able to carry out screenings correctly."

114. We note this and the reminder the Head of Healthcare sent to staff on 9 August in response to Mr Wheale's death and make no further recommendation, although we repeat our advice that he maintains appropriate focus on driving sustained improvement.

115. Had he remained employed by Birmingham and Solihull Mental Health Foundation, the nurse would have faced investigation under the Trust's disciplinary policy. We believe this would have been appropriate and we would have recommended that it did. It is not within our remit to make recommendations to Trusts not providing healthcare services in prisons.

Reception searching and X-ray body scan

116. Guidance to prison staff on searching is contained in the Searching Policy Framework. This says:

If a member of staff concludes either by visual observations or via a body scan that the prisoner is internally concealing an item(s), this information must be relayed to healthcare as soon as possible in case the internally concealed item may cause a risk to the prisoner. Information must include what the item could be (for example, drugs / mobile phone / weapon), enabling healthcare to manage the health risks to the prisoner. And:

If the prisoner refuses or is unable to safely remove or pass a suspected item the prison must consider the risks presented by that prisoner to themselves and/or others. In all cases the prison must consider the location and observation requirements of the prisoner. This could include use of segregation and/or ACCT, if applicable, locating the prisoner in healthcare, or sending the prisoner for outside medical intervention. This decision should be made in conjunction with the advice from healthcare.

117. The same guidance is echoed in the Use of X-Ray Body Scanners (adult male prisons) Policy Framework which says that prisoners seen by staff to internally conceal an item may be managed as if they have provided a positive scan, which requires healthcare to be informed immediately. Birmingham's secreted item policy required all staff who suspect or discover a prisoner of having secreted items to inform the duty governor, the CSU, the security department, safer custody and healthcare.

118. If there had been any doubt that Mr Wheale was concealing a package it was removed during the search process when the reception officer saw Mr Wheale retrieve an item from his shoe and conceal it internally. At this point, the officer should have informed the list of people above. Mr Wheale's assertion shortly afterwards that he had consumed a substance which he said was a single tablet of diazepam should have made it imperative that the officer informed the necessary people immediately.

119. The officer did inform the orderly officer and security department and told the prison investigator that he told two CMs, but they both denied this. Crucially he did not inform healthcare staff and failed to recognise a clear increase in risk to Mr Wheale's health.

120. We understand from the prison's investigation that the officer did not consider informing healthcare staff or that Mr Wheale's risk of harm had increased because Mr Wheale said he had taken a single tablet and that it was his medication. We consider that this was a serious error of judgement and a significant missed opportunity to ensure Mr Wheale received proper medical assessment, care and transfer to hospital. The officer did not know the quantity or identity of the substance Mr Wheale might have consumed. Neither did he retrieve the bag Mr Wheale showed him for evidence and testing using the prison's drug trace testing equipment.

121. We are satisfied that the prison has appropriately investigated the actions of the officer on 7 August and that the Governor will be holding a disciplinary hearing in due course.

Risk assessment in the CSU

Segregation health screen

122. Birmingham's secreted item policy required healthcare staff to assess the prisoner's health, offer advice on the most appropriate location and complete the Initial Segregation Health Screen. As part of this process the policy required them to explain that holding items internally is extremely dangerous and take the prisoner's blood pressure.

123. In common with other members of staff, the nurse in the CSU was unaware of this policy and completed a standard segregation health screen. She was aware that Mr Wheale was suspected of concealing an item. She said she had looked at his medical record but was unable to account for why she was not aware of the results of his urine test.

124. The clinical reviewer was concerned that the nurse did not discuss or consider the risks and potential consequences of having a secreted package with either Mr Wheale or prison staff. Leaving aside the fact that she was not aware of the secreted item policy, this should have formed a fundamental part of any healthcare risk assessment. The clinical reviewer was also concerned that the nurse focused solely on Mr Wheale's mental health and said she would not have performed any physical observations in any case. We consider that the nurse's understanding that, as long as the prisoner was not suicidal, appeared fine and was talking it was safe to segregate them, demonstrated an inadequate understanding of the risks of segregating prisoners.

125. The Head of Healthcare told the clinical reviewer in November 2024 that work was ongoing to "upskill" mental health nurses to complete physical assessments and clinical observations if appropriate during segregation health screens. The nurse who completed the segregation health screen is no longer employed at the prison so we make no recommendation regarding her.

Authority to segregate

126. The Use of X-Ray Body Scanners (adult male prisons) Policy Framework requires an operational manager to record a defensible decision on any actions taken or not taken when considering the location of a prisoner deemed to be internally concealing an item. This could include their location and requirements for frequency of observations. Birmingham's secreted item policy also required the duty governor to consider the nature of the item, the risks to the individual and the risk to security when locating the prisoner.

127. The Head of Security told the investigator that his understanding was that prisoners concealing items were taken to the CSU and processed in the normal way. He said it was not his practice to speak to prisoners when signing the authority to segregate and he usually just signed once the nurse had agreed it was safe to segregate. We consider that he too demonstrated insufficient understanding of the risks and potential consequences for prisoners concealing items.

First night welfare check by the nurse

128. The nurse did not ask Mr Wheale about the nature or location of his pain because she thought he was not allowed to receive any pain relief due to concealing an item. The clinical reviewer noted that under Birmingham's Standard Operating Policy (SOP) for 'The assessment and provision of Clinical Substance misuse services', no opiate substitution therapy (OST) can be prescribed in these circumstances due to the possibility of overdose, but paracetamol is low risk and can be given if clinically indicated. The fact that she thought she was unable to give Mr Wheale any medication should not have precluded the nurse from exploring why Mr Wheale was in pain and where the site of his pain was. She knew he was suspected of concealing an item and this should have prompted greater clinical curiosity.

Secreted item policy

129. The prison's secreted item policy listed a number of actions for the CSU CM and for regular searching of the prisoner and his cell. CSU staff were required to complete a secreted item log and a secreted item observation sheet with the level of observations set after discussion with healthcare staff.

130. None of the CSU staff spoken to for this investigation, including two officers who had worked in the CSU for over four years each, said they were aware of the secreted item policy, and no one could recall any instances of prisoners suspected of concealing items being monitored more closely. None of the secreted item policy documents were completed and no one knew where to find the policy.

Risk assessment conclusion

131. There were a number of failures by operational and healthcare staff to follow national and local guidance for the risk assessment of prisoners in reception and the assessment and management of prisoners deemed to be concealing items. These failures were evidently systemic and endemic. This is the third investigation at Birmingham to identify weaknesses in reception risk assessment. Nobody was aware of the requirements of the prison's secreted item policy and most had never heard of it and did not know where to find it.

132. Overall, there was a complete and collective failure among all staff to recognise that prisoners concealing items are at serious risk of harm. This resulted in a lack of clinical assessment and monitoring and meant that there was no effective oversight to prevent Mr Wheale's death.

133. In September 2024, the Head of Security re-wrote and re-issued the secreted item policy and brought in random checks to test compliance. We welcome this but we do not think that it gets to the heart of the main issue in this case - the fundamental cross-prison lack of awareness of the risks to prisoners from concealed items. As a result, no one considered measures to mitigate those risks, including whether Mr Wheale should have gone to hospital for testing and monitoring in an acute environment or whether he could be safely managed by increased observation and clinical monitoring in the prison environment. The difference in how Mr Wheale was treated by the police is stark. We make the following recommendation:

The Governor and Head of Healthcare should deliver training to staff emphasising the potential risk of harm to a prisoner suspected of secreting items and introduce a robust assurance process to satisfy themselves that this learning has been embedded.

134. We suspect that staff at Birmingham are not alone in focusing on the security risk posed by secreted items rather than on the potential risk of harm to the prisoner. HMPPS colleagues responsible for the relevant policy areas should consider whether wider awareness training is necessary.

Clinical care

135. The clinical reviewer concluded that the clinical care offered to Mr Wheale was not of the required standard and therefore not equivalent to that which would have been received in the wider community. The clinical reviewer was concerned that, as well as not following or not being aware of guidance, nursing staff showed a lack of professional curiosity, a lack of empathy and a lack of motivation to attempt to develop a therapeutic relationship with Mr Wheale.

136. We have covered the majority of her concerns in the sections above. In addition to these the clinical reviewer noted that the reception nurse did not plan to review Mr Wheale's blood pressure which was not in the normal range during the reception health screen and the dose of naloxone given during the emergency response was not recorded.

137. The clinical reviewer questioned whether the GP's decision to stop CPR was in line with resuscitation guidance given the defibrillator administered an electric shock when first attached to Mr Wheale. We are satisfied that a guideline is not a substitute for an informed clinical decision and that the GP explained his decision at interview.

Governor to note

Emergency call

138. Although radio traffic showed that the initial transmissions from staff in the CSU were inaudible, the control room officer called the ambulance service immediately she was aware they were radioing a code blue. The emergency services call handler asked whether the patient was breathing and arranged an ambulance as soon as the control room officer told him there was a code blue emergency. He did not ask what that meant or for any other details and did not say what level of priority he had assigned to the call. We therefore consider that it was reasonable for the control room officer to have assumed that the call handler understood the nature of the emergency and had sent an ambulance with the top priority of category one.

139. In fact he had assigned the call category two and the call was only correctly prioritised in the control room officer's second call when she was able to confirm that Mr Wheale was not breathing. This did not make a difference to the outcome in Mr Wheale's case and we are aware that HMPPS and NHSE are currently developing further national guidance in relation to medical emergencies. We make no recommendation. However, the Governor should note that staff should not assume that the ambulance service will know what a code blue emergency means and that the only way to ensure an ambulance is dispatched with the highest priority is if they tell them that the patient is not breathing or conscious.

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