	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **HM Prison & Probation Service**
1	**CORONER** I am Ian Dreelan, Assistant Coroner for Birmingham and Solihull
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 15 August 2024 I commenced an investigation into the death of Gavin James WHEALE. The investigation concluded at the end of the inquest. The conclusion of the inquest was; It is the unanimous opinion of the Jury that Mr Wheale did die due to mixed drug interactions additionally, the events examined in this inquest highlight shortcomings in the following areas at the time of Mr Wheale's death: 1. The training of custodial and medical staff at HMP Birmingham in the implementation of policies and procedures designed to facilitate the arrival, processing and housing of prisoners considered 'at risk' or vulnerable. This had no impact on Mr Wheale's death. 2. 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 This had no impact on Mr Wheale's death. 3. 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. This had no impact on Mr Wheale's death. 4. 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. This had no impact on Mr Wheale's death. Conclusion of the Jury as to the death: Drug Related.
4	**CIRCUMSTANCES OF THE DEATH** On 6/8/24, Gavin James Wheale was arrested on a recall to prison. He remained under constant supervision and handcuffed as he was suspected to be concealing an item. He was then transported by GeoAmey on 7/8/24 to HMP Birmingham. At 12.45, Mr Wheale was handed to HMP staff, where he was no longer handcuffed or under constant supervision. Mr Wheale provided a urine sample that tested positive for cocaine, benzodiazepines, cannabinoids and opiates. He began the body scanner process at 16.00 on 7/8/24, which came back as inconclusive. A short time later, Mr Wheale was seen waving a plastic bag in the air, which was empty, but said it had contained Diazepam, and he had taken it. He was then placed in a holding cell in the Care and Separation Unit (CSU). At 14.26 on 8/824, Mr Wheale was found unresponsive in his CSU cell. He was pronounced dead at 14.39. Following a post mortem, the medical cause of death was determined to be: **1a Mixed drug interactions (Morphine, Cocaine and Diazepam)** **1b**

	1c **1d** **II**
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – 1. At the time Mr Wheale resided in HMP Birmingham, HMP Birmingham Secreted Item Policy (January 2020) was in force. An updated policy was issued after Mr Wheale's death (dated Aug 2024). Both versions of the policy accept that 'There is a clear risk to a prisoner's health when an item is secreted internally'. My concern is that focus of the policy is the prevention of contraband entering the prison system and therefore it presupposes the outcome of the secreted item(s) being surrendered or disposed of by the prisoner. It does not provide clear guidance to staff on a situation, as with Mr Wheale, where an item previously concealed is then claimed to have been (or indeed a situation where it was witnessed to have been) removed and ingested without its previous packaging. 2. Evidence was heard from WMP and GEOAmey staff dealing with their required procedures where a person in their custody, in this instance Mr Wheale, was known or suspected of concealing items; both organisations required constant supervision and handcuffing. My concern is that upon handover to HMP Birmingham prisoners who have previously been under constant supervision, with their movement restricted, enter a regime with no equivalent levels of monitoring rendering HMP Birmingham unable to fully discharge their duty of care to that prisoner.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths, and I believe you 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 4 September 2025. 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:

	Prison & Probation Ombudsman HM Inspectorate of Prisons Independent Advisory Panel on Deaths in Custody I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. She may send a copy of this report to any person who she 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	**10 July 2025** Signature:  **Ian Dreelan** **Assistant Coroner for Birmingham and Solihull**