	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Rt. Hon. Jeremy Hunt MP** **Secretary of State for Health and Social Care** **39 Victoria Street** **London** **SW1H 0EU**
1	**CORONER** I am Mr Andrew Haigh Senior Coroner for the Coroner area of Staffordshire South
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 14 December 2016 I commenced an investigation into the death of Matthew Gayle aged 31 years. The investigation concluded at the end of the Inquest on 26 March 2018. The conclusion of the inquest was natural causes.
4	**CIRCUMSTANCES OF THE DEATH** Matthew was as serving prisoner at HMP Oakwood who was found dead in his cell on the morning of 8 December 2016. It has not been possible to determine the precise cause of his death but it is likely to have been naturally occurring.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed a matter 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 **MATTER OF CONCERN** is as follows. – Histopathology is very important for determining causes of deaths and it can play a significant role in preventing deaths in the future. When Matthew was found dead he had some illicit drug paraphernalia in one of his hands. He was a young man and the immediate suspicion was that this was a drug related death. The pathologist who conducted the autopsy examined Matthew's body and took samples for toxicology. Toxicology was carefully carried out (including checking for new psychoactive substances) and the result was that there was nothing in Matthew's system likely to have caused his death. No histology had been carried out because it was anticipated that toxicology would provide answers. Possibly if histology had been carried out it may have produced a more accurate cause of death for Matthew.

	I would make it clear that I do not seek to criticise the pathologist in this respect. You will be aware that there are a declining number of consultant histopathologists who are prepared to carry out autopsies for Coroners and many of those who still perform that function are working under substantial pressure. It is important for the proper investigation of death and the prevention of future deaths that there are sufficient histopathologists to carry out autopsies for Coroner when these are required. I would greatly appreciate your assistance with the following: **1.** Are active steps being taken to increase the number of consultant histopathologists who will carry out autopsies for Coroners? **2.** Will it be a compulsory part of training of doctors who wish to become histopathologists that they do have experience in Coroners' autopsies? **3.** When engaging consultant histopathologists will NHS Trusts appoint doctors who are both competent and willing to carry out autopsies for Coroners? **4.** When appointing consultant histopathologists will NHS Trusts ensure that their contractual arrangements enable them to have time to carry out Coroners' autopsies? **5.** Is there any move to increase the fees payable to consultant histopathologists for carrying out Coroners' autopsies? **6.** Are any steps being taken to progress the Hutton report in establishing specialist centres for histopathology? **7.** Are you able to provide me with details of any consultant histopathologists who are prepared to carry out autopsies in the large geographical area that I cover?
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 22nd May 2018. 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: • Tuckers Solicitors (for the family) • DWF Solicitors (for G4S) • Clyde and Co Solicitors (for Care UK) • Capsticks Solicitors (for South Staffordshire and Shropshire NHS Foundation Trust). I have also sent it to the Royal College of Pathologists, the Prisons and Probation

	Ombudsman, the Independent Monitoring Board for HMP Oakwood and all MPs whose constituencies fall within my Coronial area who may find it useful or of interest. 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. 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	**27 March 2018** ..... Andrew A Haigh HM Senior Coroner Coroner's Office No 1 Staffordshire Place Stafford ST16 2LP Tel No: 01785 276127 Fax No: 01785 276128 sscor@staffordshire.gov.uk