Moore, Alan

From: Moore, Alan
Sent: 03 May 2017 10:33
To: 'Aaron Duggan'
Subject: RE: Letter to Chief Constable, Simon Byrne ~[NOT PROTECTIVELY MARKED]~

Dear Superintendent

I am grateful to you for briefing me. I have looked at our files in case there is anything I can assist you with by way of general background in advance of your meeting.

On 15 February this year Mr Rheinberg met with Dr Harvey, Medical Director at the Countess of Chester Hospital (COCH), and Stephen Cross its Director of Corporate and Legal Services. The meeting, which was held in the coroner's office, had been called by Dr Harvey and Mr Cross. I was asked to join in part way through the meeting.

Briefly, Mr Cross referred to a number of neonatal deaths at the COCH. Seemingly there had been some form of 'internal' reviews by the COCH. There had also been an external review by the Royal College. Following these reviews clinicians from the neonatal unit at the COCH had written to the Chief Executive of the COCH, aggrieved regarding some of the findings. They asked whether the coroner could hold an inquest in each case. Mr Rheinberg explained that the coroner may only hold an inquest where he has jurisdiction to do so, in other words where there are proper legal grounds to hold an inquest. The inquest process, he said, is not a form of governance for hospital trusts and the like.

Following the meeting Mr Rheinberg looked into how many of the deaths had been referred to this office and, if so, how they had been investigated and dealt with. He wrote to Mr Cross on 21 February indicating that out of 17 deaths 6 had not been reported to this office; 8 had been reported and had been dealt with either by a Part A or Part B (natural cause of death) or an inquest; the 3 remaining cases are to proceed to inquest. The names of the babies are as follows.

Deaths never reported to the coroner:

I&S
Child I
I&S
I&S
I&S
Child H

Deaths already dealt with:

Child A
Child C
Child E
I&S
I&S
I&S
I&S
I&S

Inquests outstanding:

Child D
Child O