Witness name: Mrs Christine C Hurst

Statement No: 001

Exhibits: CH/1

Dated: 15th January 2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF MRS CHRISTINE CECILIA HURST

I, Christine Cecilia Hurst, will say as follows:-

At the time of making this statement, I do not have access to the Coroner's records; I can only supply information from my personal recall.

SECTION 1 Professional Background

1. In 1993 I became a Coroner's Officer (CO); I was employed by Cheshire Constabulary. The role had previously been carried out by a police officer, however this was a time when there was increasing 'civilianisation' of some police roles and I was the first non-police background CO in Cheshire. The role of a CO in Cheshire at that time was less office based than it is now.

Coroner's Duty to Investigate

2. Under Section 1 of the Coroners and Justice Act 2009, a Coroner has a duty to investigate certain deaths:

> "(1) A senior Coroner who is made aware that the body of a deceased person is within that Coroner's area must as soon as practicable conduct an investigation into the person's death if subsection (2) applies.
>
> (2)This subsection applies if the Coroner has reason to suspect that—

a. the deceased died a violent or unnatural death,
b. the cause of death is unknown, or
c. the deceased died while in custody or otherwise in state detention."

Coroner's Officer (CO) role

3. Coroners are assisted by Coroners Officers (CO) to make the relevant enquiries to investigate deaths reported to the Coroner. The role of the CO varies from Coroner area to Coroner area. Some COs are office based, some attend scenes of death. Although COs are employed by the police or local authority, they must retain their independence and work to the direction of the Coroner. The employer cannot interfere in the work of the CO.

Training for the role of CO.

4. In 1993, my training for the CO role was 'on the job' over a 2 month period by the outgoing incumbent who was a serving police officer. I had a nursing, secretarial and administrative background (see paragraphs 14-16 below) which proved invaluable as there is a significant medical component to the job, as well as a requirement for good communication and organisational skills. It was a baptism by fire, but with such a high volume and varied case load, and with the support of the Coroner, working closely with police officers, attending post-mortems and inquest hearings and my own reading and research into the investigation of sudden deaths, I believe I quickly became proficient in the role.

Death referrals to the Cheshire Coroner

5. When I was in post, deaths in Cheshire were usually reported daily to the Coroner via the CO and through the following routes:

a. **Police referrals**: On a Sudden Death Form 92. These are usually deaths in the community and vary from natural cause deaths due to sudden collapse at home or in the street, to unnatural deaths such as road traffic collisions, suicides, work related accidents, drowning, slips, trips, falls, drug and alcohol toxicity related deaths and suspicious deaths.
b. **General Practitioners (GPs) referrals**: Prior to 2015/16, these cases were reported by a GP via a telephone conversation with a CO. In 2015/16 electronic referrals were introduced and referrals are now sent by email to the CO's email address. Such cases were referred by GP if they had not seen the

patient or did not know the cause of death or the death was linked to an unnatural element, such as industrial disease, previous trauma etc.

c. **Hospital Doctors referrals**: Prior to 2015/16 these cases were reported by the hospital doctor via a telephone conversation with the CO, in 2015/16 this changed to electronic referrals. Such deaths were reported if the cause of death was unknown, or was related to trauma eg fracture, head injury, or due to industrial disease, or if the patient had died during or after an operation or procedure, or a medical error or omission that may have resulted in the death.

d. **Registrars of Births and Deaths** Where the death can't be registered because it does not comply with the legislation or it required reporting to a coroner because of any of the aforementioned.

6. Medical Examiner system: Today, all hospital deaths are scrutinised by a Medical Examiner (ME), who will refer any cases that require the attention of the Coroner. When this system was being piloted, it resulted in fewer hospital deaths being reported to the Coroner, but those that were, were usually more complex medical cases. The ME system is now being rolled out for deaths in the community ie GP referrals.

My duties as a CO in Cheshire:

7. For the Cheshire Coroner's purposes, the County is divided into four areas: Warrington, Macclesfield, Chester and Crewe. When I became a CO in 1993, there were 4 COs, line managed by a detective inspector; a CO was allocated to an area and based at the local police station. At that time, about 4000 plus deaths per annum were reported to the Cheshire Coroner. I covered the Macclesfield Area and my case load was approximately 800 cases per annum, circa 12% of which were inquest cases which required further investigation. I had an input in every case, including those deaths that required a police investigation.

8. Below are the tasks I undertook on a daily basis:
   (a) Receive sudden death referrals from the police, GPs and hospital doctors.
   (b) Make further enquiries with GPs, hospital doctors, police and other witnesses regarding the circumstances of the death.
   (c) Contact the next of kin to explain why the Coroner was involved and guide them through the coronial process and confirm the name and spellings of the deceased for registration purposes.

(d) Liaise with the Coroner in each case for judicial direction and decision.

(e) Arrange for body removal from the place of death to the mortuary as required.

(f) Liaise with mortuary staff and pathologists in relation to arranging post-mortem examinations.

(g) Inform next of kin of the causes of death given and how to register the death; or inform them that further investigation is required and that either an investigation or inquest will need to be opened.

(h) Arrange for release of the deceased to the next of kin's nominated funeral director.

(i) Conduct identifications at mortuaries and Accident and Emergency departments with next of kin where required.

(j) Attend post-mortem examinations as directed by the Coroner.

9. Below, are the tasks I undertook in relation to inquest cases:

a. Review the information already gathered from the initial enquiries and information received.

b. Obtain an antecedent statement from next of kin to gather any information which may be pertinent to the case and also to establish if next of kin have any concerns they wish to raise.

c. Liaise with the police to obtain a statement from a witness or to obtain a copy of the police file in relation to the police investigation of the death eg traffic collisions, suicides, accidental deaths or suspicious deaths.

d. Liaise with and obtain reports from other investigative bodies such as the Fire investigators, Health and Safety Executive, Prison and Probation Ombudsman etc.

e. Liaise with hospital Legal Services departments in relation to hospital deaths, request medical reports from consultants or other medical professionals involved, and copies of any sudden untoward incident reports (SUI) and root cause analysis reports (RCA) and obtain a copy of any medical records if required.

f. Obtain medical reports from GP's.

g. Obtain statements and relevant documentation from staff in relation to care home/nursing home deaths.

h. Liaise with solicitors to obtain any "in life" statements, or if they are to represent a family at an inquest.

i. Regularly update the next of kin with regard to the Inquest process and the progress of the investigation.

j. Compile an inquest file and review *all* information and reports obtained and submit a full inquest file to the Coroner for further direction.
k. Warn witnesses for court (now done by administrative staff).
l. Attend Coroner's inquests to act as court usher and support the next of kin at inquest (less so now as this is now done by Court officers).

My role and duties as a Senior Coroner's Officer in Cheshire (Snr CO)

10. In 1998 I became the Snr CO, which was a new role. I was responsible for managing the CO service for Cheshire Police and the Cheshire Coroner. At that time I had three COs on my team. In addition to my management role I still had a full case load of 800+ cases. I was later provided with assistance from a police officer on light duties.

11. Various public inquiries (ie the Bristol Baby, Alder Hey, Shipman Inquiry) and various case law have, over the years had a significant impact on the Coroner service. Numbers of deaths reported were increasing as was their complexity. By 2007 when the COs were centralised and based at the West Annexe at Warrington Town Hall (although we were still not based with the Coroner, who was based in the East Annexe) my team had increased to 11 COs and 2 administration officers. Each CO had circa 450 cases and 45+ inquest cases. As we were very busy, I also retained my own small case load, of which some were investigations and inquest cases.

12. In 2015, my team dealt with 5,212 deaths of which 816 (16%) were inquest cases. In 2016 this increased to 5,564 deaths reported of which 962 (17%) were inquest cases. In 2016, Cheshire was the third busiest Coroner's area in England and Wales.

13. <u>My duties as Senior CO included:</u>

a. Staff selection and recruitment.
b. Efficient and effective management of staff and their workloads, ensuring compliance with legislation and local policies.
c. Development of good practice with standard operating procedures and training for COs and staff.
d. Advice to and supervision as required of COs in relation to their case work.
e. Conducting professional development reviews; to identify staff development, training needs and appropriate training courses.
f. Conduct regular team briefings.

g. Development and management of a CO case database, to accurately and efficiently record information about the deceased, the circumstances of the death, the cause of death, and a CO's actions and inputs, including contact with next of kin and compliance with the Human Tissue Act 2004.
h. Health and safety and welfare provision for staff.
i. Delivery of training input to probationer police officers and newly promoted detectives regarding attendance and investigation of sudden deaths.
j. Attend regular meetings with the Coroner and pathologists.
k. Attend regular management meetings with senior police officers in relation to the work of the department and the requirements of the Coroner. Advising of any changes in legislation and/or the team's practice and procedures.
l. Attend national conferences as appropriate.
m. Manage/resolve any complaints.
n. Manage disciplinary matters related to staff.

Previous Nursing/Medical secretarial background

14. Prior to becoming a CO, I trained at the Liverpool Royal Infirmary and qualified as a State Enrolled nurse in 1977. The State Enrolled nurse was a purely practical, bedside, nursing role. The State Registered nurse role included ward management aspects, which at that time I was not interested in. Post qualification (as I had young children), I worked 2-3 nights per week at the Royal Liverpool Hospital nurse bank I worked in a number of disciplines including; Accident and Emergency, General surgery, General medicine, Gynaecology and Orthopaedics. When working on the wards I was often the senior nurse in charge of the ward with responsibility for the nursing care of up to 28 patients.

15. In 1981 I moved to Essex and began work for the nurse bank at Basildon District General Hospital. During this time, I would usually work on the adult wards and in the Accident and Emergency department, however, although I was not trained in neonatal care, I was, due to staffing shortages, asked on a number of occasions to work on the Special Baby Care Unit (SCBU) where I worked under a the guidance of a qualified and experienced neonatal nurse.

16. In 1987 I completed a two year AMSPAR (Association of Medical Secretaries and Practice Managers and Administrators and Receptionists) course. My first medical secretarial role was for a consultant psychiatrist.

Coroners Officers and Staff Association (COASA) – Evidence to the Shipman Inquiry.

17. The COASA (formerly Coroner's Officers Association (COA) was formed in 1997. I am one of the founder members. I later became deputy Chair and Chair.

18. The COASA was formed to enhance the role of COs, a post that was rapidly becoming 'civilianised', ie post holders were from more diverse working backgrounds and not from a policing background. As there was no formal training or qualification for COs our aim was to develop and deliver some form of training for those working within the service.

19. In my role as Deputy Chair I gave evidence to the Shipman Inquiry (I refer to exhibit CH/1 **[INQ0012341]** The Shipman Inquiry, Third report: death certification and the investigation of deaths by coroners. Chapter 8 The Role of the Coroner's Officer.) This was regarding my own practice as a CO and the resources and training (or lack thereof) for COs nationally.

20. In 2005 I gave evidence to a Department for Constitutional Affairs Select Committee about the role of the CO and the lack resources and training for COs.

Training

21. The COASA formed a training group comprised of myself and two other colleagues, Sandi Meisner and Debbie Large. Debbie later became a senior lecturer at Teesside University and developed three; two-week university accredited training modules for those working within the Coroner service. The modules were:

a. Coroner's Law and Grief and Bereavement issues.
b. Fundamental Medicine for Coroner's Officers.
c. Medico-legal Death Investigation for those working in the Coroner service.

22. The courses were very well received, however, not all COs were able to attend due to a) lack of will by their employer due to the cost and b) lack of staff to release COs to attend. Sandi Meisner and I became guest lecturers for two of the courses. I later gained a University Certificate in Postgraduate Professional Development in Learning and Teaching in Higher Education. In 2009 I took a 12 month career break from the Coroner's office to work as a senior lecturer at Teesside University to assist my colleague with developing and delivering two of the courses.

23. Following the implementation of the Coroners and Justice Act 2009, it was unclear whether CO training would come under the umbrella of the Chief Coroner. My understanding is that the Teesside courses were discontinued because of this uncertainty.

Training today

24. All COs are still trained "on the Job" but do now receive two days Chief Coroner training per annum. I am aware that the University of Bolton is currently developing some accredited diploma and certificate level training for those working within the Coroner service and there has been mention of the development of an induction programme for new COs.

25. Although in March 2017 I retired from the Coroner Service, I have retained an interest and passion for the service. I am currently acting Chair of the COASA and hope to reinvigorate the association with a new website with training components and a much needed update of the COASA Guide to Practice and Procedure manual which our training group members co-authored. I volunteer to assist on the Chief Coroner training courses for COs as a syndicate leader for the group work which helps to keep me updated. I also work on a freelance basis to deliver training and mentoring for Coroners officers as requested – this is purely on a word of mouth basis.

SECTION 2 - Review of Neonatal Deaths

How Neonatal deaths were reported to the Cheshire Coroner

26. During my time in post, Neonatal deaths were reported to the Cheshire Coroner in the same way as all other hospital deaths. As previously mentioned, around 2015 the system for doctors to report deaths changed to e-referrals. Prior to this change the reporting doctor would telephone the Coroner's office and discuss the case with a CO who would write down all the relevant information. Following the introduction of the e-referral system, the reporting doctor would:

a. Attend the Bereavement office at the hospital to either complete a medical certificate of cause of death or complete a Coroner's referral form with details of the deceased, and provide the medical circumstances surrounding the death as well as any relevant documentation. They would refer to any medical notes which were usually at the Bereavement office.

b. The completed referral was then emailed to the Coroner officers email inbox.
c. In all cases any doctor could at any time, telephone the CO for their area to discuss any other matters or concerns.
d. If the CO required any further medical information they could telephone the reporting doctor or, if necessary the consultant in the case.
e. The CO would enter all the information provided by the doctor onto the CO database and make any further enquiries necessary including contacting the Next of Kin to advise them as to why the Coroner is involved and to obtain any further information. This CO database document was then emailed or faxed to the Coroner's office for the Coroner's decision and further directive.

Coroner's directive that all Child Deaths should be reported to him.

27. Around 2015 (unfortunately, I can't remember the exact dates), the then Senior Coroner, Mr Nicholas Rheinberg, gave an instruction to the CO team, that he required the deaths of all children up to the age of 18 in the Cheshire area to be reported to him. This included all natural deaths and all deaths in hospital. Mr Rheinberg did not give me or my deputy Stephanie Davies, his reasons for this. I do not know if he sent a written directive to the hospitals and GPs, if so this would have been dealt with by the administration staff in his office.

28. Consequently, during 2015/16 my CO team were dealing with an increased number of child death cases, however, that did not necessarily mean the numbers of child deaths in Cheshire had increased.

29. We had no baseline as to what numbers we should expect to deal with as less than 50% of all deaths are reported to a coroner and we would not normally deal with the expected death of a child for example due to a cancer.

30. Prior to this directive from the Coroner, the Coroner's office would only receive reports of neonatal deaths where the cause of death was unknown, or if there was an issue such as a medical or medication error or omission that may have resulted in the death or where a baby had died from accidental or non-accidental trauma. Such cases were relatively few and far between.

Transfers of babies to other hospitals outside the Cheshire area.

31. Where a sick baby had been transferred from the Countess of Chester hospital to another hospital neonatal unit (Arrowe Park hospital, Alder Hey Children's hospital or the Liverpool Womens' hospital) where they subsequently died; such a case would not normally be reported to the Cheshire Coroner as the baby had died within another Coroner's Area (See Section 1 paragraph 2 above – a Coroner's duty to investigate).

32. As I am now retired from the service, I do not have access to the records of how many baby deaths were reported to the Coroner by the doctors from the Countess of Chester hospital during 2015/16. The Cheshire Coroner's Office will hold records of all reported cases.

Paediatric post-mortems

33. For contextual purposes I am providing information about types of post-mortem examinations and retention of tissue.

34. When a baby or child dies and a post-mortem examination is required, the examination is usually conducted by a Paediatric pathologist. However, in cases where there is anything suspicious, eg allegation of third party involvement, the Coroner would call in the police immediately and there would, more than likely, be a requirement to have a forensic post-mortem examination. This would be conducted by a Home Office approved, specially trained Forensic pathologist who would conduct the post mortem examination alongside the Paediatric pathologist.

35. In the majority of cases, the CO is the person who would make contact with the baby's parents to explain the Coroner's process and the requirement for a post-mortem examination and the likely need for tissue samples to be taken for histology, toxicology microbiology etc for analysis. In some cases it may be necessary to retain whole organs. The CO will also discuss these aspects with the parents.

36. Following the post-mortem examination, the pathologist will notify the Coroner of his or her preliminary findings, and what samples have been retained and for how long. The CO, will contact the parents and inform them of the same and obtain their directive as to what should happen to the tissue once the tests have been completed. The CO will then update the family as and when there are any findings.

37. Unfortunately it is not uncommon for the results of these tests to take many months, thus there is a considerable delay before the full post-mortem examination report is

made available to the Coroner. In such cases, so that the family can have a funeral, the Coroner can open an investigation and issue documents for the burial or cremation to take place or they can open an inquest. In a suspicious death, the police will conduct a criminal investigation.

38. In non-suspicious cases, once the results of the post-mortem examination and tissue sample analyses are received, then the Coroner can, depending on the cause of death given, either discontinue the investigation or proceed to inquest.

SECTION 3 - Snr CO Review of two of the two neonatal triplet deaths

39. As I do not have access to the Coroner's records, I can only supply information from my personal recall.

40. It was probably Monday the 28th June 2016; I was working in my office when one of the Chester COs, Christopher Madra, came to see me to discuss reports of two baby deaths he had received from the Countess of Hospital. They were two brothers of triplets. All death reports we receive are sad, but baby and children deaths are more so and my heart sank. As Christopher had only been in post for 2 months and his other colleagues were very busy with other cases, I felt that it was inappropriate for him to deal with such cases, so I took them to deal with them myself.

41. I immediately stopped what I had been doing and read the referrals for both cases, I recall there were some similarities in the circumstances regarding the collapse of both babies. I am unsure if Christopher Madra had already entered some details onto the COs Database which holds the records for all cases and actions taken by COs or whether I did. I think probably the latter (the Coroner had a separate database – unfortunately the two were not linked). I recall that there had been no complications during the delivery and the condition of the babies at birth, that their APGAR scores were good and their weights (around 4 pounds plus) were good, which when I checked was the average for triplet babies. My understanding was that they had to stay in the neonatal unit to gain weight and that all three babies had been doing well.

42. The sudden collapse of the two babies seemed inexplicable. My thought process was that if it was an infection or underlying organ failure then there would surely have been a gradual decline in the babies' health, therefore something acute must have

happened for the babies to suddenly collapse like that. I can't explain it, but at that time, something felt 'off' and I felt a sense of unease about the cases.

43. Sometime later, possibly on the same day, I recall speaking on the telephone with Doctor V Doctor V, a consultant paediatrician at the Countess of Chester Hospital. I wanted to clarify the information that had been received about the two cases. I had spoken with Doctor V on a previous case, but I can't say when that was; so as we had spoken before, when our conversation began, I felt that Doctor V was initially at ease speaking with me

44. During our conversation it was clear that Doctor V was naturally upset about the babies' deaths and she was perplexed as to why the babies had suddenly collapsed; and, although I did not want to upset Doctor V any further, nor did I want to alert her to my unease about the cases at this stage, I felt it right that I 'drop' into the conversation, a question about who was on duty at the time the of the babies collapse.

45. When I did, Doctor V tone immediately changed and she became a little short with me, saying - words to the effect - *What do you mean? Don't you think my colleagues and I are distressed enough without you implying that someone may have done something?* I was a little taken aback and thought I had clearly not been as subtle as I had hoped as she had seen through my question and I had clearly upset her.

46. In order to placate her I recall responding with words to the effect that 'I'm not implying anything, I am asking because it is my job as the CO investigating the cases for the Coroner to gather as much information as possible for the pathologist and the coroner; and should I require any further information then I may need to contact the staff on duty at the time'. I don't recall speaking to Doctor V again about the cases.

47. As the cause of death was unknown, a post-mortem examination was required to hopefully establish a cause of death. I telephoned the parents of the two babies to introduce myself and let them know what was going to happen. I spoke with the father and he confirmed to me that the babies had been doing very well and what a terrible shock it had been. I do recall asking him how their third baby son was doing and I was so relieved to hear that he was doing well. I went on to explain that as the doctor was not able to give the Coroner a cause of death, there would probably be a need to conduct a post mortem examination and this would be done at Alder Hey Hospital.

48. After speaking to the father, I would have completed all the necessary case documentation and sent it through to the coroner for authorisation for a post-mortem examination to take place, which I duly received.

49. I arranged for the baby boys to be transferred to Alder Hey Children's hospital along with their medical notes. I think the pathologist who did the post-mortem examinations was Dr Kokai. I hoped that the post-mortem results would be able to explain the sudden collapses.

50. It would have been a day or two later, that the post-mortem examination would have been conducted. As expected the pathologist needed to retain samples for further testing so unfortunately it would take a number of months before the full post mortem report providing a cause of death would be available. The Coroner directed that an investigation needed to be opened.

51. I telephoned the father of the babies to update him and to let him know that it would take some months before all the results of the tests would be available. I told him that to enable arrangements for the funerals to go ahead, the Coroner would open an investigation and issue the relevant documentation to the funeral director.

52. I can't recall when I heard that a review of all of the baby deaths on the unit was to be carried out by the Royal College of Paediatrics and Child Health (RCPCH), but I do know I felt relieved to hear this - as I hoped an independent expert review would give some answers and if not then maybe identify if something untoward may have happened.

53. Some months later, possibly October, the results of the post-mortem report, including the results of the tissue analyses was received. I can't recall the exact cause of death given, but the deaths were deemed due to natural causes.

54. In view of the cause of death given, the Snr Coroner, informed me that he intended to discontinue the investigation into the cases of the two baby boys that I had been involved with. Normally, I would have prepared the documentation to do so, but I could not shake the feeling of unease. I had been hoping that the RCPCH report would have been published by then. I decided to walk over to the Coroner's office and ask Mr Rheinberg, if he would mind waiting to discontinue the investigations until after

the RCPCH report was in as there may be some findings or further information and I would prefer to be able to discuss this aspect with the parents as well . He agreed.

55. I believe it was during that visit to the Coroner's office that one of the Coroner's administrative staff (I can't recall who), when I told her why I wanted to see the Coroner she then told me that Mr Rheinberg was keeping an eye on the numbers of baby deaths being reported. I do not know if Mr Rheinberg had had any communication with the Countess of Chester hospital regarding this matter, or whether this was just within his office.

56. Mr Rheinberg retired in March 2017 and Mr Alan Moore, who had been the Area Coroner, became the Senior Coroner. In that same month the RCPCH report into the baby deaths was published.

SECTION 4 - The Royal College of Paediatricians Invited Service Review of the CoCH dated November 2016

57. I must have previously discussed my unease about the cases at some stage with my Deputy, Stephanie Davies as she knew I was waiting to see a copy of the RCPCH report. I don't recall the date, but I do recall Stephanie bringing the report to me. I was very keen to read it.

58. Having quickly read through the report, my understanding was that the RCPCH review had not identified anything wrong with the care. I felt reassured and pleased that nothing untoward had been highlighted. However, when I read further on in the report about the unexplained mottling seen in some of the babies, I thought that this was an unusual finding and my unease returned. This was the first I had heard of this anomaly, I do not recall it being mentioned in any of the medical information I had received in the either of the two triplet cases and I don't know if it was reported in any previous cases. Yet again I was relieved to read that there was a recommendation for another more thorough expert review of each of the cases.

59. I do recall after reading the report, walking out of my office and saying to my deputy, Stephanie Davies, words to the effect *I'm still not happy, I think we may have another Bev Allitt here.* I recall Stephanie looking at me in astonishment. I told her about the mottling.

60. The new Senior Coroner Mr Alan Moore, had a somewhat different approach to the types of deaths that should be reported to the Coroner (as demonstrated in the Coroners annual statistics, by 2021, deaths reported had fallen from a high of 5564 in 2016 to a low of 2670 in 2021), he also had a differing view of the input of COs in the investigation process.

61. As I was in no way an expert in paediatric medicine, neonatal nursing care or pathology, I had nothing I could go on, it was only a 'hunch' and 'unease'. I deeply hoped I was wrong. I&S I&S .

SECTION 5 – My concerns re the reports of death to the coroner.

62. Prior to my retirement at the end of March 2017 the Coroner's investigation into the two triplet cases remained open. I handed the files to my deputy Stephanie Davies. I had no further professional dealings with the case.

63. In 2018, I read in a newspaper article that a nurse had been questioned over the deaths of babies at the Countess of Chester hospital. I did not know if the two baby cases I had dealt with were part of that investigation so when I read in newspaper article some time later, I was devastated to see that the names of the two baby boys I had dealt with were on that list. I cried. I was so desperately saddened that my "hunch" had probably been right.

64. As mentioned earlier in this statement, in 2016, the Coroner's Office in Cheshire had 5,564 deaths reported to it. I estimate that approximately two thirds of which would have been reported by hospital doctors and general practitioners throughout the County. In all cases, including the inquest cases, the CO would have been in touch with either the hospital doctors or GP surgeries for medical information. So it was not, unusual by any means for doctors to discuss cases with the Coroner's Office.

65. When reporting a death to the coroner, doctors should provide the coroner with as much information as possible regarding the medical circumstances. Doctors have an opportunity to raise and discuss any concerns they have about the circumstances of a death with the Coroner's office and often did.

66. During and after the trial of Lucy Letby, I was aghast and very dismayed to learn from the news and the TV documentary that followed, that Doctors at the Countess of Chester Hospital had been raising concerns about Ms Letby with the Hospital management for many months throughout 2015 / 2016.

67. Doctors do not require permission from the Chief Executive's Office in a hospital to report a death to the Coroner. I&S

I&S

68. When staff raised concerns within the hospital over three unexplained baby deaths at the Countess of Chester hospital in July 2015, why did they not report their concerns to the Coroner?

69. If a death is due to a medication error ie overdose of insulin (as I now believe was in one of the cases in 2015) the Coroner should have been made aware. In such a case the Coroner, at the very least, would have asked the police to investigate how the error occurred and an inquest would have been held.

70. I&S

I&S Had she told me of those concerns, I would have immediately informed the Coroner and I have no doubt this would have altered the course of the Coroner's investigation, the police would have been called in without delay and a forensic post-mortem examination conducted.

71. I have to question why, I&S the information that a nurse had been removed from the neonatal unit only 3 weeks after the deaths of the two triplets babies was withheld from the Coroner?

72. Had I&S *any* of the I&S doctors raised their concerns at the time of the deaths of any of these babies I have absolutely no doubt that I or the CO concerned would have immediately informed the Coroner, who would have directed that the police investigate.

73. Prior to 2019 there was no statutory duty for a doctor to report a death to the Coroner. I am pleased that under The Notification of Deaths Regulations 2019, which came into force in October 2019, medical practitioners now have a new statutory duty to report deaths under certain circumstances to the coroner.

74. I do regret not discussing my unease about the cases with the Coroner, but I don't think it would have gone anywhere as I had nothing to back my hunch up with. The Coroner relies on those reporting deaths to him/her to be factual and truthful.

SECTION 6 - DOCUMENTATION

75. I do not hold any documentation in relation to the Coroner's investigation of the two triplet babies or any other cases.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: PD

Dated: 15th January 2024