Witness Name: **Stephanie Caroline Davies**
Statement No.**1**
Exhibits: **19**
Dated: **30 January 2024**

THIRLWALL INQUIRY

WITNESS STATEMENT OF MISS STEPHANIE CAROLINE DAVIES

I, **Stephanie Caroline Davies**, will say as follows: -

SECTION 1 – PROFESSIONAL BACKGROUND

1. I first became a Coroner's Officer in February 2006 when I was employed by Thames Valley Police and worked to the direction of the Buckinghamshire Coroner, Mr. Richard Hulett. This was following successful completion of three academic degrees (BSc Hons Applied Psychology, MSc Forensic Behavioural Science and BSc Hons Forensic Science). I had also completed two professional courses in Bloodstain Pattern Analysis, as well as work experience with the NYPD, and Coroner's Offices in Cheshire and Stockport.

2. On 30 April 2007 I started employment with Cheshire Constabulary, working to the direction of the Cheshire Coroner, who was at that time Mr. Nicholas Leslie Rheinberg.

3. In May 2015 I was promoted to Assistant Senior Coroner's Officer, and in April 2017 I was promoted to Senior Coroner's Officer – I took over from Christine Hurst when she retired. The (then) Senior Coroner Mr. Rheinberg also retired in March 2017, and his successor was Mr. Alan Gordon Moore.

Coroner's Officer Role

4. I worked for Thames Valley Police for thirteen months between February 2006 and March 2007. This was a very hands-on role where I attended scenes of unnatural deaths, conducted formal identifications of the deceased, attended post

mortem examinations, took statements from witnesses and gave evidence at inquest hearings. I was also on-call for the police, and would be called out to death scenes so that I could conduct full inquisitorial investigations into those deaths on behalf of the Coroner.

5. In Buckinghamshire I essentially 'hit the ground running' and often had to make quick decisions in a variety of circumstances. I cannot recall the number of cases I dealt with in the Buckinghamshire Coroner's jurisdiction, but it must have been fewer than the typical numbers covered in Cheshire due to the hands-on responsibility I had for each of my inquest cases and the scenes that I attended.

6. I was one of a team of just two Coroner's Officers, where between us we covered High Wycombe and surrounding areas in South Buckinghamshire. We were line-managed by a Detective Inspector who was based at the same police station. My first years' experience as Coroner's Officer was challenging but I found I had a natural talent for the role and so I started looking for similar roles closer to home in Cheshire.

7. In April 2007 I started employment with Cheshire Constabulary as a Scale 6 Coroner's Officer. Despite having the same job title as before, the role was more office-based in comparison to my previous role.

8. I attach as **Exhibit SD/1** **INQ0011600** a document that I acquired shortly after I started working for Cheshire, an extract from the Shipman Inquiry entitled *'Chapter Eight: The Role of the Coroner's Officer'* (pages 183-194). In this document, on page 188, is a summary of the role of the Coroner's Officers in Cheshire at the time.

9. For the first couple of months in the role, I was located with Christine Hurst (who was the Senior Coroner's Officer) at Macclesfield Police Station, and then in June 2007 all of the Cheshire Coroner's Officers (located in Macclesfield, Crewe, Chester and Warrington) amalgamated into one team at the East Annexe at Warrington Town Hall.

10. This was a larger team in Cheshire; a team of thirteen – ten Coroner's Officers, two Coroner's Admin Officers and one Senior Coroner's Officer. I had known the Senior Coroner's Officer, Christine since 2005 when I did some work experience

at her office. I was also a member of the Coroner's Officers Association (now known as the Coroner's Officers and Staff Association – COASA).

11. The Coroner's Officers' department was overseen by the head of MIT (Major Investigation Team) who was a DCI (Detective Chief Inspector). Occasionally the DCI and their Superintendent would visit our office for meetings and to say hello to the team.

12. The work I did as a Coroner's Officer in Cheshire was much more office based compared to what I was used to in Buckinghamshire. A lot of enquiries were made by telephone or computer, and the only statements I took (at first) were for medical deaths or deaths due to industrial disease.

13. The Coroner's Officers would obtain all medical reports, requesting them by post, email or by telephone. I rarely attended post mortem examinations or conducted formal identifications myself, mainly due to the lack of time to do so, but also given that the area I covered was located a long drive from the office. There was therefore, a reliance on police officers to carry out inquest enquiries on behalf of the Coroner's Officers.

14. After 2-3 years in the role, the area I was covering started a pilot scheme in that the three 'Crewe' Coroner's Officers (myself included) would have more responsibility for the 'non-medical' inquest files rather than the police. This meant that instead of a police officer, the Coroner's Officers would obtain relevant witness statements and select what evidence was required for the inquest. This was for the more straight-forward cases only, and did not include road traffic collisions, train deaths or those investigations carried out by MIT.

15. I thrived working on inquest cases in this manner as it was more in line with my previous experience as well as my qualifications. It took pressure off front-line police officers and it was cost-saving for the police. Unfortunately the other two Coroner's Officers in the pilot could not cope with the new challenges so it had to be discontinued. However with permission from the Coroner and the Senior Coroner's Officer, I continued working on inquest cases as per the pilot as it gave me better job satisfaction.

16. I started to get feedback from the Coroners that my inquest files were superior to the others, and I also had feedback from police officers that this alternative method made their demanding roles easier. I was occasionally called to give evidence at (non-contentious) inquest hearings to summarise my findings, which prevented the need to automatically call busy police officers to court.

17. The caseload numbers for each Coroner's Officer was high, given the high annual case numbers that came through to the Cheshire office at that time. In total whilst I was employed by Cheshire Constabulary I was individually responsible for overseeing in excess of 5000 cases, of which around 20% were inquest cases. So, whilst I was in this role, I was dealing with approximately 500-600 cases a year, of which approximately 100 per year were inquest cases.

18. Sometimes I would cover more cases than my peers, to account for staff absences. Myself and Christine Hurst would often find ourselves being the only members of staff left in the office after the rest of the staff finished work at 16:00hrs promptly. I tended not to mind however, as I loved the role and I was passionate about the high quality service that our department provided to the public. I eventually moved closer to the office in Warrington, to cut down on my commuting time.

19. During my years as a Coroner's Officer in Cheshire, I completed three professional courses at Teesside University (funded by Cheshire Constabulary): Fundamental Medicine for Coroner's Officers, Coroner's Law and the Bereaved, and Medico-Legal Death Investigation.

20. In October 2014, the Chief Coroner (at that time HH Judge Peter Thornton QC) sent requests to all Coroners that he was looking for 20 Coroner's Officer Syndicate Leaders to assist with the national Judicial College Coroner's Officers Training. He was looking for Coroner's Officers that had substantial and recent work as a Coroner's Officer, a demonstrable commitment and interest in training, and had good communication and interpersonal skills. I was successful in my application and I started this additional role in January 2015 for a couple of years. Cheshire Constabulary permitted me to attend these training sessions in work time, and the Judicial College paid for the travel and accommodation costs.

Assistant Senior Coroner's Officer Role

21. In 2015 Cheshire Constabulary created a new post of Assistant Senior Coroner's Officer, which was a hybrid post – part management and part casework. The demands of the department required this new role. I was the successful applicant and in May 2015, and I became Christine Hurst's deputy manager.

22. My caseload dropped to around 50% of what I was covering previously, but I had more management responsibility in that I deputised for Christine in her absence, I dealt with annual leave requests and sickness in the department, I attended meetings, and I oversaw some of the more contentious and high profile inquest cases.

23. I was covering approximately 300 cases a year (of which around 50 were inquests), but I was still investigating the non-contentious inquest files myself. I trained new Coroner's Officers and I recall a Coroner **I&S** saying to me that he knew which members of staff I had individually trained, as it was reflected in the quality of their work. I attach as **Exhibit SD/2** a document I put **INQ0011608** together as part of the training I provided to new Coroner's Officers, which gives some insight into the procedures Coroner's Officers followed in Cheshire at that time.

24. In July 2015 I was the appointed Coroner's Officer for the Bosley Explosion which claimed the lives of four people. Myself and the Senior Coroner Mr. Rheinberg attended the scene of the explosion and I gave evidence at each of the inquest openings on behalf of the four families. I worked closely with MIT Family Liaison Officers (FLOs) and this strengthened the relationship between the Major Investigation Team and our office. This case earned me, and the Family Liaison Officers, a Chief Constable's Commendation.

Senior Coroner's Officer Role

25. In April 2017 I took over as Senior Coroner's Officer when Christine Hurst retired on 31 March 2017. She had enjoyed a long career in the Cheshire Coroner's Service and she is still very highly regarded at a national level. That same month (on 10 March 2017) the Senior Coroner Mr. Rheinberg had also retired, and his successor was his then deputy, Mr. Alan Moore.

26. When Mr. Moore took over from Mr. Rheinberg he introduced a number of changes. In July 2017 he reduced the criteria of reportable deaths in Cheshire, which saw the annual number of reported deaths to the Cheshire Coroner fall from around 5500 to around 3000 cases (please see *SECTION 2* for more information on the categories of reportable deaths to the Cheshire Coroner).

27. By now, my role was essentially 100% management based, so technically my individual caseload was minimal. However, I oversaw all inquest cases coming through to the department and would quality assure all inquest files before they were submitted to the Coroner (the quality assurance of the inquest files was previously done by Detective Inspectors in each CID area). I still took the occasional case during times of staff shortage, or I would assist the less experienced staff with their cases.

28. In late Summer / early Autumn 2018, Cheshire Constabulary put together a *'Force Management Statement: Coroner's Office'* which was an insight into the key demands, caseloads and changes that our department had seen over the years. Most of the information and statistics came directly from me, and myself and our departmental line manager DCI Simon Blackwell (head of MIT) ensured this document was accurate before it was published internally within the organisation. I attach this document as **Exhibit SD/3** **INQ0011609**

29. The reduction in reportable criteria meant that the Coroner's Officers had more time on their hands, so in November 2018 Mr. Moore then introduced his 'Guidance' for Coroner's Officers covering his requirements in inquest files. He wanted Coroner's Officers to cast a more active and critical eye over their files, instead of just 'passively' requesting police officers to do files on their behalf. When this was introduced, to assist my team with the changes I put together a two page summary of his multiple page document. I attach this summary as **Exhibit SD/4** **INQ0011610**

30. I was already used to working on inquest files in this more proactive manner, as that had been my method for many years. However, the team of Coroner's Officers – who were not as familiar with this more proactive way of working, were quite resistant to these changes. I later found out that instead of taking verbal two-way statements from families and witnesses, the Coroner's Officers were

instead emailing lists of questions (or questionnaires) out, so it was no longer a two-way 'interview' as such. The resultant statements then became shorter. However, I recall that Mr. Moore did not explicitly express any concern with these briefer statements.

31. As head of the Coroner's Officers Department, I was considered the 'force expert' by senior police officers in matters pertaining to the Coroner's service as well as death-related matters (for example, please see under the section 'Coroners' in the meeting minutes **Exhibit SD/5** a comment made by the then head of **INQ0011611** MIT – DCI Simon Blackwell – when he was addressing senior police managers at a Crime Operations meeting in 2018).

32. I would email a daily 'Death Report' to senior investigating police officers every morning stating which unnatural deaths had occurred in Cheshire over the previous 24 hours. I would highlight if there were any suspicious circumstances, or if there were any outstanding police or coronial enquiries.

33. Despite not being on-call, I would occasionally be contacted out of hours by the police to deal with urgent matters such as gathering medical evidence for forensic post mortem examinations, or whenever the police could not get hold of Mr. Moore, or if I needed to attend any short-notice meetings at police headquarters (HQ).

34. I would occasionally be contacted by DCI Blackwell when he was the SIO on duty (Senior Investigating Officer) where he would be at a death scene and there were unexplained features at those scenes. He sought my advice over a number of scenarios such as; unexplained multiple bloodstain patterns in a house, unusual marks on a deceased female's neck, and a drowning victim with a potential head injury.

35. I also provided lectures 'in-house' to probationer police officers, new detectives, family liaison officers, detective sergeants, detective inspectors, nurses, and doctors. In addition I presented at national conferences, such as at CDOP (Child Death Overview Panels) and police FLO national conferences.

36. After I attended some self-funded specialist courses in America in 2019 (in Staged Crime Scene Investigation, Psychological Autopsy Investigation, and

Advanced Homicide Investigation), the training department at Cheshire Constabulary requested that I incorporated some of my learning into the new detectives course. The lecture I presented went from 1.5 hours to 3 hours in length and was hugely successful during its somewhat short inception.

37. Between August 2020 and my resignation in December 2022, I was suspended by Cheshire Constabulary, due to reasons that I believe are not relevant to this inquiry. So in effect my last day actively working in my role was on 26 August 2020.

Other Relevant Positions held

38. I resigned from my role as Senior Coroner's Officer from Cheshire Constabulary on 12 December 2022, and my employment formally ended following my notice period on 12 February 2023.

39. I had previously started a part-time PhD in Equivocal Death Investigation at the University of Liverpool on 1 October 2018 which was part-funded by the College of Policing, but this course was forced to end uncompleted – again due to reasons that are unlikely to be relevant to this inquiry.

40. Since then I have not taken up new full time employment as such, but I continue to give guest lectures at two universities; the University of Chester (to Policing students) and Liverpool John Moores University (to Criminal Justice, Forensic Psychology, and Forensic Anthropology students). I am also a Trustee and Volunteer at my local RSPCA branch in Warrington.

41. In April 2023 I had a book chapter published, where I describe how police investigators may be vulnerable at crime scenes if they misinterpret the scene evidence, due to a range of intrinsic and extrinsic factors [reference: Davies, S (2023). *Crime Scene Investigation.* In Corteen, K; Steele, R; Cross, N (Eds) *Forensic Psychology, Crime and Policing: Key Concepts and Practical Debates* pp. 291-296. Policy Press].

42. I am also due to have a book chapter published in 2024-2025 in the upcoming CRC Press forensic textbook: *Investigation of Equivocal Deaths (Suicides),* authored by A.S. Chancellor.

43. I have continued my professional development since resignation from Cheshire Constabulary. In Summer 2024 I will have completed a Diploma in Forensic Medical Sciences (DipFMS), and in September 2024 I am commencing a multidisciplinary Professional Doctorate (DProf) at an undisclosed UK university. This doctorate will explore the main causes of *Death Scene Misinterpretation*, and how such errors can be prevented in the future.

SECTION 2 – REVIEW OF NEONATAL DEATHS

List of Reportable Deaths to the Coroner in Cheshire

44. In January 2009 the Cheshire Coroner Mr. Rheinberg produced and circulated a document entitled *'Practice Directions for Doctors'*. This booklet included the categories of deaths that were reportable to the Cheshire Coroner at that time, and it contained 18 specific criteria of reportable deaths. I attach this document as **Exhibit SD/6** **INQ0011612**

45. On Page 2 of this document, item (xvii) of the reportable criteria stated, ***'Deaths involving children under the age of 18 from whatever cause MUST be reported'.*** I am not aware of who was on the distribution list of this booklet, but one would assume this booklet was sent to all doctors in Cheshire that had the responsibility of issuing MCCDs (Medical Certificate of Cause of Death) – i.e. doctors in the hospitals as well as in the community.

46. In July 2013, when the new Coroners and Justice Act came into force, Mr. Rheinberg updated this document and again it was circulated to (I assume) all doctors in Cheshire. The copy of the document I have is titled *'REPORTING DEATHS TO THE CORONER'.* This time there were 23 specific categories of deaths that were reportable to the Cheshire Coroner at that time. I attach this document as **Exhibit SD/7** **INQ0011613**

47. On Page 3 of this document, item (xxi) of the reportable criteria stated, like before: ***'Deaths involving children under the age of 18 from whatever cause MUST be reported'.***

48. I do not know when Mr. Rheinberg added this criterion of having all child deaths reported to him, it may have been in place when I started working in the Cheshire Coroner's service in 2007. But I do know that whenever Mr. Rheinberg added an item to this list, there was usually a very good reason to do so i.e. that there had been a miss or a near-miss in the past where his duty to investigate was invoked but for whatever reason the death had not been reported to him.

49. On 14 June 2017, three months after he took over as Senior Coroner in Cheshire, Mr. Moore sent an email out to all Cheshire Coroners, the Coroner's Officers and his admin team stating that he was reducing this list of reportable deaths, in line with that advised by the Chief Coroner. This meant that the number of categories would be reduced from 23 to 12. I attach this email as **Exhibit SD/8** **INQ0011614**

50. I also attach a document entitled, *'Reporting Deaths to the Coroner: Changes to the Reporting Criteria in Cheshire'* as **Exhibit SD/9** . This document (where my copy has the watermark 'Draft' emblazoned through the centre) was circulated again (I assume) to all doctors in Cheshire. **INQ0011615**

51. This document stated how the reportable criteria was being reduced from 23 discrete categories down to 12, in line with the Chief Coroner's Guidance. At the time I printed out my copy of the list, I had written at the top *'Child Deaths…'*. I can only assume I wrote this at that time because it was one of the notable omissions in the new list. On the back of this document I had written *'Liverpool'* and underlined it twice. From memory I was going to enquire with the Liverpool Coroner if child deaths were automatically reported to him. However, I cannot recall if I ever made any such an enquiry.

52. I was not alone in having some concerns when the automatic referral of deaths under the age of 18 was omitted – they were only reported if they fell under the new criteria. This was especially relevant because the Medical Examiner system (which is a system where all MCCDs would be scrutinised) had not yet started in England and Wales.

53. **I&S**

Coroner's Officers Database

54. Before elaborating on the particulars of the neonatal review I did, I need to explain more about how our Coroner's Officers Database operated and why it was first devised in Cheshire.

55. After a high-profile murder trial and subsequent GMC Inquiry, Christine Hurst (the then Cheshire Senior Coroner's Officer) wanted to ensure that notes pertaining to cases were no longer stored in handwritten form. This was to ensure that her team would not be as vulnerable as she had been in the GMC Inquiry.

56. With Christine's input, Cheshire Police IT Services devised a bespoke Coroner's Officers Database where every action that a Coroner's Officer took was recorded in a non-editable format.

57. The database was securely hosted on the Cheshire Constabulary IT servers, but only authorised personnel had access to this database. This included all staff in Cheshire Police's Coroner's Officers Department and a select few in Cheshire Police's IT Services Department. Cheshire Police Officers had to request permission from the Coroner (via the Coroner's Officers) if they required information or data that was stored in this database. Despite the Cheshire Coroner being the 'Data Controller', he and his team did not have automatic access to the database. The information he required would be populated by the Coroner's Officer and then sent across by fax or by email.

58. The database went live, I think, in late 2004. At the time it was potentially the first of its kind in England and Wales that used a bespoke IT system to record Coroner's Officers actions. By way of comparison, in Buckinghamshire, we had no such database but we did keep an excel spreadsheet (entitled from memory *'Register'*) which recorded very brief details of those cases reported to us. It did not record our actions, however.

59. On receipt of a report of a death, the Coroner's Officers in Cheshire would create a new case on the database and then manually input details in relevant populated fields or drop-down selection menus, such as:

- Name of Coroner's Officer

- Details of the Deceased (name, date of birth, address, date of death, place of death etc)
- GP details and when last seen by the GP
- Circumstances of Death
- Past Medical History
- Prescribed Medication
- Recommendation (Post Mortem, Part A, NFA etc)
- Notification to Next-of-Kin (NoK)
- Cause of Death / Post Mortem Results
- Additional Information (i.e. continuation of circumstances / other relevant details)
- Inquest details
- Request and receipt dates of inquest evidence / documents

60. Whenever an action was changed on the database, the system would automatically save these in a 'Case Log' (for example it would record when a Coroner's Officer progressed a case to an inquest following a post mortem examination).

61. The Coroner's Officers could also add manual updates to the 'Case Log' themselves, for example if say a family member phoned up with a specific question, this would (should) be inputted by the Coroner's Officer and then saved in the non-editable format in the Case Log.

62. Some of the earlier populated fields could still be edited whilst the case was still open on the database however (for example if the spelling of the deceased's name needed to be corrected, or a middle name added). The Case Log could not be edited or deleted however – only added to.

63. If a Coroner's Officer for a case changed whilst a case was still 'live', the name of the Coroner's Officer could be updated, and the system would automatically record this change.

64. I attach as **Exhibit SD/10** a 'User Guide' that was authored by a Cheshire Police Coroner's Admin Officer. This document was created in September 2004 (presumably when the database first went live) and was updated in April 2007 (when myself and three other Coroner's Officers started). This document was

included in the SOPs (Standard Operating Procedures) designed by Christine Hurst for all new Cheshire Coroner's Officers as part of their induction. **INQ0011601**

65. Once the key details of a new case had been inputted by the Coroner's Officer, the database was then able to generate a PDF file (Portable Document Format) known as the *'HMC AUTHORISATION FORM 1'* (or *'HMC1 Form'* for short) that could then be printed or saved to the Coroner's Officer's individual police drive on their work computer. This PDF form was faxed (in later years emailed) to the Coroner for his/her authorisation, and for cases that required a post mortem examination, this same form – along with the Coroner's signed authorisation – would be faxed (in later years emailed) to the mortuary for the pathologist to peruse prior to carrying out their examination. I attach a blank example of this 'HMC1 Form' as **Exhibit SD/11** **INQ0011602**

66. The database was designed so information could be inputted manually by the Coroner's Officer in an efficient and secure format. To enable two-handed typing, the Coroner's Officers were issued with headsets to use when taking reports of deaths from doctors or when speaking to families. Spelling mistakes and grammatical errors tended to be corrected after the call(s) had finished.

67. The database also served as a vital aide-memoir for Coroner's Officers. For example, in the 'Notification to NoK' section there was a series of checkboxes which the Coroner's Officer selected when that aspect of the conversation was covered in the call.

68. Over the years, updates were made to the database in line with legislative changes or operational improvements. The blank HMC1 form previously referred to was relevant to deaths reported to our department in 2014, for example.

69. The database was able to populate inquest request letters such as requesting evidence from doctors or NHS Trusts, or when requesting attendance to give evidence at an inquest. This helped our busy department save time whilst doing routine administrative tasks.

70. It was also later possible (from my memory around 2014-15 I think?) to scan and upload documents to the database. For example, if a hard copy of a PM report was received, this would be scanned in by our admin officers using our Cheshire

Police networked photocopiers, and by accessing the scanned document via the relevant scan drive *'W_Coroners: \\hq-srv-scan'* on the Cheshire Police Server. I attach as **Exhibit SD/12** the list of police server drives I had access to as the Senior Coroner's Officer. The Coroner's Officers had access to the scan drive and also to a Coroner's Officers shared drive (*'Coroners Officers: \\HQ-FILE01'*) – where we stored templates and Standard Operating Procedures. From memory I also stored my range of monitoring spreadsheets in this shared drive. **INQ0011603**

71. When doctors reported deaths to us, for many years this would be a verbal conversation between the doctor and the Coroner's Officer, and the Coroner's Officer would input a summary of what the doctor said into the 'Circumstances of Death' section on the database.

72. In later years, post-2017, rather than a conversation over the phone, doctors would record details of a reportable death into an 'e-Referral Form' which was then emailed to the Coroner's Officers Group Mailbox. I attach as **Exhibit SD/13** an example template of a Hospital e-Referral form. From memory, Warrington Hospital were the first hospital to implement this form. **INQ0011604**

73. Hence, for the CoCH cases in question in 2015 and 2016, it is most likely that the inputted 'Circumstances' section was effectively what the Coroner's Officer understood the doctor was saying during a conversation over the telephone, and not as an 'e-Referral' (where the doctors own writing would have just been copied and pasted by the Coroner's Officer into the database).

74. The data contained in the Coroner's Officers database could then act as a data 'Universe' for carrying out statistical analyses. This was done by using a software called 'Business Objects' – 'BObs' for short. This enabled the extrapolation of populated fields stored in the Database to be produced into a readable format, i.e. in the form of a PDF file or Excel Spreadsheet.

75. I was trained to use this software and I often ran analyses on behalf of the police and the Coroner, in specific areas such as monitoring Coroner's Officers individual caseloads, suicide trends, drug-related deaths, child deaths, Home Office (forensic) post mortems and deaths in custody. It was also useful to gather evidence where say there had been a perceived high incidence of deaths reported from a particular hospital or care home. With my academic background

in psychology and statistics, I was able to produce meaningful reports based on the data that a BObs search could return.

76. When a case was closed, the Coroner's Officer would then close the case on the database. It could always be reopened again by one of the Coroner's Officers team for whatever reason if required (and the system would record this action in the Case Log).

77. Any papers derived and printed from the database (such as the HMC1 form) would be archived in the Cheshire Police archives, and papers received by the Coroner would be archived in his own archives in the basement. In effect there were two copies of every file – a Coroner's Officers copy, and the Coroner's copy. Any documents uploaded to the case would remain accessible to anyone in the Coroner's Officers team, even after the case had been closed on the database.

Neonatal Deaths in CoCH – Prior to May 2017

78. I first became aware of a potential issue with neonatal deaths at the Countess of Chester Hospital (CoCH) when in June 2016 we had two neonatal deaths reported to our office – they were brothers from a triplets birth. They had been born prematurely, but after initially doing well, they suddenly died of an unknown cause.

79. A I&S Coroner's Officer passed these cases to the Senior Coroner's Officer (Christine) who then discussed the cases with a Consultant Paediatrician. I recall Christine turning to me in the office after speaking to the reporting doctor, and saying something along the lines of; ***"Something just does not seem right about these cases."***

80. The next time I recall that these deaths were mentioned, was a few months later, so it must have been around Autumn 2016. It was when our office received a copy of an independent report by the Royal College of Paediatrics and Child Health regarding the high mortality rate in neonates at CoCH.

81. Christine read this report and then approached me about it. I remember Christine holding a copy of the report in her hands, and saying to me something along the lines of; ***"Mottling?! What's caused that? How unusual. Something definitely***

isn't right here. I fear we have another Beverley Allitt on our hands."
Beverley Allitt was a nurse who was convicted of murdering and attempting to murder a number of babies in the early nineteen nineties.

82. At that time I was not aware of any other potentially linked cases especially as cases from the Chester area seldom came via me, or Christine for that matter – they were mainly dealt with by the three Coroner's Officers that covered the Chester area.

83. I believe that Mr. Rheinberg had also been sent a copy of the independent review but I do not know if he discussed this review with anyone or indeed if he ever discussed the high number of neonatal deaths with anyone.

84. Remembering how Mr. Rheinberg was, he most likely would have asked the hospital for an explanation into the high mortality rate – he was very much on the ball with things like that. However I was not sighted on any such correspondence. As previously mentioned, Mr. Rheinberg gave the directive some years before that all deaths of children under the age of 18 must be reported to our office, no matter what the cause.

May 2017 – Gold Group Meeting

85. In May 2017, around a month after I was promoted to Senior Coroner's Officer, at short-notice I was informed that my attendance was required at a Gold Group meeting at Cheshire Police Headquarters (in Winsford, Cheshire).

86. I cannot recall the exact date in May 2017 that this meeting was held, but from memory I think it was on a Thursday afternoon. I think it was the first (or one of the first) Gold Group meetings regarding the issue in question.

87. The meeting was chaired by the then Deputy Chief Constable Darren Martland, who did most of the talking. I&S I&S I&S I&S I remember he was sat a couple of seats away from me, to my side.

88. In essence, a report had been made to the police from the Countess of Chester Hospital regarding concerns about potentially linked neonatal deaths and near-fatal collapses, and that Cheshire Police were being asked by the hospital to investigate for any potential criminality behind these incidents.

89. However, I recall that the purpose of this Gold Group meeting was to discuss whether or not to actually investigate the concerns, as opposed to how they would commence such an investigation.

90. This really surprised me, because to me, if concerns had been raised by senior clinicians about potential criminality in a number of deaths and collapses, there should automatically be an investigation until the evidence proves otherwise? I was however mindful that given that I had only recently become the head of the Coroner's Officers department, perhaps I was being naïve when it came to the world of police politics and how their limited resources could be distributed.

91. I also clearly recall that at that meeting the consensus amongst senior police leaders was that they were *not* going to investigate these concerns. I cannot remember the exact reasons given, but it was in the region of the lack of evidence, the time period that had elapsed since the deaths, and the lack of available police resources.

92. Then a question or a comment was made asking if these deaths were actually explained. When this latter aspect was discussed amongst senior police officers, Mr. Martland then turned to me. He said that before a decision on whether or not to investigate the cases could be made, the Gold Group needed to know for certain if these neonatal deaths were indeed explained.

93. Before the meeting came to a close, I was given the formal directive by Mr. Martland to review all of the baby deaths that occurred at CoCH between June 2015 and June 2016 that had been reported to our office, and to report back to the Gold Group the following morning. That gave me little time to conduct a comprehensive review.

94. At that time I did not have my own work-issued tablet or laptop so I could not do this review at home, so after I left Police HQ I headed back to my office in Warrington to review the cases.

95. The first thing I did was to run a 'BObs Search'. I was trained to use this software and had used it several times before to run detailed searches on behalf of the department.

96. This software had access to the Cheshire Constabulary bespoke Coroners Officers Database 'Universe' and I selected my search criteria and parameters:

- **Division:** Chester
- **Age of deceased**: 0 / Value less than 1
- **Place of death**: COCH / Chester Hospital / Countess of Chester
- **Date range:** Between 01 June 2015 and 30 June 2016
- **Selected fields to show**:
    - Name of Deceased
    - Date of Birth
    - Date of Death
    - Coroner's Recommendation (Part A / PM / Investigation / Inquest)
    - Post Mortem (Yes / No)
    - Cause of Death (1a, 1b, 1c, II)
    - Pathologist name / Name of Doctor issuing MCCD
    - Circumstances of the Death
    - Additional Information
    - Inquest Date
    - Inquest Conclusion

97. I then extracted the results into an excel spreadsheet format and tidied up the columns (for example, I merged the data found in 'Additional information' with the 'Circumstances of Death' sections; I merged all cause of death fields into one column, I modified some of the headings so they made sense and I wrapped the text in each cell so it was readable). I present this spreadsheet as **Exhibit SD/14 INQ0007346**

98. I added a column **'Any Concerns Raised?'**

99. I then retrieved all available paper copies of the files that were in the office (i.e. those that were not yet archived) and I found the relevant records within our database.

100. The results brought back 13 cases of child deaths under the age of 1 that had occurred at CoCH between June 2015 and June 2016.

101. In 2015 there were 8 cases, and 2016 there were 5 cases.

102. I looked at each of the cases in chronological order by perusing the paper version of the file (if available in the office) and accessing the database entries. If a document wasn't available as a hard copy, I would download it from our database in case it had been uploaded there. I especially needed to see all of the available post mortem reports.

103. I was very limited on time. The Town Hall closed at 18:30hrs so I knew I had to review these cases quickly. Sometimes the Town Hall Keepers would let me stay until 19:00hrs so it's very likely that I requested to stay later on this occasion.

104. Of the cases I reviewed I found that:

- **4** were 'Part A' cases – i.e. the Coroner had confirmed that the reporting doctor could issue a Medical Certificate of Cause of Death (MCCD) for the child, and that a post mortem examination was not required.

- **5** had had paediatric post mortem examinations at Alder Hey Hospital which indicated natural causes, and the Coroner had discontinued these investigations so there was no requirement for an inquest hearing.

- **2** were still awaiting a Coroner's decision on whether or not the investigation could be discontinued, but the causes of deaths given following the paediatric post mortem examinations indicated natural causes.

- **2** had gone to inquest; one (an unascertained cause of death) was concluded with a narrative conclusion, and the other one had an inquest date set for later on in May 2017.

105. The 'Part A' cases had the least information about the case in the file. Part A cases can literally just be a conversation with the reporting doctor, and then approval from the Coroner for the doctor to issue. In most cases, a conversation is had with the family to ensure there are no concerns.

106. However, not all families were spoken to by the Coroner's Officers for these Part A cases. The Coroner had previously agreed that due to the sensitivity of baby deaths we did not want to cause further distress by contacting the parents where the cause of death was clearly natural and where no post mortem examination was needed. In such cases, the Coroner's Officer would ordinarily check with the doctor or the bereavement office if the family had expressed any concerns.

107. For all of the Part A cases in this review, the families were not spoken to by the Coroner's Officer. But for all of the other cases (i.e. where a post mortem examination was required) they were spoken to by the Coroner's Officer. I recorded any comments the family made to the Coroner's Officer into the spreadsheet under the 'Any Concerns Raised' column. I recall that I examined not only the 'Circumstances' sections, but also the 'Additional Information' sections as well as the Case Logs for each of the cases.

108. At first glance, there did not appear to be any obvious themes sticking out when I reviewed each case. The causes of deaths appeared to be 'natural' with the only common factor that I could see at that time being 'prematurity'.

109. The main aspect that helped me to form my conclusion, was the wording in some or all of the paediatric post mortem examination reports conducted by Dr. George Kokai, Paediatric Pathologist based (at that time) at Alder Hey Hospital. Out of the thirteen cases, he had conducted post mortem examinations on five of them.

110. I distinctly remember that Dr Kokai had made comments along the lines of; ***"in the absence of any other information or evidence, the only cause of death I am left with – through a process of elimination – is 'extreme prematurity.'"***

111. Given that the hospital were now saying that they potentially had new information or evidence in relation to these deaths, this meant that technically the causes of deaths for these babies may need to be altered in light of this new information.

112. I had also considered that, had these post mortem examinations had the input of a Home Office Registered Forensic Pathologist, and had there been suspicious circumstances reported from the outset – that the cause of death could very well have been different than the one that was recorded.

113. One thing I did notice in my spreadsheet is that a doctor had reported a neonatal death to the Coroner back in June 2015, and the Coroner's Officer had written in their summary: ***"Reported that this had been 3rd death in 12 days for neonatal."***

114. This information will have gone direct to the Coroner (via the 'HMC1 Form'), and not via myself or Christine. The first time I became aware of this comment from June 2015 was when I was carrying out my review in May 2017.

115. I am also not aware if this information regarding the excess in neonatal deaths was acted on by anyone. My understanding was that the average for neonatal deaths would have been more like three *a year*, not three in 12 days.

116. So in the last column, entitled 'Any Concerns Raised' I wrote ***"?missed opportunities".***

117. Therefore, in terms of my final conclusion, I wrote a short paragraph stating that the babies deaths were *not* sufficiently explained, and I reiterated how I came to that conclusion. I can only remember handwriting my conclusion (rather than putting it into a Word document) – as by then I was out of time and the Town Hall Keepers were locking up the building.

118. I saved the finished spreadsheet firstly onto my individual police 'H drive': '*home07$20509'* on police server *'\\hq-file01',* and then onto an encrypted USB stick (**Exhibit SD/15**) ready to take with me to HQ first thing the next morning. In usual circumstances, I would have printed off a copy too but I cannot explicitly remember doing so (I may not have had time to). I put all paper copies

of the files into the bottom right-hand drawer in my office, and locked it before leaving. **INQ0007351**

119. The following morning, which from memory I think might have been a Friday morning, the Gold Group got together again at Police Headquarters.

120. I cannot remember if there were any other outstanding actions for anyone else – I can only remember that the main agenda item for that meeting was my answer to the question if these baby deaths were explained.

121. I verbally stated to the Gold Group that now we potentially had new information / evidence – and that these causes of deaths may need to be amended considering this new evidence – I concluded that in my opinion, no – these deaths were *not* explained. I will have verbally referred to my spreadsheet and the comments that Dr. Kokai made in his post mortem reports.

122. This meeting wrapped up quite quickly, and I distinctly recall that no decision was made at that time by the police.

123. After the meeting I remember I emailed my spreadsheet (and I likely included my comments / conclusion as well) to my direct line manager, DI Paul Hughes. Paul went on to be the Senior Investigating Officer.

124. The spreadsheet 'Properties' (**Exhibit SD/16**) on the USB drive shows that this spreadsheet was last saved by me on the USB stick at 11:22hrs on 08 May 2017 and last printed at 10:41hrs on 08 May 2017. This date happens to have been on a Monday (I am still sure the Gold Group meetings were a few days before). I do remember reflecting on the work I had done, and for the sake of completion, I remember that I did print off a copy of the spreadsheet and I added that to my handwritten notes. I placed everything into a cardboard cover file (which from memory was red in colour) and I put this on top of the Coroner's Officers copy files of the relevant baby deaths that were in my locked drawer in my office. **INQ0011605**

125. I am certain that I was never copied into any of the Gold Group meeting minutes – at least I cannot remember seeing any.

126. I do not know where my handwritten notes are now I&S

I&S

127. I do not recall going to any other Gold Group meetings after those two – I guess now that I had done the review they no longer needed my input.

128. About a week or two later, DI Paul Hughes visited my office. I think he was due to have a meeting with Mr. Moore, because otherwise he would seldom visit our office. In passing Paul updated me on the police decision about whether or not they would investigate the hospital's concerns about the neonatal deaths. He told me that one of the main reasons the police decided to go ahead and investigate, was because of the review I did. I remember being astounded by this, as I did not think my review had had that much impact. I&S

I&S

After the Review

129. Following on from that, I heard very little about the investigation itself. In fact myself and my team were not even told that there would be a press release – which came out in the media on 18 May 2017. Some Coroner's Officers (mainly those that covered the Chester area) were understandably unsettled that they had not been forewarned of the press release – but sadly I had not been either.

Communications with Others about the Cases

130. Out of those thirteen cases, prior to doing the review I had not discussed any of the cases with any healthcare professionals, or any of the families, or with the Coroner. Nor had I been the initial Coroner's Officer for any of those cases. I had only briefly discussed two of the cases with Christine Hurst, as previously mentioned – in June 2016 and Autumn 2016.

131. Not long after the press release, on 30 May 2017 an email (**Exhibit SD/17**) was sent to me and to two others at CoCH (to Rajiv Mittall – Consultant Paediatrician and to Ian Harvey – Medical Director) from a Detective Superintendent in Strategic Public Protection – DSI Peter Shaw. **INQ0011606**

132. This email explained that any future neonatal deaths must be reported directly to the police for at least for the next 6 months. I updated my team that any baby deaths reported by CoCH must go through me so I could liaise directly with the police. From memory there were no further neonatal deaths reported to us from CoCH in the months that followed.

133. Later on in 2017, the Pan-Cheshire Child Death Overview Panel (CDOP) drew up a new Memorandum of Understanding (MOU) between them and the new Coroner Mr. Moore. I cannot remember exactly why, but it could be that they were concerned that deaths under the age of 18 were no longer (automatically) reportable to the coroner under his new criteria. I attach this document as **Exhibit SD/18** **INQ0011607**. This document was not dated, but it makes reference to the list of reportable deaths having been *'distributed in July 2017'* so this MOU must have been created after July 2017.

134. I had written on my copy of the MOU ***"CDOP MOU – agreed by HMCs"***. Meaning that the Coroners had agreed to the wording of the MOU and Mr. Moore will have sent a signed copy back to CDOP.

135. The agreement was also in place for me to continue monitoring child deaths and I kept a (separate) spreadsheet updated. Every time our office was notified of a death of a child under the age of 18, I would send an email notification to CDOP. I would also forward on any post mortem reports and inquest conclusions to them as per the MOU. In addition as Senior Coroner's Officer, I attended all panel meetings that were chaired by CDOP.

136. The last communication I had with any of my colleagues about 'Operation Hummingbird' (the name of the police investigation into the CoCH neonatal deaths and collapses) was when DI Paul Hughes and I attended a meeting with Mr. Moore, in November or December 2017.

137. I had (prior to that meeting) emailed to my work email address an extract out of a book I was reading that I thought Paul might find useful. This email was sent from my personal email address to my work one, with the subject line ***'Extract from book for SIO'.*** I sent this email at 12:08hrs on Saturday 25 November 2017. I attach this email as **Exhibit SD/19** **INQ0007350**

138. Paul was by then the SIO for Operation Hummingbird and I printed off this book extract which included a section entitled: ***'Table 8.3. Behaviors That Signal a Potential Health-Care Serial Killer'*** (taken from Ramsland, K. (2018). *The Psychology of Death Investigations: Behavioral Analysis for Psychological Autopsy and Criminal Profiling.* CRC Press).

139. I handed this printed page extract to Paul as we were leaving Mr. Moore's office I&S

I&S

140. I cannot recall much of the detail of the meeting with the Coroner about Operation Hummingbird, but I remember Paul saying one theory the police had was to do with insulin.

141. I also recall saying to Paul, around that same time, that it appeared the police only had the Coroner's Officers copies of the paper files – and that it would be better to also view the Coroner's *original* files that were stored in his basement, because these files contained original wet-signed documents and often had further correspondence that the Coroner's Officers had not been copied into. I do not know if this advice was ever acted on by the police however.

142. In addition, I do not recall if Cheshire Constabulary ever requested direct access to the database Case Logs pertaining to these neonatal deaths. I can only recall that I will have copied any pertinent information that I could see from the Case Logs, and I would have pasted that information directly into my spreadsheet.

SECTION 3 – EXHIBITS

143. I attach to this statement the following exhibits:

EXHIBIT REF. NO	EXHIBIT NAME	EXHIBIT FORMAT	HOW OBTAINED	DESCRIPTION
SD/1	Extract from Shipman Inquiry	Paper print-out	Handed to me in July 2023 by	This is an extract from the Shipman Inquiry that I acquired shortly after I started working for

			Cheshire Police	Cheshire. On page 188 is a summary of the Coroner's Officers role in Cheshire at the time.
SD/2	CO Training Guides 2016	Paper print-out	Handed to me in July 2023 by Cheshire Police	This is a document I put together as part of the training I provided to new Coroner's Officers, which gives some insight into the procedures Coroner's Officers followed in Cheshire at the time.
SD/3	CO Dept Force Statement 2018	Paper print-out	Handed to me in July 2023 by Cheshire Police	This document *'Force Management Statement: Coroner's Office'* gives an insight into the key demands, caseloads and changes that our department had seen over the years.
SD/4	CO Guidance Summary 2018	Paper print-out	Handed to me in July 2023 by Cheshire Police	This is a two page summary I designed for my team when Mr. Moore introduced his multiple page Guidance to Coroner's Officers in 2018.
SD/5	Minutes inc. SCD Skillset 2018	Paper print-out	Handed to me in July 2023 by Cheshire Police	Meeting minutes from a Crime Operations meeting in 2018. Page 2 has a section under the title 'Coroners' which substantiates how senior police officers in Cheshire Constabulary viewed my experience and capabilities pertaining to deaths.

SD/6	NLR Reportable Criteria 2009	Copy of original booklet	Handed to me in July 2023 by Cheshire Police	Booklet entitled *'Practice Directions for Doctors'* produced and circulated by Coroner Mr. Rheinberg in 2009.
SD/7	NLR Reportable Criteria 2013	Paper print-out	Handed to me in July 2023 by Cheshire Police	Copy of *'REPORTING DEATHS TO THE CORONER'* produced and circulated by Coroner Mr. Rheinberg in 2013.
SD/8	AGM email re changes Reportable Criteria 2017	Paper print-out	Handed to me in July 2023 by Cheshire Police	Email sent by new Senior Coroner Mr. Moore to all Cheshire Coroners, Coroner's Officers and his admin team about reducing the reportable deaths criteria.
SD/9	AGM Reportable Criteria 2017	Paper print-out	Handed to me in July 2023 by Cheshire Police	Copy of Mr. Moore's new list of reportable criteria that was circulated in 2017.
SD/10	CO Database User Guide 2007	Paper print-out	Handed to me in July 2023 by Cheshire Police	This was a 'User Guide' for new Coroner's Officers working with the bespoke Coroner's Officers Database as part of their induction.
SD/11	Blank HMC1 form	Paper print-out	Handed to me in July 2023 by Cheshire Police	Example of blank 'HMC1 Form' which is the format that the coroner and pathologists would receive.
SD/12	ChesPol CO Drive List	Paper print-out	Handed to me in July 2023 by Cheshire Police	List of IT drives including the Coroner's Officers scan drive and our shared folder.

SD/13	Dr eReferral form template	Paper print-out	Handed to me in July 2023 by Cheshire Police	Example of a Hospital 'e-Referral Form' which started post-2017.
SD/14	COCH Child Death Review	Electronic: Spreadsheet on USB Stick	Handed to me in July 2023 by Cheshire Police	This is the spreadsheet I compiled to assist with my review of CoCH neonatal deaths that had occurred between June 2015 and June 2016.
SD/15	[Original USB Stick]	Integral Crypto USB Stick	Handed to me in July 2023 by Cheshire Police	This is the original USB stick that contains the CoCH child death spreadsheet that formed the main part of my review in May 2017. There are other documents and files stored on this USB stick that are not relevant to this inquiry. For complete transparency (and as instructed) since I was made aware that I would have to submit this USB stick as an exhibit – I have not removed or altered any of the contents.
SD/16	USB Stick Properties	Electronic: screenshots (accessed Dec 2023)	The original USB stick was handed to me in July 2023 by Cheshire Police	This contains screenshots of the USB spreadsheet properties, showing that the spreadsheet has not been altered since May 2017.
SD/17	Email re future COCH neonatal deaths	Paper print-out	Handed to me in July 2023 by Cheshire Police	Email dated 30 May 2017 containing the instruction for future CoCH baby deaths to be reported directly to the police.

SD/18	CDOP MOU	Paper print-out	Handed to me in July 2023 by Cheshire Police	New CDOP Memorandum of Understanding agreed by the Coroner Mr. Moore.
SD/19	Email Extract from Book for SIO	Electronic: Sent email	Accessed Dec 2023 via personal email account	Email extract from a book that I passed onto SIO DI Paul Hughes.

144. **I&S** **I&S**. My last day of employment after I had served my notice period, was on 12 February 2023.

145. The first time I was permitted to collect my personal belongings from my former office, was on 11 July 2023. On my arrival at the office there were three boxes with my name on waiting for me to pick up. They had been prepacked by either the police, or by someone in my former team.

146. **I&S**

I&S

147. **I&S**

I&S

148. I also found amongst the items returned to me were two encrypted USB sticks; one that I could not access which then wiped itself clean (after inputting the incorrect password), and another one that I could access as I had inputted the correct password. I saw that the contents of this USB stick included past presentations. I remembered I always saved presentations onto a USB stick before travelling to the destination where I was giving the presentation.

149. It wasn't until a month or so later when I was preparing for a guest lecture at Liverpool John Moores University when I decided to look at the presentations stored on the USB stick again. It was then that I spotted the excel file 'COCH Child Deaths' amongst the presentations, which I had not noticed the first time. It was the very same spreadsheet that I had compiled for Cheshire Constabulary in May 2017.

150. When the Lucy Letby verdict was announced in the media, I thought about this spreadsheet and I remembered how reluctant Cheshire Police were to even start an investigation into the deaths and near-fatal collapses, and how my review had been one of the key factors that had prompted them to investigate after all.

151. I decided to reach out to the Thirlwall Public Inquiry, because I wanted to report this issue as a '**Near Miss**'. In that Cheshire Constabulary very nearly missed the opportunity to identify these murders and attempted murders, because the force were going to decline investigating the concerns raised by the Countess of Chester Hospital.

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: 30 January 2024