Friday, 6 December 2024

(9.59 am)

LADY JUSTICE THIRLWALL: Ms Langdale.

MS LANGDALE: My Lady, may I call Mr Rheinberg.

LADY JUSTICE THIRLWALL: Mr Rheinberg, do come forward.

MR NICHOLAS RHEINBERG (sworn)

Questions by MS LANGDALE

LADY JUSTICE THIRLWALL: Do sit down.

A. Thank you.

MS LANGDALE: Mr Rheinberg, you prepared a statement for the Inquiry dated 11 April 2024.

Can you confirm that the contents are true and accurate as far as you are concerned?

A. Yes, I confirm that.

Q. You tell us you qualified as a solicitor in 1974 working as a partner in a local solicitors' practice. You, in February 1992, were appointed Coroner for East Somerset as a part-time post.

In July 1999, appointed to the full time post of Coroner for Cheshire acquiring the title Senior Coroner when the law changed in July 2013 with the coming into force of the Coroners and Justice Act 2009.

Can you tell us, Mr Rheinberg, and you expand it from paragraph 5 onwards, the Coroner's relationship

with the police?

A. Yes. Complicated relationships within the Coroner's office. So we are funded by the local authority and in Cheshire certainly part funded by the police in that the police in Cheshire provided me with my Coroner's officers.

So my Coroner's officers had I suppose potentially a dual loyalty; they obviously were loyal to the police, who employed them, but also loyal to me as leader of the Coroners Service.

The advantage in having police employees, although they were no longer serving officers, was that they had access to the police computer and so could keep abreast of information that was available to police officers and I suppose the most important part of that was what's sometimes called the STORM log where all incidents could be picked up on.

So typically my officers would come into the office really quite early and have reference to the STORM log and they could pick out perhaps matters that might be coming my way, as it were, at the earliest possible opportunity.

Q. You say at paragraph 10:

"My most frequent contact with senior police officers would be in relation to organ donation and

deaths where there was a suspicion of criminality in relation to the deaths."

You continue further down:

"... indeed, in an obviously suspicious case it would often be the police who contacted me asking me to order a forensic postmortem examination."

A. Yes. Coroners take a more active part than perhaps is generally known in relation to suspicious deaths.

So although we see on television the police ordering a pathologist and running the show, as it were, in fact the permission has to come from the Coroner because the Coroner has custody of -- of the deceased's body and it's only by the Coroner's authority that a postmortem examination can take place.

When there are suspicious circumstances, it would not be appropriate for a general pathologist to carry out a postmortem examination, instead appropriate to employ one of the fully trained forensic pathologists, I think there are about 35 currently in the country.

Q. So where there is suspicious circumstances, or you are made aware of them, where children are concerned, what's the difference between a postmortem examination where there's no suspicion and the one that you would order if there was suspicion? What do you

expect to happen where there is suspicion in a forensic postmortem situation?

A. Moving away from the death of a child, the normal routine in respect of an individual requiring a postmortem would be for a general pathologist to carry out that responsibility and it would be quite a swift process in -- in many cases. The pathologist would scan any medical information that was available, look at the circumstances as described to the pathologist, rely on the anatomical assistant to eviscerate and then would examine first externally and then the organs each in turn, produce a postmortem report.

When it comes --

Q. Would you expect engagement between the pathologist and the clinicians who had seen the deceased around the time of death or before death in a forensic analysis?

A. It --

LADY JUSTICE THIRLWALL: I wonder if we just might be at cross-purposes or it may be that I've got at cross-purposes. I think the question was about forensic pathology --

A. Yes, I was sort of -- my Lady --

LADY JUSTICE THIRLWALL: You then answered about general pathology.

A. Yes.

LADY JUSTICE THIRLWALL: But I think the question then was in relation to forensic, so can we just be clear --

A. My Lady --

LADY JUSTICE THIRLWALL: -- about which we are talking about?

A. Yes.

LADY JUSTICE THIRLWALL: So you have given a general background in relation to forensic pathology but perhaps it might help if we move on to forensic.

A. Yes, absolutely.

I was trying to sort of build the -- the picture by way of contrast.

So if a forensic pathologist is employed, the scrutiny and care is very much greater. The forensic pathologist will demand a very full background briefing by the police, the police will be present during the entire process.

There will be a meticulous external examination of the body looking and documenting every single injury, blemish, anything that is found, whether it is ultimately going to be relevant in relation to the cause of death.

The internal examination takes place with similar

care. There will be a Scenes Of Crime Officer in attendance taking photographs of anything relevant as directed by the pathologist, who will tend to carry out a commentary as he or she is going on so that everybody understands what is happening and to be sure that the appropriate photographs for instance are taken.

Everything that is going to be withheld for further examination, for instance small pieces of tissue, are given exhibit numbers and so the process continues until the examination has been completed to the pathologist's satisfaction.

A process that will take a number of hours, whereas in the case of a general postmortem perhaps 30 minutes or so may be devoted to the process. With the forensic postmortem it's meticulous in every degree, carried out by a pathologist who has been trained to look for and interpret forensically all relevant details.

Q. Should it be meticulous in terms of the information the pathologist gets from the clinicians about?

A. Yes, it's absolutely vital that the forensic pathologist is fully briefed, both from the police who will provide as accurate information as possible with regard to the circumstances surrounding the death. If there is relevant medical information to be had, then

a very full briefing is needed in written form from the clinician or clinicians.

So, for instance, you will have the case of an individual who is brought into hospital near death, who is given treatment, but sadly does not survive. There are suspicions surrounding the death so a forensic pathologist has been engaged and then the pathologist will need to be briefed on every set of circumstances relating to the hospital stay: what tests have been carried out, what results there have been -- what diagnoses have been offered by the treating doctors.

Q. You say at paragraph 24 of your statement, if you have a look in the first sentence:

"Unfortunately, it is very often the case with infant pathology that a cause of death cannot be found."

Are you referring there to babies who die at home usually in their sleep by SIDS? You mention SIDS, or what are you referring to?

A. Right. Yes, you are right, that would present the greatest difficulty but even with hospital tests the pathology may be extremely difficult to find or to interpret to the extent of offering an opinion as to the cause of death. But you are right, the problem would be very much greater in all likelihood if the death has occurred in the community.

Q. Paragraph 27, you tell us:

"From my earliest years as a Coroner, I was conscious of the fact that there were many deaths that should have been the subject of an Inquest but were never reported to the Coroner."

You in fact issued guidance, if we can go to INQ0017840, page 1. Putting on the screen, Mr Rheinberg, your September 2024 version of the guidance --

A. Yes.

Q. -- I know there was subsequent that you have alerted us to.

But you set out there:

"Reporting deaths to the Coroner, contact details."

You say you gave a mobile number as well for those purposes. If we go to page 2.

"Setting out circumstances of reporting."

Page 3, we see (xxi):

"Deaths involving children under the age of 18 from whatever cause must be reported."

Over the page, page 4.

"Common misconceptions and difficulties."

And you set out four bullet points up from the bottom:

"Do not guess. You have a duty to report on the

cause of death to the best of your knowledge, information and belief."

We see at page 5 that is signed off by you. Did you endeavour to promulgate that guidance as best you could?

A. Yes. I made sure that every single doctor within -- within Cheshire had a copy.

Q. How do you say you did that?

A. There was the -- I think if I remember correctly there were two bodies in Cheshire, Cheshire being divided in half. They -- all GPs were members, as it were, and so by informing that particular or those particular bodies, sending a copy of the direction and requiring it to be sent to every single GP and receiving confirmation that that had been done.

And similarly, in, in hospitals, I made sure that every new intake of doctors as part of their induction pack was given a copy of my directions.

Q. We see -- if that can come off the screen, please, and have instead INQ0008638, page 1 -- a document emanating from the Countess of Chester's internal guidance, "Guidance on Writing Statements".

I don't know if you have seen this before, Mr Rheinberg.

A. No, I don't remember this.

Q. It's not your document so there's no reason why you should have done?

A. No.

Q. Take your time to read page 1, I just want to ask your comments about hints and tips over the next page but read the whole document.

(Pause).

A. Yes, thank you.

Q. And the next page.

A. Yes.

Q. Then the next page under "Hints and Tips"?

A. Yes.

Q. Do you see the third bullet point:

"Avoid criticism of colleagues/other departments."

A. Yes.

Q. What do you think of that as a hint or a tip?

A. It not very helpful.

It's -- I suppose it's in the context of Inquests are not there to apportion blame, but if there have been medical mistakes --

Q. Yes.

A. -- it's very, very important that these come to light. Not so as -- not as a matter of retribution or punishment but to first of all to identify what has happened, what has caused or contributed to the death

and hopefully so that lessons can be learnt and similar tragedies can be avoided for the future.

Q. Four bullet points down:

"You are not being called as an expert. Don't give opinions, leave that to senior Consultants. Just stick to facts."

The Inquiry has heard evidence from a junior doctor at that their understanding was they just stuck to the facts and wrote the period of time they were caring for an infant in isolation, just sticking to the facts of their involvement at any period of time in the care of a baby.

Just stick to facts, what would you say about that? Does that need elaboration or not?

A. Right, okay, well, doctors, unless specifically called as expert witnesses, are witnesses of fact, witnesses of fact are not permitted to give opinions.

However, within the Coroner's Office in Cheshire, when -- when I was there we were holding an enormous number of Inquests and it wasn't appropriate to instruct an expert in every case. We would never have got through a huge list of cases if that was -- if that was done and also the cost would have been very great.

In those circumstances, where someone perhaps of

Consultant grade was giving evidence, it was my practice to accept expert evidence in -- from them if appropriate.

Q. To be fair to the Countess of Chester document, if you go over to the next page, finally, it states:

"Do not repeat what is already in the notes. Expand and clarify if appropriate and do not leave out significant information"?

A. Sorry, I am not hearing you.

Q. The top two bullet points?

LADY JUSTICE THIRLWALL: She is just reading the top line.

MS LANGDALE: Just read it, thank you.

A. Okay, got it, yes.

Q. That can come down and now can we have on the screen INQ0008941, page 24, please.

This, Mr Rheinberg, is a guidance document, I think, prepared by you and records show it was sent to Mrs Sarah Harper-Lea on 1 July 2016 attached to request for statement. So this is guidance I think that you have drafted. Do you recognise that as your guidance or guidance from the Coroner's Office, perhaps it's not yours.

LADY JUSTICE THIRLWALL: I think your name is at

the bottom.
A. Yes, yes. Thank you. Yes, I don't remember issuing this but clearly it is advice that I have given.
Q. You set out at 5 and 6 more broadly, don't you:
"From details extracted from the notes, set out relevant medical information relating to the cause or circumstances of the death following the chronology order."
At 6 you say:
"Hearsay evidence is acceptable provided you are confident of the accuracy of the information you are giving."
Can you just expand on what you meant by that, "hearsay evidence is acceptable", which is perhaps different from sticking to the facts of your own knowledge in a moment in time, isn't it?
A. Yes. The rules of evidence in the Coroners Court are not the same as in the civil and criminal courts and we are permitted to accept hearsay evidence.
The good practice would demand that as much as possible one would rely on hard evidence, adhering to the usual rules of evidence, but we could spread our net wider and still -- and not be in contravention of any of

the rules.
Q. Thank you, that can go down.
I am going to move now, Mr Rheinberg, to Baby A and the death of Child A. I make it clear at the outset I am not asking you any questions about your decision-making and the Inquest itself. We are interested in exploring the information provided to you?
A. Okay.
Q. And the adequacy of that, so I am going take you to various documents on the screen and where it's helpful for you, refer you to a paragraph in your statement where you have set out postmortem results that might make it easier for you to set those out for us?
A. Okay.
Q. So Child A, we know Child A's death was reported to the Coroner on 8 June 2015 and in an investigation opened, a postmortem gave cause of death unascertained and there was an Inquest held on 10 October and a narrative verdict given.
If we can start, please, with INQ0002042, page 174, so we know the death has been reported to you in June 2015 and you have here when it comes on the screen --
A. Right.
Q. -- we see at the bottom 2016, the parents'

solicitor writing:
"Frustrated over the duration of the investigations as the death happened a year ago."
If we go, take your time to read that and we will put another document up then.
If we can have INQ0002042, page 173.
What do you say in response?
A. What do I say, sorry?
Q. Yes, what do you say in response, if you don't mind reading out your email so we have it on the record?
A. Right. I was expecting a full report from the hospital. Bearing in mind the circumstances surrounding the death of Baby A, there had been medical errors that could potentially have been implicated in the death. I think I remember correctly it was in relation to the insertion of lines.
Q. A long line, yes.
A. And of potential relevance the fact that the misplacement of one of the lines coincided with an arrest quite shortly afterwards.
So my anticipation was that there would be -- would have been a very full investigation, either internally or through an independent person called in by the Trust and clearly that report would be very important in relation to the Inquest.

Q. So you respond and then suggest dates to avoid from their perspective --
A. Yes.
Q. -- moving it forward. Thank you.
If we can then have INQ0002042, page 186. This email is an email from Mr Cross to you?
A. Oh right, yes.
Q. Suggesting an obstetric secondary review will be sent to you?
A. Yes.
Q. You then, if we go to page 169 -- it's the same INQ number, Mrs Killingback, it's just a different page, 169 -- what do you say there to the mother's solicitor or parents' solicitor?
A. Sorry, what?
Q. What do you say there in this email?
A. It was a letter.
Q. Yes, a letter. What are you setting out?
A. It -- it's my preliminary decision as to the relevant witnesses to the Inquest, bearing in mind the fact that Baby A's Family were legally represented, I wanted to run this past the solicitors in case they had any suggestions about further witnesses that they might regard as relevant, so that I could consider any representations in that regard.

Q. You say subject to anything unexpected within the SUI. So again explain what you are expecting from an SUI?

A. A detailed review of -- of what had happened.

Typically, these reports would come through with all participants anonymised through a series of letters and so if unasked the Trust sent me through a list of the witnesses to match up to the letters, I would always demand the -- a means of identifying which witnesses are being referred to and so after a detailed report I could check that I hadn't missed out any witnesses from my preliminary list.

Q. Can we next have, please, INQ0050707, page 1. It's not an email that you saw?

A. No.

Q. But it's been sent to your office from Joshua Swash --

A. Right.

Q. -- A paralegal at the Countess of Chester and it says:

"Please could you bring this to the attention of Mr Rheinberg.

"As stated in Stephen Cross's email of Friday, 12 August please find attached the OSR report for this case and action plan documents. Please note the NNU

practice and record-keeping ..."

Et cetera and it relates to Child A only?

A. Yes.

Q. So you are sent that.

We then see in September, if we can have INQ0002042, page 155, a letter from the solicitors for the parents --

A. Yes.

Q. -- of Baby A. Take your time to read that.

A. Yes.

(Pause)

Thank you, yes, I am familiar with that letter.

Q. Yes. They say:

"We were of the understanding that a full investigation was taking place."

They are unhappy, aren't they --

A. Yes.

Q. -- with what they have received. A short document that bears the date 1 July 2015. Do you think that was the page that Dr Brearey -- the one before --

A. Yes.

Q. -- that they were sent?

It doesn't look from that letter as though they were sent the Thematic Review document but they were sent Dr Brearey's letter; do you think that's right?

Mortality Thematic Review has been redacted due to the other patients' confidentiality."

If we can see what that looks like, please, it's INQ0008841 page 1.

So this appears, Mr Rheinberg, to have been sent on 19 August --

A. Right.

Q. -- 2016.

The Inquiry has seen different versions of this but this copy for you is -- appears as follows for the Coroner's Office, see page 1 there. If we can go over the page to page 2, page 3, page 4, 5, 6 and then the last page, page?

A. Yes.

Q. Page 7 and page 8, please. So this appears to only have Child A but as the document refers to, there are other babies in a version of that, but you have been sent the one related or the office has been sent the one in relation to Baby A ^.

You also tell us at paragraph 43 of your statement, if we can have on the screen INQ0002042, page 777, you are sent that.

A. Yes.

Q. We see:

"Learning from these cases notable excellence in

A. Yes.

Q. If we go to INQ0002042, page 154, your letter to them?

A. Yes.

Q. "... [you] too was disappointed with the brevity of the report which I received. However, I have no power to order a hospital to conduct an investigation, still less give directions as to the nature and extent of any investigation that's undertaken."

And that you won't be adjourning the Inquest next week.

"It would be inappropriate to do so."

If we go next to 0167, so the same INQ number ending 2042 and then 0167, your office, when it comes up, chasing statements.

If we go to page, the next page of that, 168 first, we know Dr Saladi's statement is in fact dated 16 August 2015, Theresa McCormack's April 2016, Ravi Jayaram's July 2015 and February 2016 and I think the ones on the first page too between February, April 2016 I think only Dr Harkness' was later in September.

In terms of that time lapse in receiving statements, was that not unusual or was that ...

A. No, it -- it -- it wasn't unusual to have to chase for statements. I had developed a protocol with all the hospitals giving deadlines with regard to production of statements, et cetera. On occasions, those deadlines were breached, they were -- they were followed up and the usual result would be an apology and the statement to hand.

This was unusual. It -- there were to me at any rate unacceptable delays.

Q. We know you are moving forwards to the Inquest on 10 October. On 6 October you get this email, INQ0053069, page 1.

We see from the bottom from Mr Cross:

"Dear Mr Rheinberg, you will recall that in your absence I advised your deputy that the Countess was undertaking a review of neonatal deaths by the Royal College of Paediatrics and Child Health which was undertaken at the beginning of September and the Trust is awaiting their report. The Review Team have indicated that they were entirely satisfied with the care within the neonatal unit and raised no concerns. However, they recommended that a detailed forensic Casenote Review of each of the deaths from July 2015 should be undertaken, so consequently this is still work in progress."

Over the page, if we can:

"I have instructed Louis Browne of counsel in this matter and he is fully aware of the review and Dr Jayaram as the lead Consultant is also fully aware of this matter. He is called to give evidence at this Inquest and will be able to answer any questions regarding the review."

For completeness, if we go back to the previous page and look at the email at the top. Thank you, that's been enlarged, we see for our purposes that Mr Cross makes it clear that he hasn't sent a copy to the Coroner?

A. Yes.

Q. But explained it in the email below.

In terms of the email below, it's clear you weren't sent a copy at that stage. Were you aware that Mr Moore had had a conversation with Mr Cross previously about the fact that a review was being undertaken?

A. No. I think if I remember correctly from the documents provided to me that it was alleged or stated that a telephone conversation had taken place between Mr Cross and Mr Moore, was it 13 July?

Q. It was in July.

A. Yes. And that this conversation imparted information to Mr Moore which was to be passed on to me

as I was not in -- available to take the call. That, that -- I picked that up from the documents sent to me.

Q. Indeed, Mr Moore said yesterday so you are aware that he was -- he did take a call --

A. Yes.

Q. -- that was meant for you where he was told about the RCPCH review and that a review was being undertaken?

A. Yes.

Q. And that he told you about the call and said that there was a review being undertaken?

A. Yes. I am absolutely positive he -- he will have done so. He was meticulous in that regard. It's my failing memory, I'm afraid, I -- I can't remember. But I did know that there was -- was to be a review. It may have been that conversation that had been passed on by Mr Moore, but I -- I can't now remember.

Q. To be clear, Mr Moore's evidence was that when he said that to you, you were aware of a review into neonatal deaths but his evidence is he wasn't aware that there was a suspicion about a nurse or a member of staff --

A. No.

Q. -- being involved in deaths but you were -- he was aware of neonatal deaths and a review?

A. Oh absolutely. I mean, it was a concern that there had been a number of deaths at the Countess of Chester and good to know that the matter was being looked into independently. But certainly so far as I was concerned there was not a whisper of any suspicion.

Q. And indeed when you hear the Inquest for 10 October 2016, as we know when we go through the sequence, by then you have had the deaths of A,C,D,E,I, O and P --

A. Yes.

Q. -- notified to you. So you were aware of a series of neonatal deaths?

A. Yes.

Q. We have got a note of the Inquest hearing, we have got a number of notes and there seems to be a particularly full one from the Family's solicitors. If we can look, please, at INQ0107909, page 8. If we can just have the last paragraph on the screen. Perhaps enlarge that. Dr Jayaram's evidence.

Mr Rheinberg, we see you asked Dr Jayaram whether or not he has seen anything similar. Can you read that again now --

A. Yes, I will, yes.

Q. -- and tell us what you understood from that

evidence?
A. Okay.
(Pause)
So I don't remember this. So my understanding will be relating to the reading of this now.
Q. Yes, understood.
(Pause)
A. Yes, I have read that.
Q. What did you make of that at the time? What did you understand from that?
A. Well, he was giving details or referring to previous cases and where the cause could not be found and that whilst there was nothing specific in relation to the department, it was being downgraded as a general safeguard presumably pending a -- the result of a review just in case there was something amiss within the department from a clinical excellence point of view.
Q. Thank you. That can go down. If we go to your statement, please, at paragraph 45, you set out there your conclusions and you say at the end of paragraph 45 you had stated:
"'It cannot be determined what caused Child A's collapse and subsequent death and further it cannot be determined whether this was due to a natural or unnatural event'."

Can you just clarify for us, which you do later in your statement, what you were referring to there when you said "or a natural event"?
A. Okay, there were two possible factors that could have been relevant to the cause of death. The one iatrogenic, the other natural. So I have already mentioned the misplaced line, misplaced on two occasions and I think it was after the second line insertion, misinsertion, very shortly afterwards that there was a collapse.
The other pathological finding was a crossing over of the pulmonary artery and that was described by the pathologist as "extraordinarily rare", I think it was something like 27 cases only known, but unlikely to explain the death, although the pathologist set out a theoretical basis upon which death could have ensued, but then rather dismissed it.
I was struck by the coincidence of the error and the death, although I had to take on board the pathologist's opinion that this probably was not relevant so far as the cause of death was concerned.
So this was one of those very unfortunate cases where despite all the investigations that had been undertaken, and in particular despite a paediatric postmortem, the -- the cause of death was not apparent

so I could theoretically have just put "open verdict" --
Q. Don't worry, we are not worried about your decision -- not worried about that?
A. It didn't strike me that that was appropriate.
Q. Child C, moving to Child C. We know Child C's death was reported to the Coroner on 15 June 2015 and an investigation was opened. If you go to paragraph 53 of your statement, we see you ordered a postmortem examination to be performed.
Can you tell us what the conclusion of that was and therefore how the investigation discontinued?
A. Right. I can't remember offhand the specifics of the report, I think it was Dr Kokai.
Q. Don't worry, you summarise it at paragraph 53 of your statement?
A. Sorry, I will look it up.
Q. It may be easier -- I would look it up rather than ...
A. Which paragraph?
Q. 53. You say:
"At an early stage the pathologist indicated his opinion that Child C had died from natural causes but was unable to provide a cause of death without carrying out further tests."
A. Yes.

Q. "[You] opened an investigation. Dr Kokai had already expressed an opinion that the cause of death was natural. Nevertheless ..."
A. Yes.
Q. "... at that stage the cause of death was unknown."
A. Yes.
Q. "After an investigation had been formally opened Dr Kokai gave his opinion as to the cause of death. The cause given was naturally occurring."
Therefore you discontinued the investigation?
A. Yes, and this would follow a very usual line with a paediatric postmortem. There would be an immediate response from the -- or a speedy response from the pathologist, to give a steer as to where things might be going. But the opinion as to the cause of death being withheld until all investigations, both microscopic and biological, had been undertaken.
Q. Child D's death was reported on 22 June 2015. If we go to INQ0002045, page 8, we see Dr Newby reporting that death, referred to it being the third death in 12 days for neonatal?
A. Yes.
Q. Also a further episode of apnoeic event and CPR for previous twin death. Surviving Twin had

successful ... ^
Postmortem was conducted and we know that the conclusion of that was pneumonia with acute lung injury and you had provisionally decided to discontinue the investigation but received a letter, didn't you, from the parents requesting further investigation?
A. Yes.
Q. So your letter in response, INQ0002045, page 962.
A. Yes.
Q. Tell us what you are saying there or stating there.
A. Messrs Gamlins had been appointed to act for the Family. I think I had received a letter from Baby D's parents direct, giving a number of details relating to what they saw as mismanagement in relation to the death and I decided that this did need further investigation, and although a natural cause of death had been given, and so in normal circumstances a discontinuance would be the only course of action appropriate, in these particular circumstances I decided to accede to the request made by Messrs Gamlins.
Q. If we can have the next page up, the same INQ number page 974.
While it comes up, Mr Rheinberg --

Q. And you set out at paragraph 66:
"It appears from the paperwork that she [that is the doctor] was satisfied that the reporting doctor had correctly identified the cause of death which could be registered without a postmortem examination or further investigation by the Coroner's Office."
Sorry, I should make clear it was somebody at the Coroner's Office working as a senior partner in a GP practice, forensically trained, et cetera, she was satisfied that the reporting doctor had correctly identified the cause of death and so it was there was no postmortem and no Inquest; is that right?
A. Yes. Correct.
Q. So where there was no request for an Inquest the Coroner's Office also had to ratify or see that and --
A. Sorry?
Q. The Coroner's Office needed to look at that for themselves and ratify what the doctor had said?
A. Absolutely, yes. From a legal point of view, the death, strictly speaking, didn't have to be reported because the cause of death was known or purportedly known and purportedly the cause of death was -- was natural.
But this was in adherence to my Practice Direction

A. Yes.
Q. -- you retired in March, didn't you?
A. Yes.
Q. March 2017?
A. Yes.
Q. We see a letter that your successor Mr Moore sends on 3 May 2017:
"Dear Mr Cross,
"I write further to Mr Rheinberg's letter to you dated 13 February in which he indicated he was looking forward to receiving from you copies of the in-depth reviews carried out in respect of Twins and Child D and Child A."
A. Yes.
Q. That is sent 3 May. And I think that's the day after the Countess of Chester have written to the police. But at this point, Mr Moore is asking for those reviews?
A. Yes, yes.
Q. That can come down. Child E. If you can go to paragraph 65 of your statement, please?
A. Right, thank you.
Q. Child E's death was reported on 4 August 2015. There was no postmortem and no Inquest opened?
A. No.

that all deaths of children under the age of 18 should be reported. So quite proper that the death was reported.
Q. Child I's death was reported on 23 October 2015. You tell us at paragraph 67 of your statement that the investigation was discontinued following receipt of a postmortem on 6 February 2016.
A. Yes.
Q. You set out at paragraph 69 that:
"Dr Kokai produced a full postmortem report dated 10 February [and] gave his opinion as to the cause of death as hypoxic ischaemic damage of brain and chronic lung disease of prematurity due to extreme prematurity."
The concluding remarks, he wrote:
"'I find it justifiable to conclude that Child I's death was a result of natural causes and a result of a combination of several underlying pathological processes as a consequence of prematurity ...'"
And so it was that investigation was discontinued.
A. Correct. Yes.
Q. We then come to two babies from three Triplets and deaths are notified to you as well and if we go to INQ0002046 0083, we see this is an email, isn't it, to you from your office, Christine Hurst?
LADY JUSTICE THIRLWALL: It's just coming up now.

MS LANGDALE: It's actually page 83, please. 2046, page 83, not that page.

LADY JUSTICE THIRLWALL: Can we take that off, please?

MS LANGDALE: Yes. 0083.

A. Right.

Q. We see there attached postmortem reports for Babies O and P.

A. Yes.

Q. You tell us as indeed Christine Hurst mentioned in her statement to the Inquiry that soon after the deaths had been reported, you had a conversation and she came over to your office to discuss the deaths.

By all means refresh your memory from paragraph 74 of your statement, if you would like to do so.

A. Yes.

Q. So what do you remember now about any conversation between you both?

A. Christine and I had frequent conversations on all manner of things relating to the jurisdiction. But I do remember her coming over and us having a discussion about our concerns about the -- this being yet another unexpected death of an infant or infants at the Countess of Chester Hospital.

they might have statistically expected, what information were you relying on for that? Can you remember now or would you rather we went through --

A. Well, I know generally it was an investigation into the operation of the unit to identify any shortcomings or any issues that could explain some or all of the deaths or might have been a factor rather than explaining the causes of death.

Q. If we can go to INQ0058202, page 3, these are follow-up emails on reports for Babies O and P but also refer to the review, so let's look at these emails in sequence.

So you see at the bottom from Claire Raggett at the hospital to Christine Hurst, your office, 31 October?

A. Yes.

Q. "Good afternoon Christine,

"I write further to our telephone conversation and I have just spoken to Stephen who has asked Josh to send the two reports over to you this afternoon. The Reports are unsigned as [Dr V] is on leave until Friday when she will be in a position to sign them."

So these are reports relating to O and P:

"But to avoid any delay for the Coroner to have sight of the report Stephen asked for the unsigned reports to be sent over to you. In respect of the

Q. If we can go to page 82, the page before.

Your response at the top, 17 October:

"The postmortem reports" --

A. Yes.

Q. "... disclose a naturally occurring death and I am discontinuing the investigations. There is nothing in the reports to indicate any clinical mismanagement in relation to these deaths which were both sudden and unexpected. It can be seen Dr Kokai ascribes the death to prematurity, albeit the processes which occurred in each case were different.

"I am aware of the investigation that you refer to. The hospital itself called for an investigation by dint of the fact that they had experienced a number of perinatal deaths in excess of what they might have statistically expected. The investigation was not instituted because of specific concerns about the deaths in this instance and as noted above, I know of no clinical mismanagement."

So you were aware of the review at that time?

A. Yes.

Q. The RCPCH review?

A. Yes.

Q. In terms of referring to what it was looking into, a number of perinatal deaths in excess of what

review, the Trust has now received a draft report which it is considering factual accuracy and this will be done by the end of this week.

"It is anticipated that the final report will be received within 14 days from the review as receipt of the Trust comments which will then be in a position to share with the Coroner.

"I have also raised your earlier email with Stephen which, as you suggested, raises a number of issues particularly around the strict legal position regarding the time of death and we will be interested to hear your view in due course."

Then we see above that, so that is the email that is come to your office 31 October, 7 December:

"Hi Claire, any news on the review done by the College yet?"

A. Yes, yes.

Q. So -- and if we go, please, to page 87, it's a different INQ number actually, INQ0002046: page 86 actually is the first page of it.

Can we have page 88, please and the email at the bottom of page 88.

A. Right.

Q. "Good morning Christine."

From Claire Raggett:

"I write further to my email yesterday [this is 9 December]. Stephen has met with Ian Harvey earlier this morning and as mentioned, the neonatal service review has been received in the Trust. The review does advise that the Countess undertake some internal review which will involve a secondary review of some of the cases.

"The Trust would like permission from the Coroner to approach the appropriate pathologist where they have been involved with a particular death. This will enable us to be in a position to present a comprehensive review to the Coroner which we would anticipate to be completed earlier in the New Year.

"It would be helpful for Ian and Stephen to meet with the Coroner to discuss the findings of the reviews. Perhaps you could suggest some dates for the Coroner for a meeting, say third week of January 2017."

Then above, from Christine Hurst to you.

A. Yes.

Q. "Please see regarding the Royal College Review at the Countess of Chester, the Children O and P cases were, as I was told, part of the review."

If we go back to page 86, your response to Christine:

"This does seem to be going over backwards.

However, I have no objection to the Trust consulting pathologist. At this stage I would like a copy of the document which has been produced. I also need to know which cases the Trust decide to review. Finally, I would like a date for the final comprehensive review. Early in the New Year is too vague and in any event I would want to have an opportunity to see the review and consider its implications prior to my retirement."

LADY JUSTICE THIRLWALL: Were you able to see that, we had a bit of movement of the document?

A. Sorry?

LADY JUSTICE THIRLWALL: Are we all content we have now had a chance to look at it?

MS LANGDALE: Can you see it?

A. I can, yes.

Q. And you can confirm that is what you sent between yourselves at that time?

A. Absolutely, yes.

Q. If we go now to page 91, same INQ number, 91.

At the bottom of the page:

"Hi Claire, [17 January] Mr Rheinberg has asked that he is sent without further delay a copy of the neonatal service review."

20 January:

"Good morning Chris

"I write further to your email below. Stephen has asked that I forward a copy of the review for the attention of the Coroner. Please note this is still confidential to the Trust board and will be shared with our relevant clinicians at a meeting to be held on Thursday, 26 January.

"Stephen has therefore asked you to advise the Coroner accordingly and once it has been shared with our clinicians the Trust has a communication plan for a wider dissemination of the report."

Do you see that?

A. Yes, I do, yes.

Q. So we know a report is sent to you. We need to go to a document from within the Countess of Chester to see what was sent to you, specifically and if we can have please on the screen, INQ0058202, page 1. This is early stages for the Trust with this report.

So they say we see from the email from Mr Cross:

"Please see email below which confirms I have sent the redacted version of the review to the Coroner as agreed."

So with his colleagues stating he sends the redacted version?

A. Yes.

Q. I am going to put on the screen the bits that

were therefore redacted, Mr Rheinberg --

A. Okay.

Q. -- at that time. INQ0009618, page 8, paragraph 3.12. If we can just highlight that. That paragraph.

A. Right. Oh, thank you.

Q. So mention a nurse had been rostered on shift for all the deaths although the nurse had not always been assigned to care for that specific infant?

A. Yes.

Q. Sorry. Can we go back to it. 3.12:

"Subsequently paediatric lead and all the Consultant paediatricians had become convinced by the link although this was a subjective view with no other evidence or reports of clinical concerns about the nurse beyond this simple correlation an allegation made to the Medical Director and Director of Nursing."

Then if we go to page 9 of the same INQ number and those three paragraphs as well, if you can read those.

(Pause)

A. Thank you.

Q. Then the next page, where the blue starts "recommendations", you see that? That's on the redacted version but the top two paragraphs.

A. Okay.

(Pause)
Thank you.
Q. Can we then have an email, please, that can come down, INQ0002046, page 95. This is an email from you to Christine Hurst and cc'ing Mr Moore. You say here:
"Having reviewed the files again in relation to the tragic deaths of the two Twins there is nothing to indicate that the deaths were anything other than due to natural causes. I was going to discontinue the investigations but the parents asked me to wait until the result of the Royal College's investigations into neonates at Countess of Chester had been concluded.
"This report has now been received and its findings do not add any information pertinent to the deaths in question. The Countess of Chester called the Royal College in because statistically there had been a rise in infant mortality which could not easily be explained. The report reveals a level of understaffing for a unit of its size, possible delays in referrals to tertiary care and other matters which no doubt will be addressed. However, nothing in the report throws any light on the deaths in question and these being natural deaths with nothing to indicate gross human failure, I have no jurisdiction to hold Inquests.

"Let the parents absorb the report and please communicate my thoughts to them."
You hadn't seen the full report at that time. Do you think you would have liked to have done or would it have made no difference to see --
A. Well, clearly I had not received the full report. My attitude would be somewhat different or would have been somewhat different if I had seen those passages which appear to have been redacted.
Q. Why would it have been any different?
A. Well -- it, it opened up a whole new line of enquiry. We, we have a mystery: why are there more deaths than would be expected? A review which apparently or appears to throw no light on the matter, but in particular doesn't show any systemic failure which could explain the deaths other than staffing level issues.
The paragraphs that were redacted clearly raise a matter that needs investigation, and the response to that would be reporting the matter to the police, whether or not I would have out of courtesy told the Countess of Chester my intention to give them an opportunity to make representations, I don't know.
But clearly this was a matter that needed further independent investigation.

Q. If we can go, please, to INQ0002046, page 77, internal emails between yourself and your office, Christine Hurst on 1 February.
Ms Hurst tells you:
"In the email I forwarded to you from Claire Raggett from the Countess of Chester she confirmed that an independent review is to be done of each unexpected death and that a full independent review of Children O and P and Child A cases currently been undertaken.
"In light of this do you wish to discontinue the investigation or wait until these reviews are complete?"
And you say:
"We will await the outcome of the review."
A. Yes.
Q. On 8 February --
A. Sorry to interrupt. Is this in relation to -- yes, it is. If I remember correctly the parents had, of the two babies had made a request that the Inquests or the investigations shouldn't be discontinued despite the fact that Dr Kokai had found the deaths due to natural causes and it seemed a perfectly reasonable request in view of the fact that there were further investigations to be undertaken.
So I countermanded my original instruction that the

investigation should be discontinued.
Q. It's apparent from your communications that you do communicate with parents when you are minded to discontinue in case they have anything to add or say. We see that in the case of Baby D --
A. Yes.
Q. -- and here. So --
A. It would most normally be not me direct but my officers on my behalf. When solicitors were involved, then normally I would engage in correspondence direct.
Q. If we can go please to INQ0005815, page 1. That's a letter to Mr Cross from Christine Hurst.
A. Yes.
Q. She says:
"I was assured last week by your department that all Family members would be contacted and informed about the Royal College of Paediatrics report prior to it being made public. In light of this assurance I therefore did not get in touch with Father O,P&R to inform him that this document was now complete and that it would be going public this week. I have just received a telephone call from Father O,P&R who was extremely distraught and very angry he has not been made aware of the publication and he and his Family have only now found out about this via the babies' grandparents

who saw it on the news.
"It was a very difficult and distressing phone call"?
A. Yes.
Q. What was your understanding if you had a report like that, would you think that that should be shared with the Families or express a view about that?
A. Absolutely. Absolutely.
Q. If we can go to paragraph 95 of your statement. You tell us that you are satisfied you did have a meeting at the hospital with Mr Cross and Mr Harvey because in subsequent correspondence they refer to a meeting at the Countess on 8 February. So you don't recollect a meeting now but you think that's probably right, you did have one with them at the hospital?
A. Yes, I am sure the meeting took place. I -- I just have no recollection. Having been taken through all the documents just now, I imagine that the meeting was to discuss the report but --
Q. The RCPCH report?
A. Yes.
Q. If we go to INQ0106817, page 34, this is Mr Cross's note of a meeting. We can enlarge it and see if it helps you or not?

"NR: [presumably you] anything come out of in-depth investigations?
"IH: no theme has emerged."
And then you appear to say, if this is right:
"Wouldn't want to get in the way of talking to the Families."
Would that be the sort of thing you talked about?
A. Right. Yes, I am prepared to accept that, as I say I have no recollection.
Q. "Needs in-depth investigation. Coroner should share any further info with Families."
Then it looks like it says:
"Trust done right thing."
We don't have Mr Cross to tell us what that represents or whether there's -- what's alongside that?
A. I can't, I'm afraid --
Q. Can you remember any discussion about right thing, or doing the right thing or wrong thing, anything like that?
A. As I say, I really can't remember anything about this meeting, so I'm at the mercy of the note, as it were.
Q. Fair enough.
It then says:

A. Right. Oh, gosh.
Q. It is not easy, is it?
A. Can you translate?
Q. Yes. Top 8 February. It is that top right-hand box?
A. Yes.
Q. You can enlarge it, I think. It's better in hard copy.
A. Right.
Q. Mr Harvey outlining ...
Would you rather see a hard copy? This is a good time for a break anyway.
LADY JUSTICE THIRLWALL: We could take the break and get you a hard copy, is that convenient?
MS LANGDALE: Yes.
LADY JUSTICE THIRLWALL: So we will take a break now. We will come back at 20 to 12.
A. Thank you.
(11.20 am)
(A short break)
(11.40 am)
MS LANGDALE: Mr Rheinberg, you and I both have a hard copy.
A. Yes, that is helpful, thank you.
Q. We see that Mr Harvey outlines the meeting.

"Coroner will advise his staff no comment. Never associated paediatric deaths with the Countess."
But you have got no recollection of what that's about?
A. Yes.
Q. If we can have instead on the screen, please, INQ0002048, page 33,.
A letter from you to Mr Cross, further to the meeting of 8 February.
A. Right.
Q. It will come on screen in a moment.
A. Right.
Q. "I look forward to receiving copies of the in-depth reviews carried out in respect of the children. So far I have received no press enquiries following publication of the report."
We then know you have a meeting on 15 February?
A. Yes.
Q. If we can look, please, at INQ0002048, page 34. We know you say and also Mr Harvey says that a bundle of documents were given to you at this meeting.
Can we just look at what those documents were, please.
A. Okay.
Q. In-depth review into baby deaths. Advisory

medical report from Dr Hawdon dated October 2016. I won't put the whole report on the screen, Mr Rheinberg, but if I can ask, please, for INQ0002048, page 89 and page 90.

We see recommendations at page 90, if we go back to page 89 we see a list:

"Child D change following PM review."

So moving it in the document making it clear that is a change following a PM review?

A. Right.

Q. We see a list of other infants there.

So the Dr Hawdon report is in this bundle. Then if we go, please, to INQ0002048, page 91. We see a letter from the paediatricians to Mr Chambers and we see at paragraph 2 respectfully requesting you to urgently ask the Coroner to undertake a full investigation of all the deaths and unexpected collapses.

It sets out the Royal College Review. It sets out comments on Dr Hawdon's Casenote Reviews. And we see at paragraph 5 overleaf:

"No deaths or unexpected collapses since July 2016, unwell babies have been cared for, received intensive care and in some cases transferred to the hospitals but their clinical courses have been far more predictable and responsive to treatment than previous cases. This

change cannot solely be attributed to the redesignation of the neonatal unit or any other changes in practice.

"Some of the babies who collapsed in 2015 and 2016 were born at greater than 32 weeks' gestation and many were not receiving intensive care at the time of their collapses."

At the end, saying:

"We are making this request because patient safety is our absolute priority."

Then we see at page 93, a document entitled there we are, observations additional to the RCPCH review.

This document, I can tell you, Mr Rheinberg, includes the green text of the report, remember we looked at the green text?

A. Yes.

Q. That wasn't there, all but one paragraph. It doesn't include the last paragraph about:

"In the light of information shared with the Review Team the RCPCH advise the Trust to follow corporate processes in responding to allegations of misconduct by opening investigation."

But it does contain the other paragraphs in that green text?

LADY JUSTICE THIRLWALL: Ms Langdale, I know that you know and we know about green text. But I don't

think the version that we looked at with Mr Rheinberg had green text, it was just the original.

MS LANGDALE: That is -- my apologies, Mr Rheinberg. So the findings in relation to a nurse that you looked at earlier, remember that document?

A. Yes.

Q. This document has the same information in it --

A. Right.

Q. -- except for the last paragraph --

A. Okay.

Q. -- for our purposes.

A. Right.

Q. But it has information about the nurse in it. This document doesn't include the reference to advising the Trust to follow corporate processes but it sets out that sheet of paragraphs?

A. Yes.

Q. That sheet that had the paragraphs?

A. Okay.

Q. So it appears those are three items that you are given: the Dr Hawdon report, the Consultants' letter and the observations described as observations, that section from the RCPCH review --

A. Right.

Q. -- that you hadn't seen before?

A. Right.

Q. Tell us when you had the meeting at what stage were you given those documents?

A. I can't remember. It may have been at the outset. I -- I can't remember. In fact, I'm glad that I took a note of the meeting because that served to remind me of the meeting. Before I read my attendance note the recollection of the meeting was somewhat -- somewhat vague.

Q. Shall we go to your meeting note then and see what you can tell us about the meeting itself. INQ0002048, page 102.

A. While we are just getting that on the screen would it be unusual to have the Medical Director Mr Harvey and Mr Cross coming to see you like this?

A. Yes. Very unusual. Not unusual for me to meet representatives from the hospital. I -- if I had any issues, I would often arrange for an appointment to see the Chief Executive or the Medical Director, probably more the Medical Director than the Chief Executive. But unusual to get a delegation, as it were.

Q. So why did you think at the time they wanted to come and see you, what did they want to share or discuss with you, as far as you were concerned?

A. My understanding was that they wanted me to conduct some sort of overall review, a sort of independent inquiry into all the deaths, not something that I would have any power or authority to do. But that, that was my general understanding, that they wanted me to make some sort of further investigation. But it was just -- I don't think I was given any specific reason prior to the meeting. But that is a little bit of conjecture because I cannot quite remember the circumstances in which the meeting was arranged.

Q. So they were concerned about the deaths or wanted a review, or you can't remember now?

A. Yes. I think the fact that I asked for Alan Moore to be or suggested that he should be present was clearly going to be relevant for ongoing themes and with my retirement imminent, it was important that he shouldn't be left out of any, any discussion.

Q. If we look at paragraph 2:

"The first item of the enclosures is a bundle of in-depth reviews into the baby deaths in question and towards the end of the bundle is a sheet indicating which review relates to which baby. In the case of each review, a document will be expanded and written in an easily comprehensible form to be delivered to the

parents. We will be given a copy."

So might you have gone into the notes or Dr Hawdon's report in the meeting?

A. Yes.

Q. You look uncertain there but it makes sense from the notes, doesn't it?

A. Yes, it does, yes, yes.

Q. You are talking about the report and looking at it so you think -- how long was this meeting, roughly, do you know now?

A. I don't remember it being very long, possibly because I wasn't delivering what they hoped I would deliver.

I -- at a guess I would say about 30 minutes. But that -- that is only a bit of a guess.

Q. So it looks as though you have got -- you were sighted on the Hawdon Review or at least the babies --

A. Yes.

Q. -- that they were looking at.

Then we have got the clinicians from the neonatal unit have written to the Chief Executive and a copy of that letter is also enclosed?

A. Yes.

Q. They are asking for the Coroner to hold an Inquest in each case.

"NLR observed that Inquests can only be held when there is a jurisdiction to do so and explained that the Coroner must have a body within his jurisdiction and have reasonable cause to suspect that the death was unnatural, came with a particular further category or where the cause of death was unknown. It seems to NLR that in relation to the list of deaths in question they may into one of a number of categories as follows."

Before we go to that, do you think you read that letter, you are referring to the letter, the copy of the letter is enclosed, did you read it?

A. I -- I imagine I had -- either I had or I had received a summary of it, I -- I can't say which.

Q. So those two documents, the Hawdon document you had looked at, report, likely the letter or had it summarised. What about the third one, the observations document I have just taken you to from the RCPCH review? Did you look at that? If it helps in your statement you say "I don't recollect looking at that document"?

A. No. I have to say I would really only be guessing. I -- I can't, I have no actual collection.

Q. You say:

"If it had been the subject of any discussion, I would have made reference to this in my note."

A. Yes.

Q. But you can't remember now one way or another?

A. I can't remember. When I do take a note of a meeting or a conversation, I do try to make it comprehensive and I would hope that relevant matters that were raised or whatever would appear in -- in my note. No point in making a note if it isn't comprehensive.

Q. But --

A. But since I have no recollection, I can't -- can't say one way or the other.

Q. If we look at the six points you make, then, can you just summarise for us now what you say?

A. Well, I am explaining that in those cases where I have already had held an Inquest, I can't go back over it because I have no legal authority to do so.

I have explained that where I have, or my one of my deputies has signed a part A, a form 100A, indicating that the Coroner does not intend to exercise any jurisdiction, there are problems in holding an Inquest subsequently, the principal one of which being that you don't have a body lying within your jurisdiction, so you would need to get permission from the Chief Coroner under section 2 of the Act.

I'm explaining in clause 3 that I am not functus officio, as it were, I am not without jurisdiction if

I have discontinued an investigation and further information has -- has come to light.

Then I refer to deaths already listed for Inquest, obviously those can be heard, and then deaths where investigations are ongoing.

Then I say, I'm not sure that it is very elegant:

"NLR made it clear that the Coroner's office does not operate as a system of governance."

I got really got the idea that what the Consultants wanted was me to have an overall review of all the cases to see if there were any, any mistakes or any common themes or whatever. And I was explaining that that -- I don't have jurisdiction to do -- to do that, no authority to carry out a general review, as it were, only to hold an Inquest into a specific death.

Q. Thank you.

Just finally from me, in terms of the bundle, can you remember now having it with you and being able to flick through that?

A. I don't, no, I'm afraid.

Q. But it's reasonable looking at that as though you would have had it and at least been cross-referring to it?

A. It may well be the case. It's all a matter of interpretation from my note. I haven't got any actual

recollection.

Q. But from those present at the meeting with you, Mr Harvey and Mr Cross, it's a fair assumption for them to make that you have got that information --

A. Yes.

Q. -- or you can see that information?

A. I -- I can't challenge that.

MS LANGDALE: Thank you, those are my questions.

A. Thank you.

LADY JUSTICE THIRLWALL: Mr Skelton.

Questions by MR SKELTON

MR SKELTON: Mr Rheinberg, I ask questions on behalf of one of the Family groups --

A. Yes, thank you.

Q. -- including the Family of Child A, whose Inquest was conducted in 2016. After the death of the two Triplets O&P in June 2016, there were a series of internal meetings at the hospital attended by the Consultants and the Executives.

One such meeting took place on 29 June and was attended by Dr Brearey, Dr Saladi, Dr Jayaram, Mr Cross, and Mr Harvey.

A. Okay.

Q. You won't have been aware of these internal meetings?

A. No.

Q. I am not going to put the note of the meetings to you.

A. Right.

Q. But it is fair to say at this meeting and at other meetings at this time there was discussion about the Consultants' concerns about Lucy Letby?

A. Concerns about?

Q. Lucy Letby.

A. Oh, yes, okay.

Q. In particular, at the meeting in question on the 29th, Dr Brearey mentioned her being a common theme between the deaths as early as July 2015, after which, as you know, three children had died --

A. Yes --

Q. -- including Child A. They described the types of deterioration that the babies suffered which were sudden and unexpected, the fact that they didn't respond to resuscitation measures as would be expected and Dr Jayaram speculated that there may be some issue with injection of air and air embolism via a cannula.

But of course that discussion didn't evolve into any particular investigation as you know.

They in particular discussed the Twins on a number of occasions, including mentioning that only one of the

Twins survived but they had both collapsed, as you know?

A. Yes.

Q. Child A had a Twin who also collapsed but fortunately survived, Child B.

All of this I think you were entirely unaware of --

A. Completely.

Q. -- throughout 2015 and 2016?

A. Yes, and it's horribly disappointing.

Q. That is exactly what I was going to ask you about, Mr Rheinberg.

A. Yes.

Q. Would you have expected Mr Cross or someone else prior to Child A's Inquest to have raised those types of concerns with you as the Coroner?

A. Absolutely. It was all within the -- the ethos of the SUDI Sudden Unexpected Infant Death protocol, that we should approach all these tragedies not just in our own ivory towers; that we should share all information because we might individually have pieces of the picture to put together.

So police, hospital, everybody that has anything to add should add to the discussion, as I say, to complete a full picture what have has happened. And within Cheshire, the protocol went out under my badge, as it were, so I was the -- I was to be the co-ordinator of

action, if action was required.

So the protocol went out initially in my -- by this time it had been superseded by further iterations of the document but the initial intention was that the Coroner's office should be the focus for the inquiries partly because of course the Coroner's office had powers that the others didn't have.

So yes, I'm sorry, I have rambled on a bit but very, very disappointing that relevant information is not shared.

Q. Just on the SUDiC protocol, is that a local protocol that you would have assisted in drafting?

A. Yes. I think the first protocol was produced in 2001, it -- there was a general -- up until that time there had been a general feeling across the country that there should be better co-ordination in relation to infant deaths and I forget which area had produced the first protocol; it may have been Sussex, it may have been Suffolk, I can't remember, but a very excellent document.

And I think I'm right in saying that the triumvirate, me, Dr Nisar Mir and Dr Ruth Spedding, who put together the initial protocol, leant very heavily on that, that precedent, as it were, because it was a very good document.

Q. Just in terms of specifics. How would that -- those concerns have been or how should they have been communicated to you, by whom and by what means?

A. I suppose that we are talking about a discussion after -- some time after the events, as it were. In the initial stages under the protocol, there would be a first meeting within 72 hours, when representatives from hospital, police, paediatricians, et cetera, would decide on a strategy for further investigation.

Now, that tended to occur almost exclusively for deaths in the -- in the community rather than in hospital, although the mechanism was there to be employed for the -- in the hospital as well.

But under the spirit of the -- the protocol which the hospital had or the hospitals in Cheshire had contributed to the discussions, any information that was relevant should be passed on to the Coroner. But quite outside the protocol, that -- that should be the case in any event. I am holding Inquests, I need information. I am holding investigations. I need people to be forthcoming with information.

Q. Would you have expected Mr Cross to have contacted you with that type of information?

A. As apparent spokesman, yes.

But any individual that had that information should could and should have passed it on, whether by informal chat with me or through one of my officers.

Q. Your evidence I think in writing and today was a suspicion of that type immediately warrants contact with the police, formally or informally?

A. Absolutely. And I -- I think I explained the mechanism in my statement.

Q. Yes.

A. One of the participants or one of the SUDI team, as it were, was Inspector Mark Tasker and I think probably on getting information such as that, I might have gone straight to Inspector Tasker because he -- he would have all relevant knowledge about procedures within the police force for investigating deaths such as this.

Q. Do you take that view, that that contact with the police is required, notwithstanding that at that stage all you have is the opinion of the Consultant or body of Consultants?

A. Yes. The relationship with the police was a close one. I have already explained about my officers being employed by the -- by the -- the police and on many occasions because I only had a limited amount of officers, it was the police that were investigating on

my behalf. And in cases where the -- there was any suspicion of a gross failure within a hospital, the first thing that I would do would be contact the police to seize medical records, not that I distrusted the medics, as it were, but I didn't want any possibility of notes being interfered with or written up subsequently.

So yes, I -- I would contact the police in the event of a suspicion.

Q. Ms Langdale asked you about the Serious Untoward Incident or Serious Incident Investigation?

A. Yes.

Q. There is a series of correspondence by email and by letter which you express a great deal of frustration about the non-production of that?

A. Yes, yes.

Q. How common was it for the hospital or other hospitals in your jurisdiction not to produce a report that you requested like that?

A. If it -- there was often a delay not -- not so much in the production of the report but in the disclosure of the report but in the actual preparation of the report. But invariably when a report was available and I had requested a copy, it -- the hospital would provide it.

Q. Your answer may be understood as if one is

already there --
A. Yes.
Q. -- you would expect to get it, but if they haven't already done an investigation but you are saying "one is needed and I need to see a report" would that --
A. Okay, clearly my understanding was that this -- there was an ongoing specific investigation. So my expectation would be immediately any report was produced that I had requested, it -- a copy you would be provided to me.
Q. But not that they would do one to your direction?
A. No. No, I didn't have any power to do this. I -- I might make strong suggestions that this would, was an appropriate course for them to take, but not something that I could demand.
Q. You were provided a copy I think of the Thematic Review that had been conducted at the end of 2015 --
A. Yes.
Q. -- into 2016. Do you recall whether or not that version of the report that you saw identified that the babies had suddenly deteriorated and that was a common factor across the mortality?
A. I can't -- I can't recall. I can't recall

now.
Q. Dr Hawdon's review, Mr Cross emailed you and I think may we have the email on the screen just to sort of anchor the period of time on 6 October, INQ0053069. You will see the email there to you from Mr Cross at the bottom.
Mr Rheinberg, just by way of summary as you probably have picked up there was a lot going on after June and that included the instruction of the Royal College to do a review?
A. Yes.
Q. And their recommendation that a forensic Casenote Review --
A. Yes.
Q. -- or detailed forensic Casenote Review be done and Dr Hawdon was instructed as a result of that --
A. Yes.
Q. -- before in fact the College had formally reported?
A. Right.
Q. They advised in writing that that was needed?
A. Yes.
Q. I think what is happening here is Mr Cross is contacting you before the formal report but with the recommendation that a Casenote Review be conducted?

A. Yes.
Q. And that you can see he is saying they have indicated they are entirely satisfied with the care within the neonatal unit and raise no concerns, however they recommended the detailed forensic Casenote Review of each of the deaths. And you were aware of that from this email?
A. Yes, yes.
Q. You weren't, I think, provided with Dr Hawdon's instructions specifically?
A. No.
Q. Can I just ask you to look at those on the screen as well, please, that is INQ0012066. And the reason I ask you to look at this, Mr Rheinberg, if you could just have at that first substantive paragraph 2?
A. Paragraph?
Q. Paragraph 2 made a bit bigger because it is quite hard to read on the screen?
A. Okay, yes. Thank you.
Q. That's it, if you just take a moment to read that, Mr Rheinberg, please?
A. Yes.
(Pause)
Yes, thank you.
Q. So the information in that paragraph is not

provided to you by Mr Cross, but this is the justification that the Royal College give and you will see that it raises a few issues and in particular the pattern of deaths?
A. Yes.
Q. The mode of deterioration in some of them which is unusual --
A. Yes.
Q. -- and requires further inquiry.
Is that the type of information that you needed to know when you were approaching Child A's Inquest?
A. It -- it would be extremely helpful. I think one of the things that wasn't undertaken in relation to Child A's Inquest was an independent examination of evidence by an expert instructed by me.
The more information that I had raising questions, might well have prompted me to get independent expert advice.
Q. Is the fact that the mode of deterioration is unusual and there is a cluster of children itself something that you as Coroner would be concerned by?
A. Certainly it would be a factor, yes.
Q. Something to --
A. Of concern, yes.
Q. Something to investigate?

A. Yes.
Q. I won't ask you to read the whole document but it does mention you will see in paragraph --
A. Sorry, can I just -- sorry, just to give -- put that in context with a case that I was dealing with at that time with a cluster of deaths at an old people's home that appeared to relate to the fact that they had been lock, stock and barrel moved from another home and then had died within a period of time.
That was an investigation that I had an expert undertake because of the fact of a -- an apparent common theme.
Q. Would you have considered the other baby mortalities that occurred in the neonatal unit and thought: well do I need to start looking at these together rather than independently?
A. I -- yes, if there was any common theme identified then, yes, that, that was certainly something to take into consideration.
I have it in mind, however, on the other hand the fact that I knew that there was an independent investigation being undertaken by the Royal College, so that is something also I would take into -- into account. I'm not sure if I had been given that knowledge how the balance would, would have tipped;

whether I had thought, well, it's been looked into, or whether I would have thought: I -- I better take this up independently.
I -- I can't -- I can't say which way I -- I would have gone.
Q. What appears to occur at the Inquest into Child A, which I will come on to in a minute, if I may?
A. Yes.
Q. Is that you are looking to try and test what might have happened to this child to cause death?
A. Yes.
Q. Because on the face of it the doctors and pathologist aren't able to provide a --
A. No.
Q. An explanation that satisfies you.
If you had known that this investigation was going on independently, and also if you see from sub-paragraph (c) that it was going to be looking at rare conditions, such as air embolism and metabolic derangement, how would you have responded to that fact?
A. Yes. It would be a line that I would want to have been looked into. All that I have at, before the Inquest is a question mark: these could have been causes of death, the error with the line, the crossed pulmonary artery, but not, not a -- it was rather grabbing at

straws to find an answer.
So if there was any suggestion provided that there might have been another mechanism, that is something I definitely would have wanted to explore.
Q. At the Inquest, Dr Jayaram gave evidence --
A. Yes.
Q. -- twice.
He first gave evidence about his own involvement with the child?
A. Yes.
Q. And then I think you brought him back after speaking to the pathologist to explain his opinion?
A. Yes.
Q. So was he in that sort of quasi expert role that you previously described?
A. Yes, absolutely.
Q. So you are looking to him to assist you on --
A. Yes.
Q. -- possibilities at that point?
A. Yes.
Q. Rather than the facts of what he did or didn't do?
A. Well, I suppose he's -- I'm expecting him to give evidence on a mixed basis; the bases being his own actual knowledge and as a witness of fact but with his

expertise to explain as well.
Q. As I set out earlier in my preface to the questions, Dr Jayaram was in fact suspicious of Lucy Letby at that time and also suspected that she may have injected air into one or more children and was suspicious about Child A's death in particular. He has accepted he should have mentioned that suspicion to you. Can I ask for your reaction to that?
A. Yes. Absolute horror. Why, why not? Why wouldn't you? I -- I think in those, if that had come out at the Inquest, I would have adjourned, I wouldn't have gone on any further, and probably sought police involvement.
Q. Likewise in respect presumably of Dr Saladi although his role at the Inquest was much more minor but he was aware of the suspicions and indeed shared them as well?
A. Yes. It -- it does seem extraordinary.
Q. Can I ask you --
A. Can I ask, did either of these individuals explain why they hadn't brought that information out?
Q. It's --
LADY JUSTICE THIRLWALL: I think that is probably a matter for me to determine. You can certainly read the transcripts if you want.

A. It's inappropriate, I beg your pardon.
LADY JUSTICE THIRLWALL: No, it's all right.
MR SKELTON: The hospital were represented at the Inquest and there is a question about what their counsel, who is a senior barrister at that point, Mr Browne, knew.
But it is clear and he has accepted that he was told prior to the Inquest that there was some connection between a specific nurse and Child A which the hospital had been considering?
A. Right.
Q. He was also aware of Dr Hawdon's instructions and which is still on screen in front of you which I have taken you through?
A. Yes.
Q. I can't put it any higher than that because Mr Browne, to be fair to him, has not got a clear recollection?
A. Yes.
Q. And note isn't precise about exactly what he was told?
A. Okay.
Q. He was aware of a connection between a nurse and indeed had asked that some research be done to see if the nurse was involved with Child A's care?

A. Okay.
Q. Had advised that that fact be disclosed to the Family?
A. Yes.
Q. As far as you were concerned, the Coroner at the Inquest, would you expect counsel to raise that issue with you the fact that the hospital were considering a nurse and her connection to the Child A's death?
A. Okay. Answering more generally, first of all.
It's been my happy experience that the more senior the counsel attending an Inquest the more they embrace the philosophy, if you like, that an Inquest -- that they are here to assist the inquiry.
So it's been my experience that in asking questions of their witness, if there is relevant information, even if it might detract from their own client's position, that that question will be asked. So going back to the specific. If counsel knew of serious concerns, then, I would expect at the very least for those concerns to be put as questions to their witness so that the matter came out in the open.
I'm not sure what the legal position would be so far as the barrister actually informing the Coroner. I -- I suppose the correct course of action would be:

this is relevant, you must either disclose this yourselves, if you will not do so I am bound by my own professional conduct and must withdraw from this particular set of instructions.
But one way or another I would expect a legal representative to seek to have that information brought to the attention of the Inquest.
Q. Just finally on Child A's Inquest can I just ask for your overall observations on the Inquest and in particular the position of the Family. I think as you are aware, because you were in contact with them, the Family were represented and they were extremely anxious to find out why Child A had died?
A. Absolutely yes.
Q. Many, many months had passed since his death and they still didn't have any answers?
A. No.
Q. Can I ask just for your observations on the sort of dissonance between what the hospital knew and were investigating and the way the Inquest ended up not answering any questions?
A. Right. Of course I didn't know that there were questions that --
Q. No.
A. -- were unanswered.

From my own point of view, I was not happy with the Inquest. It didn't really achieve very much. It brought the legal process to an end, but without any -- without any solid answers and sadly that is, that -- that can be the case; that the evidence just isn't there. It can't be, can't be found.
But it was a disappointment that nothing really very solid emerged from that Inquest.
Q. In this case I was asking you specifically about the fact that the hospital were aware of things that related to Child A's death but that was never brought to the family's attention via the Inquest process?
A. Right. No, to put it mildly, that is extraordinarily disappointing.
Q. After the Inquest you had contact with -- continuing contact with the hospital. Ms Langdale has asked you about the various meetings --
A. Yes.
Q. -- and the correspondence that you had.
Can I be clear that at no time did Mr Harvey or Mr Cross or anyone else bring the -- raise the concerns directly in terms with you and discuss them with you?
A. No.
Q. Your answer to what you would have done is

exactly the same in terms of contacting the police --
A. Yes.
Q. -- and setting in train a series of investigations through that means?
A. Yes. I used -- probably it was regarded as a bit of a pain but I would go to the police with any suggestion of criminality. As I am sure you can imagine, an Coroners office in an area as large as Cheshire gets a fair number of crank email -- correspondence. The block capitals, underlined, green ink sort of style.
Some of these will relate to totally irrelevant matters, some will allege criminality no matter how extraordinary or however unlikely, or however it may be almost crystal clear that the person in question is mentally ill. All such communication was sent to the police for investigation with the instruction that I was to be informed as to the -- as to the result of that investigation.
So there would be no case of me withholding information such as that from the police. It didn't mean that it had my endorsement, it didn't mean that I was saying somebody was guilty of a crime. It was -- I was just asking in each case: please investigate.
Q. Even after Child A's Inquest had concluded,

and as you said you were functus officio by that stage --
A. Yes, yes.
Q. -- if evidence or information comes to your attention which may mean that the result of the Inquest is wrong --
A. Yes.
Q. That is something that you can raise as being a possible?
A. Absolutely and I have judicially reviewed myself. One case in particular where really very pertinent information came out due to an advance in medical understanding which showed that what had been delivered as an open verdict in fact had a -- a very specific cause and because it -- it was so important even though the appropriate conclusion would be natural causes as opposed to open, the matter in my view was so important that I -- I sought to set aside the original Inquest and start again, as it were.
So being functus officio doesn't -- well, A, obviously stop me passing on information to the police; but also it doesn't stop me going to the High Court to get my Inquest set aside.
Q. In this case, again stepping back, you were not provided with relevant information in respect of

Child A and other children. But focusing on Child A --
A. Yes.
Q. -- the reasons for that, of course, are the focus of this Inquiry, at least one of its focuses.
But can you think of any reform or recommendations that could be made to stop that from happening again?
A. Well, it -- it's so much a matter of professional conduct and particularly in this era of full disclosure, et cetera, it -- it's difficult to see how existing professional standards don't cover it already. But I can't think of anything over and above what is in existence already that could be brought into -- into play.
Q. Could it be for example that it should be made clear in policy and guidance that if a member of staff is suspicious that a child may have died from deliberate harm, no higher than that, that you at least must be informed?
A. Yes. And of course there is a duty which I think is reproduced as a medical standard that the Coroner must be informed. Back to the Middle Ages, it's always been the case that there is a duty to inform the Coroner. It's nothing new.
MR SKELTON: Thank you, Mr Rheinberg. Thank you, my Lady.

LADY JUSTICE THIRLWALL: Mr Baker.
Questions by MR BAKER
MR BAKER: Good afternoon, Mr Rheinberg, I ask questions on behalf of the other two Family groups.
A. Yes, thank you.
Q. I want to begin by asking about sharing learning between different Coroner areas.
A. Okay.
Q. So there are a number of different Coroner areas across North West --
A. Yes.
Q. -- of England?
A. Yes.
Q. Many of them adjacent to each other?
A. Yes.
Q. Do the Coroners -- Senior Coroners meet up and exchange information, learning or experience at all?
A. Yes. I was -- because my jurisdiction was contiguous to them, I was brought into the -- I was going to say "club", it sounds entirely wrong, but the Manchester Coroners held regular meetings and I was invited to join that group, as it were, so that we should strive to be consistent, nothing worse than having the Coroner in Cheshire acting completely outside the -- the practice of the Manchester Coroners.

Wider than that, we have the North West Coroners Society meeting regularly, having education sessions and to a certain extent acting as a discussion point.

Not so much though, perhaps, but what has been a unifying factor since before 2013 has been the appointment of the Chief Coroner --

Q. Yes.

A. -- and that has been enormously helpful. For the first time it sounds extraordinary to say this but for the first time ever education is compulsory and not something that you -- you go to if you happen to have the time to spare and we -- we have all the Practice Directions, legal sheets et cetera, very, very helpful in trying to get unity of practice.

Q. Yes. Now --

A. It doesn't answer your question because of course you are asking about sharing information.

Q. It goes to the next question, in fact?

A. Yes.

Q. Because of course the crimes of Harold Shipman were committed not in your jurisdiction but immediately adjacent to your jurisdiction?

A. Yes, yes.

Q. Did the Shipman crimes and subsequent Inquiry trigger any discussion or training provided to Coroners

including yourself in the North West?

A. Yes, a huge amount. It, it -- we all looked at our practices and it had a huge impact also on doctors, particularly lead general practitioners who started reporting absolutely everything and the -- it was what we described as "the Shipman effect". So it -- it didn't actually paralyze the service but it did lead to a whole lot of inappropriate referrals.

Q. Yes, but a greater awareness?

A. It created a huge awareness and, I mean, it sent a horrible shudder throughout -- well, through all the Coroners: could this occur in my jurisdiction?

Q. And in 2015, Victorino Chua was convicted of committing murders at Stepping Hill hospital?

A. Yes.

Q. Of course that would have fallen within Manchester South's jurisdiction. But again, do you recall any discussions in 2015 as part of the Manchester group relating to the crimes of Stepping Hill hospital at?

A. I am sure there will have been -- I cannot bring them to mind now.

Q. All this brings us to this: if your attention had been drawn to a cluster of unusual, unexpected, sudden, unexplained deaths with comments or concerns

about a single nurse being present for all of those deaths, or at crucial points during them, is it fair for the Chair to infer that if that had been drawn to your attention, it would have immediately triggered an alarm bell for you?

A. Yes, it would certainly trigger an alarm bell I'm not sure that I would discuss it with -- with colleagues on the basis that --

Q. No, no?

A. -- at that stage it would be tittle-tattle.

Q. Yes.

A. As opposed to something to be taken into account.

Q. I suppose the point I am making is that by the time we get to 2016/2017 --

A. Yes.

Q. -- there has been so much discussion arising out of Shipman, you have had incidents at Stepping Hill Hospital, you have had your own experience of a spike of deaths in a care home which you described --

A. Yes.

Q. -- all of that learning and information would have put you on heightened alert, wouldn't it, to information surrounding suspicions about a nurse being involved in deaths in a hospital?

A. Yes. Absolutely. Perhaps relevant to mention a murderous nurse in one of my hospitals, Leighton Hospital.

Q. Yes.

A. There are certain parallels in that case parallels, this nurse was -- it's not an appropriate word but euthanasing individuals in a way that was absolutely undetectable. She was choosing victims at the end of their life typically suffering from congestive cardiac failure which leads to a build-up of fluid on the lungs and the simple expedient that she was using was removing a pillow so that in effect the victim was dying almost drowning on their own fluid.

Absolutely no sign at postmortem. But a very terrible state of circumstances.

Q. How did that come to your attention?

A. I can't now remember. It was very early on --

Q. Yes.

A. -- fortunately and the nurse in question was arrested. It wasn't this sort of timescale.

Q. No, but given all of that experience --

A. Yes.

Q. -- one of the issues the Chair may have to determine is what information was provided to you about suspicions regard Lucy Letby?

A. Yes, yes.
Q. Would it not be fair to say that given your experience, given the general level of sensitivity towards crimes in hospital or Coroner sensitivity towards the possibility of crimes that if it was raised with you in any sort of explicit way, that you would have acted immediately upon it?
A. Yes, of course.
Q. Yes. Moving on to a slightly different topic.
You were asked a question by Ms Langdale about challenges sometimes in finding the cause of death in a neonate and it is correct the Inquiry has heard evidence from Dr McPartland that it can sometimes be challenging to identify a cause of death at postmortem?
A. Yes.
Q. That's because for a number of diseases that don't or processes that don't leave obvious marks on, to be visible at postmortem so --
A. I fear that that to some extent underlines the deficiencies in pathology.
Q. Yes.
A. You have a postmortem examination into -- with an elderly patient, you can find so much pathology you could write three or four death certificates.
Q. Yes.

A. The actual cause that's identified is the leader in the pack. But whether it actually is the cause of death is another question. With an infant, there's often so little to see that it, it is extraordinarily difficult to find a cause of death.
Q. But of course, if you have evidence from clinicians or accounts from clinicians, it is usually the clinical history that tells you what the cause of death was in those cases?
A. Yes, yes.
Q. So in other words, sepsis, which may not leave many marks --
A. Yes.
Q. -- on the body of a baby, there will be a history of sepsis --
A. Yes.
Q. -- and progression of that disease and likewise, you know, cardiac disorders, again bring about obvious symptoms in life in many cases that can be described by doctors in evidence?
A. When I first became a Coroner, it was the practice of some Coroners to give instructions that the pathologist was to be given no information whatsoever on the basis that the pathologist was to act as a totally independent expert and not in any way to be influenced

by the opinions of others.
That was absolutely crazy.
Q. Yes.
A. The pathologist cannot see an errant electrical activity within the heart that was -- that was observed in the hospital.
Q. Yes.
A. You -- you have to have as much information as possible. 99% of it may be irrelevant but the pathologist has to be engaged fully with all available evidence.
Q. If I come on to Child C whose Family I represent. Again, to be very clear, I am not asking you to comment on any judicial decision-making. I just want to understand what information was provided to you --
A. Yes.
Q. -- and in what format. You discuss the conclusions you reached with regard to cause of death at paragraph 52 of your witness statement. Effectively what you say is that it was communicated to you by Dr Kokai that there was a natural cause of death, ie hypoxic ischaemic to the heart caused by respiratory failure?
A. Yes.

Q. Lung dysfunction?
A. Yes.
Q. So the Inquiry has heard evidence to suggest that Dr Gibbs, who was the treating paediatrician for Child A, was concerned that the damage to Child C's heart occurred following his collapse; so in other words, he had a collapse and then lived for a period --
A. Right okay.
Q. -- on the edge of life --
A. Yes.
Q. Before passing away and that the damage to his heart was caused during that period?
A. Right okay.
Q. But wasn't the cause of his collapse?
A. Right.
Q. His evidence was that actually with regard to his respiratory function and heart function leading up to the collapse, that all seemed to be normal to him?
A. Okay.
Q. So he was -- he had discussions with Dr Kokai about Dr Kokai's finding and may or may not have expressed concerns to Dr Kokai, it would certainly be evidence of Mother C that she understood there to be concerns by Dr Gibbs regarding the cause of death?
A. Right.

Q. Was any of that debate communicated to you?
A. No. I can't remember having any discussion with Dr Kokai or anyone else at Alder Hey. It was a very comprehensive postmortem report that seemed to produce a very clear line of causation.
Q. Yes.
A. The appearance was of a completely natural cause of death.
Q. Yes, and of course any Coroner is reliant upon the medical expertise of the pathologist in providing their description of what the cause of death is based upon the postmortem findings, but it is ultimately the role of the Coroner is it not to determine the cause of death?
A. Absolutely, yes.
Q. In some cases a Coroner may disregard what a pathologist says because there is other evidence in conflict --
A. Absolutely. Every postmortem report is looked at extremely carefully, particularly with a paediatric postmortem, and yes, if there are any queries or any apparent anomalies, these are taken up and personally I always found Dr Kokai extremely approachable --
Q. Yes.
A. -- and more than happy to discuss matters and

explain findings.
Q. I want to be clear I am not impugning Dr Kokai's competence, but there is sometimes a difference in opinion between clinicians and pathologist as to cause of death?
A. Yes, yes, I would hope normally though that that would be made clear in a report.
Q. Yes. Indeed. And the usual way to determine that dispute, if it can be categorised as a dispute, is to have an Inquest and to hear evidence, isn't it?
A. Yes.
Q. So if there is a disagreement as to the cause of death?
A. Yes, if it -- if it is that stark.
Q. Yes.
A. And I would anticipate or expect you will have seen in the postmortem reports it's invariable the correlation between the antemortem details and the postmortem details, just to tie the two up and I would have expected something there.
Q. Indeed recognising as we you said before that the postmortem findings are contingent upon in many cases what happened in life --
A. Yes.
Q. -- when you come to that point?

A. Yes.
Q. But it would go, in Child C's case, to be important for an Inquest because it isn't a disagreement between two potential natural causes, it is a disagreement between a given natural cause or death being unascertained as a cause of death?
A. Yes, yes.
Q. That would be the reason to have an Inquest.
So that would have been relevant and important information to provide to the Coroner?
A. Yes.
Q. Yes. In relation to Child E, again you have been asked some questions, I hope not to repeat them but advice was given to the parents of Child E not to have a postmortem, or in other words that a postmortem wouldn't give any more information?
A. Right.
Q. Because the doctor concluded that the cause of death was Necrotising Enterocolitis?
A. Yes.
Q. Again, the evidence for that condition was somewhat fragile, it might be said?
A. Okay.
Q. The doctor who gave that advice has since said that actually I shouldn't have given that advice, there

wasn't enough evidence for Necrotising Enterocolitis?
A. Right, that is disturbing.
Q. Yes. Speaking as a Coroner, would you expect a clinician giving advice to parents about a postmortem to say a postmortem is going to be difficult and traumatic and it will be upsetting for you to have a postmortem, so even if there is a reason for it, we shouldn't have it?
A. What I -- well, that may or may not be the case. What I would expect was that the doctor reporting the death to make it clear that there were considerable doubts as to whether this was the correct --
Q. Yes?
A. -- diagnosis. In which case I would order a postmortem and obviously one tries to take into account the views of a family and before any postmortem the family will be consulted. Ultimately, it's for the Coroner to make the decision so it's not a question of this isn't a set of circumstances where one is contemplating in an absolutely stock natural cause death, discussing the possibility of a hospital postmortem.
This is the Coroner's case and it is the Coroner that will make the decision.
Q. So going to two key points. One is that the

Coroner is a person ultimately who make a decision about a postmortem?
A. Yes.
Q. Not the doctor or the parents. But secondly, Coroners shouldn't be misled by --
A. Oh, absolutely not. I mean, again the duty of candour, it's --
Q. Yes.
A. Am I right in recalling that it was Dr Napier that was the Assistant Coroner that dealt with -- I have got a feeling it was.
Q. It was the sitting Coroner.
A. On that particular day.
Q. I don't --
A. Right. I am almost certain it was.
Q. Yes.
A. And the advantage there would be that whereas most of my team were not medically qualified, Dr Napier is and was and -- a doctor second to none. And would have understood the nuances if full details were -- were given.
Q. But in Coroner's practice if you receive a telephone call from a treating clinician who says: I think it's Necrotising Enterocolitis, it would be a bold decision, wouldn't it, to disagree with that --

A. Oh absolutely, yes.
Q. -- conversation?
A. Oh, absolutely, yes, and I have to say that I think without exception in the case of the babies here, it was always a Consultant that made the report.
Q. Yes.
A. Which -- which is good practice. In the Coroners office we often are beset with difficulty because the -- it's the poor junior doctor that doesn't know a left leg from a right leg who's asked to report a death and trying to get something comprehensive before one gives up and says: I must speak to the Registrar ...
So to have a Consultant report a death, unusual, but one would expect a very much higher standard.
MR BAKER: Yes. Thank you, my Lady, I have no more questions.
LADY JUSTICE THIRLWALL: Thank you, Mr Baker. Ms Blackwell.

Questions by MS BLACKWELL

MS BLACKWELL: Mr Rheinberg, my name is Kate Blackwell and I ask questions on behalf of the former Executives of the Trust.
A. Yes, thank you.
Q. I don't have very many questions and they are based around the evidence that you have already given

today.
A. Okay.
Q. In terms of the meeting of 8 February 2017 --
A. Yes.
Q. -- you have told the Inquiry that you have no independent recollection of that meeting but you accept from the notes that were made that the meeting took place and that you were there?
A. Yes.
Q. Yes. And my note of one issue that was discussed during the course of that meeting, the note made by Stephen Cross --
A. Yes.
Q. Is that you are recorded as having said the Trust has done the right thing?
A. Yes.
Q. Now, in his meeting note of 15 February meeting, so the following week, there is another note made by him that echoes that note?
A. Okay.
Q. It says "absolutely right action by the Trust"
Those comments made by you about the Trust commissioning the RCPCH report and then later Dr Hawdon's report?
A. They may, may well have been.

Q. Thank you. During the course of that meeting, the second meeting on 15 February --
A. Yes.
Q. -- we know that you were provided with three documents?
A. Yes.
Q. The letter from the Consultants.
A. Yes.
Q. Dr Hawdon's report.
A. Yes.
Q. And the third document, which is headed "Observations Additional to the RCPCH Review" --
A. Yes.
Q. "... of Neonatal Services."
That includes the text that we have referred to --
A. Yes.
Q. -- as the green text?
A. Yes.
Q. You have said this morning, Mr Rheinberg, that you can't remember if that third document was discussed during the course of the meeting.
A. Yes. I think if it was, it would have been in my note.
Q. Well, we have looked at your notes --
A. Yes.

Q. -- and they are typed notes, aren't they?
A. Yes.
Q. Do we take it from that that they weren't being made contemporaneously during the course of the meeting but written up afterwards or typed up afterwards?
A. No. My writing is absolutely appalling. I take a contemporaneous note and then immediately afterwards, I type it up.
So, no. I do -- they are as near as can be properly described as a contemporaneous note.
Q. If you didn't look through that third document during the course of that meeting, would you have looked at it afterwards, perhaps in the course of typing up your notes?
A. I can't remember having done so.
Q. All right. Would it be unusual for you not to have read the full bundle of documents which you had been provided with?
A. I would hope so, but this particular time was horrendously hectic. I was seeking to hold as many Inquests as I could that on outstanding cases, handing over everything, preparing for retirement, going and doing the rounds of farewells, et cetera. So it, it was a busy time. I can't say one way or another.

Q. Should you have looked at it?
A. Yes, obviously.
Q. You have told the Inquiry this morning that the police, the hospital, clinicians, everybody, bear a responsibility for bringing any relevant information to your attention?
A. Yes.
Q. And only then does the system become fully effective?
A. Yes.
Q. We know that you were not provided with the full RCPCH report in January of 2017 and you were asked by Ms Langdale this morning what difference, if any, it would have made if you had been provided with the full report?
A. Yes.
Q. Including the green text?
A. Yes.
Q. Your answer to that was that: the redacted paragraphs clearly raised a matter that needed investigating.
A. Yes.
Q. Your response would have been to report the matter to the police?
A. Yes.

Q. You also went on in the latest session to tell the Inquiry that you were regarded as a bit of a pain because you would go to the police with any suggestion of criminality?
A. Yes.
Q. But you didn't go to the police when you were provided with that information during the course of the meeting on 15 February, did you?
A. Which suggests that I -- I hadn't seen it.
Q. You hadn't read it?
A. I hadn't read it.
Q. All right. In fact, you could have gone to the police without informing the Countess of Chester Hospital, couldn't you?
A. Of course, yes.
Q. Yes, because it's only a matter of courtesy, as you told the Inquiry --
A. Yes.
Q. -- that you would inform them if you had gone to the police.
You also told the Inquiry this morning that you had a conversation with your colleague Christine Hurst --
A. Yes.
Q. -- a Senior Coroner's officer, about the unexpected deaths at the hospital when you had had

reported to you the deaths of Child O and Child P. You told us this morning?
A. Yes.
Q. Was that the first such conversation that you had with Ms Hurst or any of your Coroner's officers?
A. No, no, it -- having three deaths quite close together in --
Q. In June of 2015.
A. -- 2015 we will, we will have discussed that as a team.
Q. What was the state of your professional curiosity back in June of 2015?
A. What was state of ...?
Q. What was the state of your professional curiosity in June of 2015? How professionally curious were you about the cluster of deaths then and what was being discussed?
A. Well, it, it was worrying. But -- well, there we are. It was worrying.
But as, as the results came, came out they all seemed to be explicable.
Q. There were no forensic postmortems in any of the neonatal deaths that were referred to you, were there?
A. Correct.

Q. As you have explained to the Inquiry, scrutiny and care is much greater with a forensic pathologist than with -- and during a forensic postmortem?

A. Right, okay. I may -- that's why I introduced the -- my mention of general postmortems.

Q. Yes.

A. A paediatric postmortem is absolutely meticulous; not in any way deficient or unsatisfactory when placed against a forensic postmortem. It's just a different focus.

So the paediatric pathologist will look with expertise with regard to paediatric mortality. The forensic pathologist will look for any evidence, signs of criminality and will involve the police to a vastly greater extent.

The postmortem typically will still be carried out by the paediatric pathologist with the forensic pathologist looking on. Typically it will be the paediatric pathologist who takes the lead in histopathological areas --

Q. Yes.

A. -- and in relation to all the other tests.

But, as I said, the focus of the forensic pathologist will be on the possibility of criminality. And what that adds to the investigation is partly the

forensic knowledge and what to look for --

Q. Yes.

A. -- but, secondly, the close communication with the police and the extra information obtained.

Q. So what you are describing in a forensic postmortem of a neonate or a child --

A. Yes.

Q. -- would be the presence of the neonatal pathologist?

A. Yes.

Q. The forensic pathologist and the police?

A. Yes, exactly. It's a collaborative process.

Q. Yes. Thank you. In terms of the deaths that were reported to you during the period relevant for this customer, there was only one. I am so sorry -- yes, there was only one Inquest held and that was in relation to Child A because there were three awaiting --

A. Yes.

Q. Child D, Child O and Child P?

A. Yes.

Q. But in fact those were adjourned once the police investigation was launched?

A. Yes, so I understand, yes.

Q. Yes. As a Coroner, the decision for you to order a postmortem is driven by the information provided

to you by the clinicians?

A. Yes.

Q. Yes, and one of the additional benefits of a forensic postmortem might be that samples would be retained. There might be a toxicological examination ordered and those additional aspects that wouldn't necessarily --

A. No, those are always standard with, with any --

Q. With any postmortem?

A. Within Alder Hey.

Q. Right.

A. I can't say for the rest of the country.

MS BLACKWELL: Yes. Thank you very much. That is all I ask, my Lady.

LADY JUSTICE THIRLWALL: Thank you very much, Ms Blackwell.

Mr Rheinberg, we are going to take a short break but I hope if we just take 15 minutes, then we can conclude. I have one or two questions for you but I want the shorthand writer to have a break and I want to check some references, so we will come back again at quarter past 1.

(1.01 pm)

(A short break)

(1.15 pm)

Questions by LADY JUSTICE THIRLWALL

LADY JUSTICE THIRLWALL: Now, Mr Rheinberg, I wanted just to ask you one or two questions about one or two of the documents.

A. Certainly.

LADY JUSTICE THIRLWALL: You will recall earlier in your evidence you were asked about the Inquest of Baby A.

A. Yes.

LADY JUSTICE THIRLWALL: And that in the early days, when you were first involved, this is well before the Inquest took place, documents were sent to you and then on -- and some of them on to the parents of Baby A. The first was the short report with Dr Brearey's signature --

A. Yes.

LADY JUSTICE THIRLWALL: -- on the bottom, do you remember.

A. Yes.

LADY JUSTICE THIRLWALL: The other document that you received, but it isn't clear to me that that was sent on was the Thematic Review. We have seen --

A. Right.

LADY JUSTICE THIRLWALL: -- various versions of the

Thematic Review but we know that you had one and we have looked at it earlier. Would you like to have a look at it just to --

A. No, I can remember. I cannot recall whether or not that was sent to the Family.

LADY JUSTICE THIRLWALL: Certainly the document that we have looked at sending the other letter --

A. Yes.

LADY JUSTICE THIRLWALL: -- doesn't include that report. Can you think of any reason why that report wasn't sent?

A. No. I -- I cannot recall the fact that it -- that anything was sent out. But so I am relying entirely on the -- the documentation that's been produced to me.

LADY JUSTICE THIRLWALL: Would there be a reason not to send it out --

A. Absolutely not.

LADY JUSTICE THIRLWALL: -- now that you have had a chance to see it?

A. No. We had a rule that everything would be sent out to a family if it was very sensitive information, such as a postmortem report, that might well be distressing, the instruction was that the report should be placed in a separate sealed envelope, clearly

marked with what it was, with the explanation given to the family that if they would prefer not to look at the document themselves, then they could send it or take it to their doctor or someone else to look at it on their behalf.

So there would never be a reason for withholding information but if it was sensitive it would be dealt with in that sort of way.

LADY JUSTICE THIRLWALL: But there would be a paper trail for that, wouldn't there, if it was dealt with like that.

A. Yes, I would hope so.

LADY JUSTICE THIRLWALL: Yes, we would expect that to have happened.

A. What was a little bit peculiar in the office at that time was that we were operating on two different computer systems, neither of which talked to the other in typical bureaucratic way.

So my office was working on one computer system, the officers were working on another.

LADY JUSTICE THIRLWALL: So does it follow from that that things got lost from time to time?

A. It was a possibility, yes.

LADY JUSTICE THIRLWALL: Do you think that might be a possibility here?

A. It is a possibility. But it's absolute speculation.

LADY JUSTICE THIRLWALL: But would you expect to have known what had been sent to the parents at the time, would that be on the file?

A. Yes, yes, I suppose so. The instruction would come from me and so I would give an instruction as to what was -- what was included. I had very good staff. They didn't often make mistakes.

LADY JUSTICE THIRLWALL: No and we have got the letter that was sent.

A. Yes, yes.

LADY JUSTICE THIRLWALL: Anyway. You presumably then thought nothing more about it --

A. No.

LADY JUSTICE THIRLWALL: -- at the Inquest.

Does it follow from that that the Thematic Review wasn't in front of you at the Inquest?

A. Almost certainly it wasn't. But again I can, I can recall in fairly shady terms the Inquest but as to what was before me, I -- I really can't say.

LADY JUSTICE THIRLWALL: And we have got the -- that you have been taken through.

A. I think the Inquest took place in a Magistrates Court in Chester, again --

LADY JUSTICE THIRLWALL: I don't think we need -- I don't think anything turns on where --

A. I am just trying to reassure myself --

LADY JUSTICE THIRLWALL: -- it took place.

A. -- I am recollecting everything correctly.

LADY JUSTICE THIRLWALL: Thinking of the right one. Yes.

Thank you.

You were asked some questions just now about the meeting of 8 February, where I think you have --

A. Yes.

LADY JUSTICE THIRLWALL: -- got at least a legible or nearly legible copy of what was said?

A. Yes, yes.

LADY JUSTICE THIRLWALL: It was put to you and you agreed that Mr Cross records you as saying that the Trust had done the right thing.

Can you remember anything about that?

A. Right, I -- sadly, I cannot remember the meeting at all. I certainly saw the note, the writing is very much better than my own. I had no reason to believe that Mr Cross wasn't accurately recording what was said.

LADY JUSTICE THIRLWALL: Recording.

A. It is just that I can't remember.

LADY JUSTICE THIRLWALL: No, all right. So I won't ask you what you meant by that. Then a few days after that, you had the meeting --

A. Yes.

LADY JUSTICE THIRLWALL: -- on 15 February. Now we are into 2017 by this stage.

A. Yes, yes.

LADY JUSTICE THIRLWALL: At that point, you have got a very detailed note.

A. Yes.

LADY JUSTICE THIRLWALL: You have explained how you kept your notes. I just wanted to refresh my memory because this is something that I may need to resolve in due course and this is the evidence from Mr Harvey --

A. Yes.

LADY JUSTICE THIRLWALL: -- who was being asked about the --

A. Yes.

LADY JUSTICE THIRLWALL: About the meeting itself. He was told that, it was put to him that:

"There's nothing that said that puts centre front, does it, that there are concerns and concerns of a nurse deliberately harming a baby?"

I should say that question was put on the basis of what your note said?

meeting was on the request that there should be a general inquiry/investigation carried out by the Coroners service.

That seemed to be the -- the theme throughout the meeting with me explaining that I couldn't, couldn't meet their requirements. So yes, I knew that the, at that stage, that the Consultants had concerns.

LADY JUSTICE THIRLWALL: What was the nature of their concerns?

A. I think just in general that some -- something wasn't going right or that they just wanted more information. I think -- I saw Alan Moore's statement, where he had said he wondered whether he had asked rather pointedly: why do you want this investigation? Is it a matter of reputational concern or whatever? By that I suppose he meant: was it a question of trying to deflect blame and find some other factor that could exonerate --

LADY JUSTICE THIRLWALL: Well, yes, he gave us his evidence and explained that wasn't what he meant but anyway --

A. But I can't remember that being said but it does rather fit in with my recollection, that just about everything that was discussed at that meeting related to the request that the Coroner's office should carry out

A. Right, yes.

LADY JUSTICE THIRLWALL: The response was:

"I recall that either Mr Cross or I in passing the paediatricians' letter across to Mr Rheinberg explained the background to that letter and the paediatricians' concerns."

He went on to say:

"I am also aware that there is documentation within the Inquiry that confirms that part of the bundle that Mr Rheinberg received was actually the full RCPCH report which included reference to the paediatricians' concerns."

So let's just unpick that a little bit. The last bit I think what's in the bundle in fact are those passages of the bundle of the RCPCH report that had been taken out and then reformatted and put into the bundle that you have; the redacted parts as we have been referring to them?

A. Yes.

LADY JUSTICE THIRLWALL: So we know that that document is in the bundle. What's your view about what's said there, that they explained the background to the letter and the paediatricians' concerns? Did they explain the paediatricians' concerns?

A. My recollection is that the focus of the

some form of investigation.

LADY JUSTICE THIRLWALL: Should I infer from that that there was no reference to the document that's headed additional observations?

A. No, no, I don't remember any actual reference to the documents. I -- I think I was handed a bundle, I seem to remember quite a thick bundle, but the -- the meeting then followed on to discuss that particular theme.

LADY JUSTICE THIRLWALL: Yes, thank you.

Those are all my questions, anybody want to ask anything else? No. Thank you very much indeed, Mr Rheinberg, you are free to go.

A. Yes, thank you, my Lady.

LADY JUSTICE THIRLWALL: You are free to go. Yes, absolutely, you are free to go?

A. Okay, thank you very much.

LADY JUSTICE THIRLWALL: So we will adjourn now and start again on.

MS LANGDALE: Tuesday at 10 am.

LADY JUSTICE THIRLWALL: -- Tuesday 10 o'clock. Thank you all very much.

(1.28 pm)

(The Inquiry adjourned until 10.00 am on Tuesday, 10 December 2024)

I N D E X