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Attendance Note

NLR and AGM attending meeting with Dr Harvey, Medical Director of the Countess of Chester Hospital and Stephen Cross from Legal Services - 15 February 2017

1. Letter of 15 February 2017 handed to me with enclosures.

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 comprehendible form to be delivered to the parents. We will be given a copy.

The clinicians from the neonatal unit have written to the Chief Executive and a copy of that letter is also enclosed. 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 within a particular further category (referring to deaths in custody, etc) or where the cause of death was unknown. It seems to NLR that in relation to the list of deaths in question they may fall into one of a number of categories as follows:-

1. Cases in respect of which an Inquest has already been held. If that is the case then the Coroner is functus officio.

2 Deaths which although reported were dealt with under a Part A with jurisdiction never formally taken. With no body within the jurisdiction, following a funeral, the Coroner could not hold an Inquest without permission from the Chief Coroner which could only be sought if there were proper grounds for doing so.

3. Deaths where a natural cause of death was shown following post mortem/investigation was discontinued. Should new facts emerge indicating an unnatural death then an Inquest will be listed.

4. Those deaths already listed for Inquest.

5. Deaths currently under investigation were either an unnatural cause is found, no cause is found or where there is an element of neglect.

   NLR made it clear that the Coroner's Office does not operate as a system of governance. That is not the purpose of an Inquest. An Inquest can only be held if there are proper legal grounds for doing so.

6. AGM asked what the clinicians hoped to achieve by seeking Inquests and wondered whether there were reputational motives there being no right of "appeal" from the Royal College's findings. This may well be the case although it was observed that no specific cause for the higher than expected deaths had been found and those shortcomings revealed by the report could more properly be categorised as systemic failures rather than failures by individual clinicians.