

- children. In respect of Child O, I see that Dr Kokai gave a partial cause of the death but withheld his opinion as to the underlying cause until he had undertaken histology (examination of small sections of tissue under the microscope). Referring to his initial report (INQ0002046_0059) I see that Dr Kokai gave the cause of death as 1(a) fresh bleeding into abdominal cavity due to 1(b) rupture of subcapsular haematoma due to be established by full histology.
73. So far as Child P is concerned Dr Kokai withheld his opinion as to the cause of death pending full histology and I refer to his report in this regard (INQ0002044_31).
74. Soon after the deaths of Children O and P had been reported to the coroner's office, I remember Christine Hurst coming over to my office to discuss the deaths. We were both concerned about the number of neonatal deaths that had occurred at the Countess of Chester Hospital in a comparatively short period of time and the deaths of the two triplets focused our concern. For my part I wondered whether there was some underlying problem with the standard and quality of care at the hospital although there had been no indication previously to show that this might be the case. I believe that it was around this time that we learned that the hospital had asked the Royal College of Paediatrics and Child Health to carry out a qualitative review and this was welcomed.
75. In view of the fact that Dr Kokai was unable to identify the underlying cause of Child O's death and had withheld his opinion as to the cause of Child P's death investigations into both deaths were opened by Alan Moore on 30th June 2016 the records of which appear at INQ0002046_0009 and INQ0002044_0011 respectively.
76. I see that I was anxious to receive the reports with a minimum of delay. I sent an email to Christin Hurst on 31st August 2016 (INQ0002046_0073) the main body of which reads as follows:
- "The infants died in June which in paediatric pathology terms is quite recent. However, this is such a tragedy that I would like swift progress made and please have Alder Hey contacted first of all for a progress report and secondly a date for the post mortem report if this is not expected imminently. Please then brief the parents".
77. Dr Kokai produced post mortem reports in respect of his examination of both children both reports being dated 10th October 2016. I refer to the report in respect of Child O (INQ0002046_0060 to 0069). Dr Kokai had now given his opinion as to the underlying cause of death which he ascribed to prematurity. On page 8 of his report (INQ0002046_0067) he wrote "Based on the above listed findings of thorough post mortem examination, detailed histological/microscopic investigations, I find it justifiable to conclude the Child O's death in (is?) due to Natural Causes and a consequence of intra-abdominal bleeding from ruptured subcapsular haematomata (=blood collections)

strange situation to have held an inquest into just one of the deaths of the two siblings. In the event the matter is academic since the investigations were subsequently adjourned without a date being fixed, at the request of the Crown Prosecution Service when Lucy Letby was charged with murder.

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84. I think that it was probably in late June 2016 with the deaths of Child O and Child P that I became concerned about the numbers of neonatal deaths at the Countess of Chester Hospital. Up until then I had considered the neonatal unit as a centre of excellence and was aware that as such they would deal with more difficult cases where the outcome might not be a happy one but nevertheless the numbers were worrying. I remember having conversations with Christine Hurst who was also concerned. I believe that it was around this time that I learned that the Countess of Chester Hospital had commissioned the Royal College of Paediatrics and Child Health to carry out a review. This was something of a comfort as I hoped that if there were deficiencies within the department, I anticipated that these would be revealed. I have to say that right up to the day of my retirement on 10th March 2017, I had not the slightest inkling or suspicion that anyone had deliberately harmed the children.
85. Had it not been for the fact that the Countess of Chester had commissioned a review by the Royal College, I believe that I would have sought a meeting with the Trust's Chief Executive. Around this time or possibly earlier, I had become concerned at the number of still births which were being reported to the Registrar of Births, Deaths and Marriages by doctors at Warrington Hospital. Although outside my remit (the coroner does not have jurisdictions to investigate still births), I asked the registrar who had originally raised the issue with me to keep me informed of still births being reported. I arranged to meet the trust's chief executive and doctors from the maternity unit, together possibly with the trust's medical director. Such a long time ago I cannot remember what procedures and strategies were put in place but I remember being satisfied that any problems were being addressed.
86. In this period 2015 / 2016 the duty of candour owed by medical professionals was very much a live matter. I had regular contact with the four major hospitals within my jurisdiction of Cheshire. Both Christine Hurst and I regularly attended the hospitals to teach young doctors the art of completing death certificates and reporting deaths to the coroner. I also gave regular talks and presentations to the hospitals where senior clinicians, junior doctors and nursing staff attended. I expected that a hospital trust that had concerns to contact me. For instance, again around this time, I had meetings with the newly appointed medical director of the Warrington and Halton Hospitals Trust. He