

[REDACTED]
Professor Fiona W Wilcox
HM Senior Coroner
For Coroner's Area of Inner West London
33 Tachbrook Street
London
SW1V 2JR

[REDACTED]

19 May 2026

Dear Coroner Wilcox,

In Re: Inquest touching the death of Baby O who died on 15 January 2024.

Regulation 28: Report to Prevent Future Deaths dated 25 March 2026

The NCA has received and carefully considered the above-mentioned report dated 25th March 2026. The NCA Legal Civil Litigation team is the NCA's nominated point of contact in relation to Inquests and Inquiries, as such we respond on behalf of the Agency.

This response is provided on behalf of the NCA pursuant to Regulation 28(3) of the Coroners (Investigations) Regulations 2013.

We write in relation to concern 6 of your report which is specifically addressed to the NCA namely:

Concern 6: That.....it may assist understanding if the NCA were to review case files nationally to establish whether in other cases of unexpected child deaths chlorpheniramine had been administered.

Whilst the NCA notes the importance of the Coroner's concern, the NCA does not hold responsibility for the conduct of national reviews into child deaths.

Op Marshall

The NCA, via the Forensic Medical Advice Team ("FMAT"), maintains the UK dataset of intrafamilial child deaths, known as "Op Marshall". This dataset supports police forces conducting investigations into child deaths nationally. The NCA role is to host and distribute the data. The NCA does not review or analyse the content of the same.

Following an intrafamilial child death occurring within its jurisdiction, the relevant Police force submits a report to FMAT. The report will include the cause of death, types of injuries sustained and any weapons used, suspect and victim details, risk factors

involved, lessons learned, experts used during the investigation and at trial and the outcome of the case at court. This information is inputted into the Op Marshall database.

At the request of an investigative police force, the Op Marshall database can be keyword searched for similar type cases involving child deaths. The results are compiled into an operational report which is forwarded to the requesting police force.

NPCC Homicide Working Group (Child Deaths Sub-Group)

The NCA respectfully submits that the responsibility for leading a review may more appropriately rest with the NPCC Homicide Working Group (Child Deaths Sub-Group). This group (led by [REDACTED] Nottinghamshire Police, for the NPCC) leads national guidance on child death investigations and is a multi-agency group which includes the NCA who, via FMAT, feed data from Op Marshall into the group. FMAT forwarded the Prevention of Death's report to the group's chair on the 21st April and if the Coroner wishes to make any enquiries of this group, it can be contacted at [REDACTED]

National Child Mortality Database (NCMD)

The National Child Mortality Database (NCMD) is a nationally mandated system hosted by the University of Bristol that collects and records data arising from the statutory child death review process. The statutory child death review process takes place for every child death occurring in England before a child's 18th birthday. The NCMD also regularly publishes national analysis on child deaths, and make recommendations to the UK government and other national organisations based upon the data collected. The NCMD works collaboratively with the HWG Child Deaths Sub-Group regarding any emerging matters of concern identified.

The NCA understands that the NCMD will endeavour to assist by conducting a search of NCMD held data to identify any records involving unexpected child deaths where chlorpheniramine has been administered, and can share any results in due course. As previously noted, however, the NCA understands that responsibility to conduct wider national reviews into child deaths may appropriately rest with the HWG Child Deaths Sub-Group, which may be more adequately resourced and have a higher capability to conduct such a review. If the Coroner wishes to raise any queries with the NCMD, [REDACTED] Deputy Director of NCMD at [REDACTED] will be able to assist.

Action by the NCA

In light of the Coroner's concern, FMAT will endeavour to assist the NPCC Homicide Working Group by conducting a keyword search of Op Marshall to identify any records involving unexpected child deaths where chlorpheniramine has been administered, and combine any relevant results into an operational report for the HWG.



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We hope that this clarifies the NCA's position.

Yours sincerely,

**Civil Litigation team
Legal Department
National Crime Agency**

Protecting the public from serious and organised crime

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