

PRIVATE EYE

SPECIAL REPORT PART 36



THE LESSONS OF THE LUCY LETBY CASE

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THE LUCY LETBY CASE: PARTS 36



Police challenge

IN THE Netflix documentary, *The Investigation of Lucy Letby*, released on 4 February, award-winning detective superintendent Paul Hughes of Cheshire Constabulary said “challenge is good” and invited scrutiny of police conduct.

Hughes got his wish on 26 March in an adjournment debate in the Commons. “The conduct of Cheshire police in the case of Lucy Letby” examined the neonatal nurse’s convictions for murder and attempted murder and was delivered



by David Davis MP. He told MPs that “I do not have time in this speech to list every egregious failure by Cheshire police” – but he gave it a good go.

Davis started by reminding the House it was Cheshire police that arrested and built the case in 1998 against solicitor Sally Clark for the murder of her two babies.

Clark was convicted in 1999 and sentenced to life imprisonment. The conviction was overturned by the appeal court in 2003 and recognised as a gross miscarriage of justice. Alas, the damage to Clark had been done and she died from alcohol poisoning four years later. “The destruction of an innocent person’s life was caused by the police, the prosecution, and the court swallowing the bogus statistical assertions by an alleged expert in her trial.”

Police whistleblowers

CHESHIRE police, Davis argued, should have been careful to “abide by all the rules and guidelines designed precisely to prevent further terrible miscarriages of justice”, but they were not.

Davis was aided in his analysis by the views of two senior police officers: Dr Steve Watts, a former assistant chief constable, who wrote national police guidelines on investigating deaths in healthcare settings; and former detective superintendent Stuart Clifton, the officer in charge of investigating nurse Beverley Allitt over the murders of four children in the early 1990s. Both concluded there were serious flaws in the police investigation, with failures to follow correct processes or explore alternative causes for the deaths and collapses.

To do so is not just a moral requirement, argued Dr Watts, but the law. Section 23(1)(a) of the Criminal Procedure and Investigations Act (CPIA) says investigators “should pursue all reasonable lines of inquiry, whether these point towards or away from the suspect”. So why was the decision taken not to treat the

doctors as suspects, or the other nurses, or the cleaners? Instead, consultants were allowed to mark their own homework and point the finger at Letby. The substandard care of sick babies in an overloaded and understaffed unit was always a more likely cause of harm. Why was this not fully explored?

CPS guidance

CROWN Prosecution Service (CPS) police guidance on investigating deaths in healthcare settings requires that decisions in “sensitive, serious and complex” cases are referred to its Serious Crime and Counter Terrorism Division (SCCTD). In addition, “homicide allegations involving 1. Four or more victims and 2. Medical authorities... should be passed on to the Special Crime Division”. Yet it was the regional CPS (Mersey-Cheshire) which made the charging decisions in the Letby case.

The SCCTD was finally involved when Cheshire police put 11 additional charges to it, based on similar cases, with one of the same experts helping the force (Dr Sandie Bohin). The SCCTD rejected all 11 because “the evidential test was not met” (Eye 1668). Might it have reached the same conclusion had it been consulted – as it should have been – on the initial charges?

NCA guidance

DR WATTS believes Cheshire police did not follow National Crime Agency guidance either: “On 26 May 2017, an email record indicates that the NCA...



advised [Cheshire police] to appoint a panel of relevant experts; they clearly defined the disciplines and provided a comprehensive list. They were: forensic & neonatal pathologists, forensic toxicologist and/or clinical pharmacologist, a nurse with experience of special baby units, a medical expert with experience of the working practices on a special unit for neonates, an obstetrician, and experts to review the medical statistics.” Cheshire police ignored it.

On 28 June 2017, NCA advisers followed up with a list of potential experts who could fill those roles. Cheshire police ignored this, too, and allowed a long-retired paediatrician who had never been a neonatologist to volunteer as lead expert.



Dr Dewi Evans took on the workload of what should have been an independent expert team. When Cheshire police asked Evans if it should follow NCA guidance and seek other expert witnesses, he said: “I do not think it’s necessary to consider additional expert opinion at this stage.”

Other experts were later called in to assess Evans’ reports, but not to examine all the evidence independently. As Clifton states, it was “completely illogical to allow other experts... to view the findings of Evans since experts are expected to give evidence of their expert findings and not be corrupted by others”. Watts states: “Evans was not independently selected but came forward himself... validators used to assess his opinions were themselves selected without adequate independence... by Evans himself”.

Evans was paid once by the police to hypothesise methods of murder on his own, and again by the CPS to offer an “independent” view of his own opinions in court.

Expert diligence

DAVIS told MPs that Cheshire police’s due diligence in the selection of experts “failed”. Evans not only lacked the requisite neonatal expertise, but Lord Justice Jackson had described his evidence in a previous case as “worthless”, stating he “makes no effort to provide a balanced opinion” and his “approach amounts to a breach of proper professional conduct”.

Insulin expert Professor Peter Hindmarsh had been dismissed from his post as an honorary consultant at Great Ormond Street before he gave evidence at the trial, yet the police only discovered this during the trial when he faced a GMC investigation for alleged failures of expertise and posing a risk to his patients. The jury was told none of this.

According to Davis, paediatrician Dr Bohin “faced numerous complaints from patient families and later was criticised for ignoring a key symptom in one of her patients”. Yet Cheshire police used her again in an (unsuccessful) attempt to have further cases prosecuted. The system for screening medical experts needs an overhaul.

Statistical ignorance

CRUCIAL to the case against Letby was the infamous shift table, presented as evidence that she was on duty for all the incidents when babies collapsed or died.

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Over 13 months, 17 deaths were associated with the unit. But the spreadsheet did not show all the deaths and collapses when Letby was not on duty – notably the avoidable death of a baby where doctors intubated the oesophagus and failed to spot their fatal error (*Eyes passim*).

Nor were deaths and collapses after Letby left the unit investigated by police, despite pleas from parents. Cheshire police did ask for the opinion of statistician Professor Jane Hutton in April 2018 to put a figure on the likelihood of a nurse being on duty “during all the deaths/collapses”. Hutton advised police that all possible causes needed to be fairly considered.

Cheshire police had signed a consultancy agreement with Prof Hutton, but police then told her the prosecutor had “instructed us not to pursue this avenue any further”. This contravenes the code for Crown prosecutors, which states: “Prosecutors cannot direct the police or other investigators.” Watts described this as “particularly egregious”; it is “not appropriate for the CPS to deter the police from acquiring evidence that may be relevant and available”. The CPIA “is binding upon the CPS to the same extent as the police; for the CPS to ‘instruct’ the

police to ignore potentially relevant evidence would clearly be a breach”.

Ask the chief constable

PROF HUTTON believes the statistical errors are “similar to those... in the Sally Clark case, but worse”. Davis has written to Mark Roberts, chief constable of Cheshire Constabulary, for clarification about how the shift spreadsheet was compiled and asking for “specific rebuttals” of points raised in parliament. Roberts refused to answer Davis’s questions and said he would “not be providing any further detail or engaging in ongoing correspondence”.

So much for welcoming challenge. Davis’ allegations are so serious that Cheshire police should refer itself to the Independent Office for Police Conduct.

What next?

THE Criminal Cases Review Commission (CCRC) is still sitting on myriad reports containing new evidence and argument that casts reasonable doubt on Letby’s convictions. Why the delay?

One clue may be the CCRC’s recent removal of its lead investigator from the Letby review, detective superintendent Shaun Edwards, after it emerged he had

praised Hughes for leading Operation Hummingbird at a 2024 awards ceremony and then on LinkedIn. “Very well deserved. National SIO of the Year detective superintendent Paul Hughes from Cheshire police... successfully led an extremely significant high profile complex investigation into the murders/ attempted murders carried out by Lucy Letby at the Countess of Chester Hospital.”

The CCRC removed Edwards “in the name of transparency”, adding: “Anything said in 2024 by DSI Edwards about a conference before he joined the CCRC has no bearing on our review.” But surely the CCRC knew Edwards’ publicly stated views before accepting him onto the Letby review? To remove him only because his words were reported by the *Sun* hardly screams due diligence or independence.



For justice to be done, the Court of Appeal must hear the evidence the jury never heard.

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