PRIVATE EYE

SPECIAL REPORT PART 5

THE LESSONS OF THE LUCY LETBY CASE

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ON THE THIRLWALL INQUIRY

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Lines of inquiry

THE UK's biggest growth industry – inquiries into health disasters – is back on track with the start of the Thirlwall Inquiry, which will spend millions figuring out how to stop NHS staff deliberately killing babies. This is alongside the multiple maternity inquiries (Morecambe Bay, Shrewsbury and Telford, East Kent, Nottingham etc) aimed at figuring out how to stop NHS staff accidentally killing a far larger number of babies and mothers.

Indeed, maternity services in England are now so inadequate that substandard care is becoming "normalised", according to the Care Quality Commission. This has a knock-on effect on neonatal services, which are also woefully understaffed. A new report from the University Hospitals of Derby and Burton NHS Foundation Trust found "care issues" that might have contributed to 150 neonatal deaths. The families of nine babies who died at University Hospitals Sussex NHS Foundation Trust over a three-year period have called for a public inquiry into the standard of its maternity care. As former health secretary Jeremy Hunt points out in his book *Zero*: "If the UK had the same stillbirth and neonatal mortality rates as Sweden, nearly 1,000 more babies would live every year."

Lack of awareness

LADY Justice Thirlwall started her inquiry into the Lucy Letby murders by criticising those who have passed judgement on the fairness of the original trial: "As far as I am aware, it has come entirely from people who were not at the trial." In fact Dr Michael Hall, who has led the charge on declaring the trial unfair (*Eyes passim*), attended throughout, in person or by video link, except for two or three half-days for which he read the transcripts of the hearings, and provided medical reports on all 17 babies who were the subjects of the trial. By contrast, Thirlwall wasn't at the trial, and nor were any of her appeal court colleagues who denied Letby an appeal.

Unheard evidence

THE problem is that the jury at the original trial heard only half the evidence. They didn't hear from any of Letby's nurse colleagues who think she is innocent but were deterred from giving evidence, nor from any experts for the defence who think the babies were sicker than portrayed and there were more plausible causes of death than murder. They didn't hear from Letby's counsellor, who encouraged her to write the Post-it notes the prosecution says were a confession. And they didn't hear from any representative of the Royal College of Paediatrics and Child Health (RCPCH), whose report exposed serious failings and showed the unit wasn't up to the task of coping with so many sick babies.

The jury didn't hear from the pathologists who didn't diagnose foul play in any of the postmortems undertaken. And they didn't hear from Dr Jane Hawdon, a consultant neonatologist at the Royal Free Hospital in London, who with a colleague reviewed 17 cases and found serious failings but no evidence of foul play.

There was no microbiologist to discuss the evidence of an infectious disease outbreak. There was no embolism expert to argue that the rashes observed were not indicative of embolism, which in any case can also occur naturally after high-pressure ventilation and resuscitation. And there was no statistical expert to argue that such variations in death rates can occur by chance, but if you want to try to attribute a cause you could link some deaths on the spreadsheet to a particular doctor on duty, or a lack of expert medical cover at night, as well as to a particular nurse.

The jury didn't hear about all the other deaths that occurred on the failing unit. They didn't know that the swipe card data was wrong and that Letby might not have been alone with babies when she was alleged to be. Nor did they hear about the third case of "definite insulin poisoning" which was shelved after the baby received a diagnosis of hyperinsulinism.

Stopping medical murder

CLEARLY the Countess of Chester neonatal unit, like many others, didn't need a murderer to account for its excess deaths, and Letby may yet get her time in the appeal court, but the inquiry's main purpose is to determine if the murders she has been convicted of should have been stopped sooner.

Richard Baker KC, acting for the families of some of the babies, told the inquiry that an audit carried out by Liverpool Women's Hospital (LWH) recorded that while Letby trained there 12 years ago, the dislodgement of endotracheal tubes on shifts she worked on was 40 times the average. His figures were promptly ridiculed by experts who have written to Thirlwall, and he must be made to account for them later, but his insinuation is that LWH harboured a trainee who was pulling out dozens of tubes while supposedly under supervision and yet passed her as competent. How? Parents will now be panicking, and lawyers will be only too ready to assist.

Blame ping pong

THE Countess of Chester managers, having been savaged in the press for not calling the police in earlier to investigate Letby, are now well lawyered-up. They point out that the RCPCH review team were told: "Letby was an enthusiastic, capable and committed nurse who had worked on the unit for four years. Her nursing colleagues were reported to think highly of her and there were apparently no issues of competency or training… According to the report, the consultants explained that their allegation was based on Letby being on shift on each occasion an infant died, combined with a 'gut feeling'; there was no other evidence to link Letby to the deaths."

A subsequent review of 17 cases by Dr Hawdon found "significant, suboptimal clinical care" in 14 cases, and that seemed a more plausible explanation than murder. The trust even hired a barrister to interview staff at the unit, and in April 2017 Simon Medland QC told the Countess of Chester board he could see "no evidence of a crime".

Notes of the trust's meeting with senior police quoted assistant chief constable Darren Martland saying: "There is nothing in the reviews, as a non-clinical expert, as to the direct allegation or suggestion of significant negligence or act that could constitute as a criminal act." Also, "there is no specific allegation at this point to suggest a criminal act. We do not have any reasonable grounds to suspect or believe this may have been the case."

Doctors in the dock

THE managers argue they were not informed about key incidents in the neonatal unit which might have raised the alarm sooner. Unexpected collapses of infants should have been reported on the incident reporting system Datix but were not, and individual case reviews were also not carried out. "The significance of not following established governance systems cannot be overstated… Objective abnormal clinical findings and near-miss incidents were not recorded or escalated."

Most concerning, the doctors who long suspected Letby of murder and allegedly called her "Nurse Death" had a statutory duty to contact the coroner after every unexpected death and voice their concerns of deliberate harm so that it was on record and a full forensic postmortem – including definitive insulin testing – could be done. The parents would have been informed at this early stage of what was happening, and why. Most crucially, it could have diagnosed or excluded murder much earlier. Why did this not happen?

CCTV

THE first and most obvious intervention after so many unexpected deaths would have been to declare to all the staff working on the unit: "We've had a series of unexplained clinical events, particularly at night, so we're going to install CCTV cameras to try to understand if there's anything we could improve on." This isn't foolproof, but it would allow real-time surveillance of individuals and provide important evidence of the performance of the whole team in spotting deteriorations or managing resuscitations. It might also catch a murderer in the act of harm. This was never done, despite clear concerns about Letby. She might have welcomed the scrutiny to help clear her name.

Nurses' questionnaire

PRIOR to the inquiry, a "rule 9 questionnaire for nurses" was sent out to all those on the 2015-16 staff list. MD has seen the responses of one of Letby's colleagues…

- **"How would you describe the relationship between medical professionals in the hospital in 2015-2016?"**

  "…my view of the trust and so-called medical 'professionals' is prejudiced by the horrendous way they treated Lucy."

- **"Did you have any concerns or suspicions about the conduct of Lucy Letby?"**

  "I had no concerns or suspicions about Lucy's conduct. She was an exemplary nurse who is completely innocent of all the alleged crimes."

- **"Were you aware of any suspicions or concerns of others about the conduct of Letby?"**

  "I do remember becoming aware that certain consultants… appeared to be trying to make Lucy a scapegoat for the increased number of deaths/collapses."

- **"Were you aware of, or worried about, the increase in the number of deaths on the NNU [neonatal unit]? If so, when was this and what did you think?"**

"Obviously, any death is a worry, but I did not think at the time, nor do I think now, that there was anything sinister about the increase in the number of deaths/collapses. I do not see how you can set a figure on how many deaths are acceptable in one particular time frame. The very reason these babies required admission to a NNU was because they had a high chance of dying or collapsing."

"Do you think if the babies had been monitored by CCTV the crimes of Letby could have been prevented?"

"Lucy did not commit any crimes. If there had been CCTV the footage would have proved her innocence."

Inquiry response

THE questionnaire was returned to the Thirlwall Inquiry on 9 April 2024. On 15 July the nurse received a disappointing email from the inquiry team: "We can confirm that you are NOT currently named on the list as an individual from whom the inquiry wishes to hear oral evidence…"

It's vital that the voices of all of those who worked most closely with Letby are heard at the inquiry, even if they contradict Thirlwall's preferred narrative. Perhaps the main reason Letby wasn't stopped earlier is that the nurses working alongside did not – and still do not – believe her to be guilty. Surely that needs to be heard and acknowledged?

The Evans factor

THE murder charges against Letby only stuck because everyone – consultants, police and jury – believed in the expertise of Dr Dewi Evans to confidently and definitively diagnose modes of murder where all other higher-ranking experts have failed. A key recommendation of the inquiry will surely be for trusts worried about neonatal murder in future to call in Dewi Evans Consulting Limited immediately. Had he been called in after the first death at Chester, Letby would presumably have been stopped in her tracks.

Dr Evans' testimony to the inquiry will be by far the most important, but he hasn't even been contacted. Why not? Meanwhile, MD has yet to find a single neonatology expert prepared to publicly support Dr Evans' modes of murder. Please contact the *Eye* if you are.

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