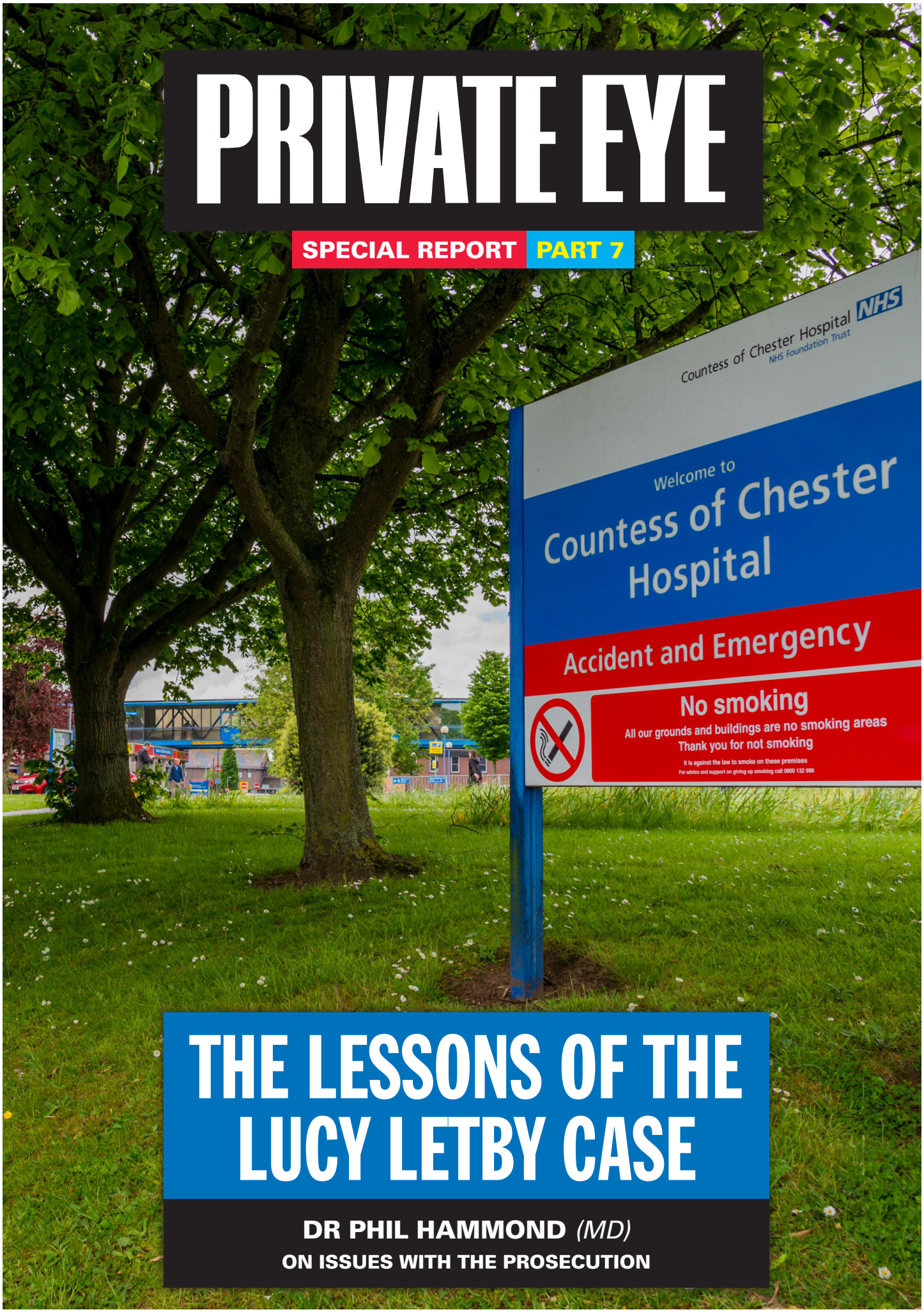

PRIVATE EYE

SPECIAL REPORT PART 7

THE LESSONS OF THE LUCY LETBY CASE

DR PHIL HAMMOND *(MD)*

ON ISSUES WITH THE PROSECUTION

THE LUCY LETBY CASE: PART 7

MD ON ISSUES WITH THE PROSECUTION

The story so far

AFTER 14 months of trying to figure out whether Lucy Letby did the things she has been convicted of doing, MD still doesn't know. There are no knockout blows. She wasn't caught in the act, she hasn't confessed and, most pertinently, the very people who most suspected her (seven consultant paediatricians) didn't do the right things to prove it.

They didn't spot the alleged insulin poisonings (even though a consultant clinical scientist phoned the ward nine minutes after analysing a grossly abnormal result to tell them what to do next). And they didn't tell the coroner they suspected deliberate harm after any of the unexpected deaths. As a result, definitive forensic tests for insulin poisoning and air embolism were never done, and cannot now be done. We will never have scientific proof of murder, and the arguments over Letby's innocence or guilt will continue.

The breathing tube argument

WHY did a consultant who caught Letby "virtually red handed" removing Baby K's breathing tube not do anything about if for a year? Could it be that it had taken a registrar three goes to get the tube in, it may not have been the right size and babies commonly dislodge their own tubes?

The insulin argument

FOUR experts in insulin testing have told the *Telegraph* (18 October) that the immunoassay insulin test used to "prove" two babies were deliberately injected is too prone to error and should *never* be used as the sole basis of a murder conviction. Letby wasn't even on duty for one poisoning, so the prosecution alleged she must have spiked many of the nutrition bags. But the level of insulin recorded in the babies was extraordinarily high, even after only part of a bag was infused. Letby would have needed to secretly inject much of the unit's insulin supply into the bags. No shortage was reported. The doctors at the time assumed the tests were false, the babies recovered and were diagnosed with neonatal hypoglycaemia. Moreover, a third baby with the same insulin picture survived and was transferred to Alder Hey, where he received a diagnosis of congenital hyperinsulinism rather than attempted murder.

The air embolism argument

THANKS to an email released by the Thirlwall Inquiry, we know the consultants suspected death by air embolism in 2016. So why not tell the coroner? Not only is it a professional and safeguarding duty, it also covers your backs and passes legal responsibility to the coroner to investigate.

Instead the consultants sent a begging letter to their chief executive Tony Chambers on 10 February 2017: "We are respectfully requesting you to urgently ask the coroner to undertake a full investigation of all the deaths and unexpected collapses that occurred on the neonatal unit between June 2015 and July 2016." This was far too late for the right tests to be done.

All seven babies who died are alleged to have had air injected into a vein. If enough is injected, it can coalesce into a frothy mass in the right side of the heart and blocks it off, or it can pass through a hole in the heart. The definitive methods of proving this are a CT scan of the baby post-mortem (far more accurate than x-rays), or opening the heart under water to observe air bubbles. Post-mortem neonatal CT scans are now routine in many centres, but they weren't in 2015-16. All the doctors had to do was request one to check for the air embolism they suspected. If they were that frightened of their chief executive, they didn't even have to mention murder, as air emboli can happen accidentally.

Alas, the doctors didn't do their duty and any chance of definitively proving and – just as important – disproving death by venous air embolism was lost. All the evidence we have is the clinical records, highly disputed skin rashes and a couple of ambiguous x-rays.

The air in the stomach argument

AIR forced down the nasogastric tube was initially alleged to be the cause of death of babies C, I and P. How it killed Baby C was explained by lead prosecution expert Dr Dewi Evans *(pictured)* in court in November 2022: "If you get a load of pressure in your abdomen, that diaphragm can't move and you then get the so-called splintage and you will soon suffocate, you won't be able to breathe and you can collapse pretty quickly. So therefore, his [Baby C's] collapse is consistent with a volume of air injected into his stomach, it splints the diaphragm, stops breathing, he's less than 800 grams, so that's what happens."

In August 2024, Evans withdrew his evidence on murder by splinting (see last *Eye*) in a signed statement to Channel 5 declaring: "None of the babies were killed as a direct result of the injection of air, or fluid and air deliberately injected into their stomachs." This matters because the theory of "death by splinting" played a big role in the trial, with 159 references of "splint" and "splinting", and detailed descriptions of how it kills, with support from other experts. Evans has now disowned it, leaving a great hole in the prosecution case. But at least we don't have to argue about splinting any more.

The statistical argument

THE absence of statistical analysis to inform the trial has greatly angered the Royal Statistical Society. However, it seems it was not the fault of Cheshire Police: the *Guardian* recently revealed that the force signed a consultancy agreement and agreed fees with Jane Hutton, a professor of statistics at the University of Warwick, to do a statistical analysis. Hutton sent them a lengthy email saying her expert report would need to analyse all the deaths at Chester, full staff rotas and deaths at other units. She then received an email stating: "We have had a further meeting this afternoon where we have informed the prosecutors that we were looking at the validity of statistical evidence again in the case. The prosecutor does not agree with our line of inquiry and has instructed us not to pursue this avenue, any further, at present."

Is the prosecutor allowed to direct the police in that way? Was the defence shown the entire email chain? It turned out to be a very sound move by the Crown Prosecution Service, as Prof Hutton has since turned into a very vocal critic of the way statistics were used in the trial. Her report would have been very unhelpful for the prosecution.

The backstairs argument

EQUALLY unhelpful to the safety of the conviction is the revelation in the same *Guardian* article that as well as a secure door between the labour ward and the neonatal unit, which left "swipe card" data for proof of entry (or it would have done, had the prosecution not got it the wrong way round – *Eyes passim*), there was another point of entry via backstairs that used a keypad but left no data trace, and that staff used it all the time and would often come and go even when not on duty.

A clever murderer could use the backstairs all the time, do all their murders off duty and evade the spreadsheet and swipe card data entirely. This makes the swipe card data and the "on duty killer spreadsheet" even more worthless. Did the police know about the unmonitored point of entry? Did they tell the defence? Did Letby know about the backstairs?

The Letby-is-strange argument

IN THE absence of solid evidence, the public inquiry has at times drifted into a live-stream of the *Daily Mail*. Letby was doubtless a bit unusual and at times inappropriate, as many NHS staff (including MD) are. Early in her career she, and a senior nurse, made an error in calculating a morphine dose (MD has done that once, too). Letby exchanged 1,300 Facebook messages with a paediatrician, but given he was much older and married with teenage children, one has to wonder who was manipulating whom.

Letby wrote notes on the advice of her counsellor that the jury accepted as confessions, and she kept handover sheets in her bedroom for the police to find. If she is a murderer, she's a very careless one. At the same time, she devised ingenious and undetectable ways of killing babies without ever being observed or leaving an internet trace. Eirian Powell, her neonatal ward manager, said it was very hard to do anything unobserved on a neonatal unit; she thought highly of Letby and never saw proof of harm. She felt a few consultants on the unit were "difficult to work with" and would blame nurses when things went wrong.

The unit only had 2-3 deaths a year, all explained, for the first 3.5 years Letby worked at the hospital. Why was she not killing then? Or was she never a killer?

The substandard care argument

BY FAR the most common cause of avoidable death on maternity and neonatal units across the

NHS is substandard care. As with many other units, the Countess of Chester hospital had all the ingredients for this, as outlined by a report from the Royal College of Paediatrics and Child Health (RCPCH), which found "significant gaps in medical and nursing rotas, with lack of compliance with standards in respect of staffing, insufficient consultant presence to safely cover the paediatric wards including the Neonatal Unit and insufficient junior and training doctors available, with too much cover from locums. Leadership was seen as remote from the unit with no specific children's champion on the board." So far, so NHS.

The possibility that substandard care could account for some of the deaths was crystallised when the managers invited a senior neonatologist, Jane Hawdon, to undertake an "advisory medical report" in October 2016, after the RCPCH visit. Her report on 17 babies found a number of deaths that could have been prevented with different care, and identified major or significant suboptimal clinical care in 14 of the 17 cases. She said further forensic investigation was needed to identify the cause of four deaths, which was done by experienced Alder Hey pathologist Dr Jo McPartland. She could not deduce murder either (see last *Eye*).

The report was pivotal to Letby's defence, as it demonstrated the likelihood of suboptimal care as a cause for the collapses and failed resuscitations of at least some of the babies, from a neonatal source far more senior than the prosecution's. So why does Hawdon not get a single mention in the entire court transcript?

Alas, it was excluded from the evidence because Letby was only charged on nine of the 17 troubling cases Hawdon identified, so it was deemed irrelevant. In fact, that makes it highly relevant, because it shows babies deteriorated unexpectedly in the absence of Letby, with substandard care a likely causal factor. It also highlights what a statistical miracle it was that when prosecution expert Dr Evans screened the notes "blind", all his suspicious cases turned out to involve Letby, but when Hawdon did it "eyes open", eight of them didn't. Why not?

Fourteen months later

DR EVANS has told the *Guardian* he has completed his final report on how Baby C died, just 14 months after Letby was convicted of killing him. It seems an odd way to conduct a criminal trial, but there are plenty of things in this case that don't stack up. Evans has revised his view multiple times in this case, but he won't be publishing his findings as he also told the *Guardian* that Cheshire Police has told him not to discuss Baby C in the press any more. (It probably didn't want him to tell the *Guardian* that either.) At the very least, he must share his report with Baby C's parents and legal team, who must be very angry and utterly bewildered.

CCRC application

LETBY's last chance of an appeal, which MD supports, is the Criminal Cases Review Commission application. The CCRC needs to consider whether there were procedural errors in the original trial (failure to disclose the Hutton emails; failure to allow the Hawdon report; failure to redact staff names and initials from the clinical records before handing them to Dewi Evans to screen "blind"). Does Evans' withdrawal of "air down the ng [nasogastric] tube" as a mode of murder invalidate some convictions? (Prosecution barrister Nicholas Johnson specifically told the jury Letby killed Baby C using air down the feeding tube based on Evans' testimony). There has never been robust scientific proof of deliberate harm. Neonatologists far more expert and current than the prosecution employed are now meticulously analysing the clinical records. They will likely argue that – far from being unexplained – many (and perhaps all) the collapses can be explained by sick babies receiving substandard care. Some babies might still be alive and thriving with better medical care. If the CCRC accepts this line of argument, Letby's absence or presence becomes an irrelevance.

Ask the other experts

MD still can't find a neonatal expert, forensic pathologist, clinical scientist or radiologist prepared to privately or publicly support the diagnoses of murder and attempted murder. On 14 October, MD emailed Evans's fellow expert witnesses – paediatrician Dr Sandie Bohin, radiologist Prof Owen Arthurs and pathologist Dr Andreas Marnerides – asking if they too are following Evans' lead in disowning the death of three of the babies by air forced down the nasogastric tube.

Thus far, none has answered. Meanwhile, the parents of the babies who died or were harmed at the hospital are waking up to the possibility that some babies might have died from clinical negligence rather than deliberate harm. How unlucky is that, unless you're a lawyer?

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