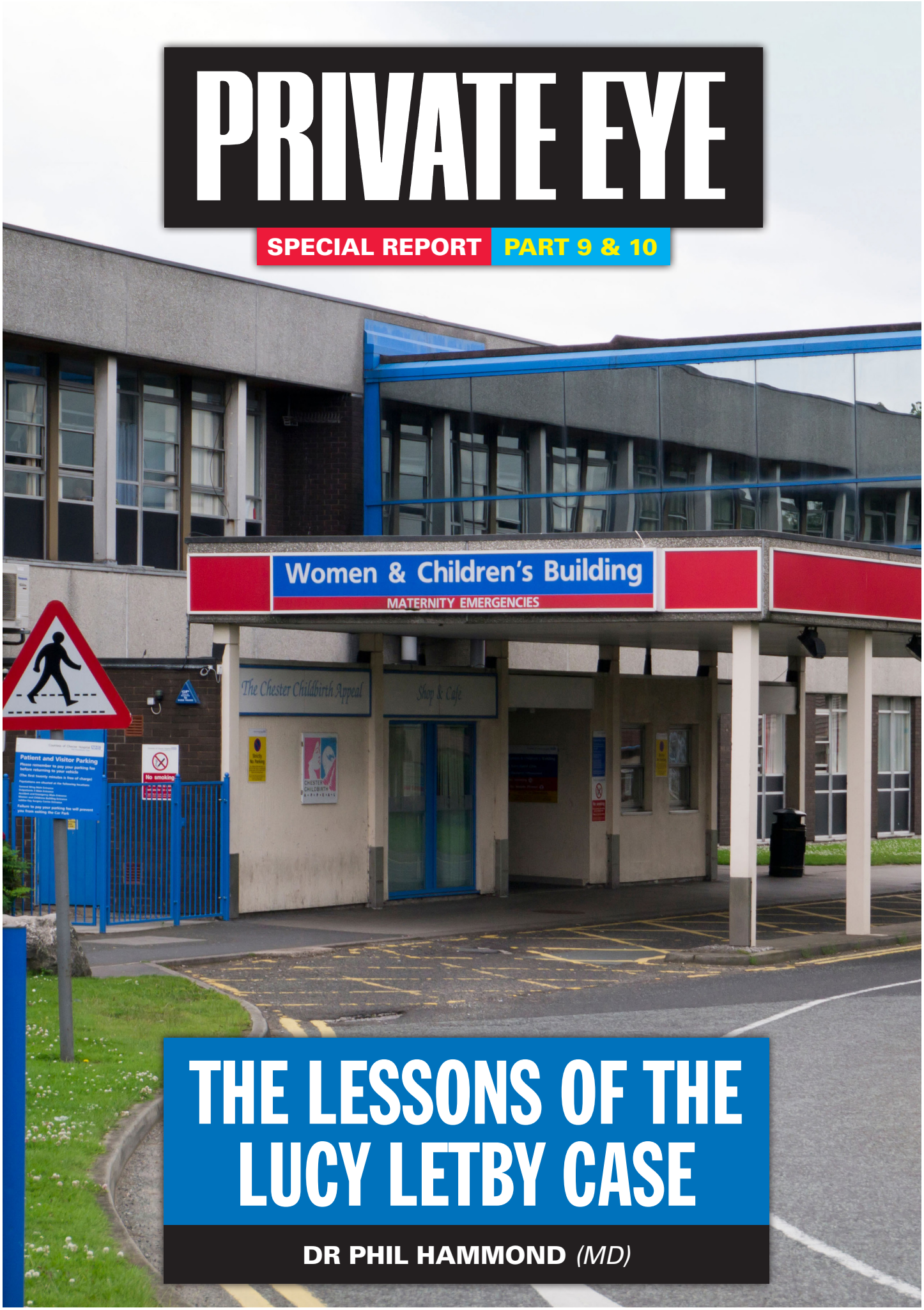
PRIVATE EYE

SPECIAL REPORT PART 9 & 10



THE LESSONS OF THE LUCY LETBY CASE

DR PHIL HAMMOND *(MD)*

THE LUCY LETBY CASE: PART 9 & 10

PART 9

CHESTER paediatrician Dr Ravi Jayaram – one of Lucy Letby's main accusers – has given evidence to the Thirlwall inquiry and apologised profusely for not acting sooner to stop the paediatric nurse from murdering babies.

Dr Jayaram should have called the police in earlier, but he had no objective evidence. Indeed, when the police were finally summoned, they had no objective evidence either. It was only when expert witness Dr Dewi Evans (*pictured*)arrived and was able to confidently conclude from the notes not just that murder and attempted murder had occurred, but how, that the case took off. Evans changed his mind on many occasions during the trial, and abandoned one method of murder post-trial. But his belief that he is right has never waned.

Last year, MD emailed Dr Jayaram to explore whether there might be more plausible alternatives to the deaths on his neonatal unit to murder. He acknowledged the unit was short staffed, had only two scheduled consultant ward rounds a week and was an infection risk due to cramped conditions and sewerage leak problems. However, he concluded, in bold: **"Even if the unit had the worst staff and provided the worst care in the history of neonatology, none of this could explain the events that happened in terms of sudden deterioration and lack of response to appropriate timely interventions."**

The obvious flaw in Dr Jayaram's reasoning is that a unit so short of experienced doctors and nurses is much less likely to provide "appropriate timely interventions". Highly experienced, practising level 3 neonatologists are reviewing the notes, in meticulous detail and pro bono, for Letby's Criminal Cases Review Commission appeal and may find collapses and deaths that are entirely explained by medical interventions that were neither timely nor appropriate and had nothing to do with Letby. Then it becomes a question of whether the CCRC believes Letby was killing under cover of a substandard unit, or whether the substandard care of critically ill babies alone could account for their collapses and deaths.

Alternatively, Letby's barrister Mark McDonald could go directly to the appeal court and argue the conviction over Baby C used radiograph evidence taken on a day when Letby was not on duty, and that after the trial lead prosecution expert Dr Dewi Evans retracted his opinion that injecting air into the stomach was the cause of death. However, the jury were told it was the cause and convicted her on that basis (*Eyes passim*).

PART 10

Second opinions

MD HAS seen a joint case report by two experienced, practising level 3 neonatologists on Baby O, one of the babies neonatal nurse Lucy Letby was convicted of murdering. The specialists looked at the notes in isolation and wrote individual reports before working together on a joint report, and it is obvious how much time, effort and detailed analysis went into it. The report gives a clear explanation as to how and why the baby died, and the missed opportunities there were to save the baby's life. Most pertinently, according to these experts, the death has absolutely nothing to do with Lucy Letby.

Intubation difficulties

IN 2015, an inquest into the death of baby Noah Robinson found Countess of Chester doctors had wrongly intubated the oesophagus, twice, and clear signs it was misplaced were ignored (*Eyes passim*). Dr Tariq Ali, a consultant neonatal and paediatric anaesthetist, reviewed the court transcripts from Letby's first trial and spotted a pattern of intubation failures with babies C, G, K and N.

Dr Ali notes multiple failed and repeated intubations documented for these babies with concerns that they were not adequately oxygenated in between the failed attempts, as evidenced by repeated oxygen desaturation readings and signs of oxygen deprivation at some of the post-mortem examinations.

Dr Ali is incredulous that Letby was found guilty of deliberately dislodging Baby K's tube (and that anyone could think accidental dislodgement couldn't happen in a child that small) and traumatising the throat of Baby N when, in Ali's view, both could be more rationally explained by intubation difficulties.

Frail babies

AS FOR baby N, Dr Ali states: "In my opinion, the blood in the airway obviously came from the first attempt at intubation. I know this because I have intubated hundreds of babies. I have also taught hundreds of doctors how to do this. Sadly, despite the greatest care I have caused bleeding many times with my laryngoscope. I have also caused bleeding by trying to introduce an endotracheal tube."

Dr Ali went on: "The doctor tried three times to intubate, in a stressful emergency situation, at 08:00 and failed. This baby had haemophilia – the smallest injury will make it likely to bleed, even if the haemophilia is mild. When did any of the expert witnesses in this trial last intubate a neonate? How many have they intubated in the past 10 years? I can tell you that bleeding associated with introduction of the laryngoscope is not rare. Particularly in a haemophiliac child in an emergency […] Professor Sally Kinsey [a professor of haematology] 'rules out heavy-handed intubation as a potential accidental cause' of bleeding. I am at a loss [to] understand how she can make this statement."

Dr Ali believes the collapses and deaths of these babies could be more plausibly explained without recourse to murder. And he adds that statements from Kinsey, retired paediatrician and lead prosecution expert Dewi Evans, and consultant paediatrician and independent witness Sandie Bohin "directly contradict my own experience as a neonatal and paediatric anaesthetist and a paediatric intensive care specialist".

This report originally featured in Private Eye issues 1637 and 1638.

To read parts 1-8 please visit www.private-eye.co.uk/specialreports