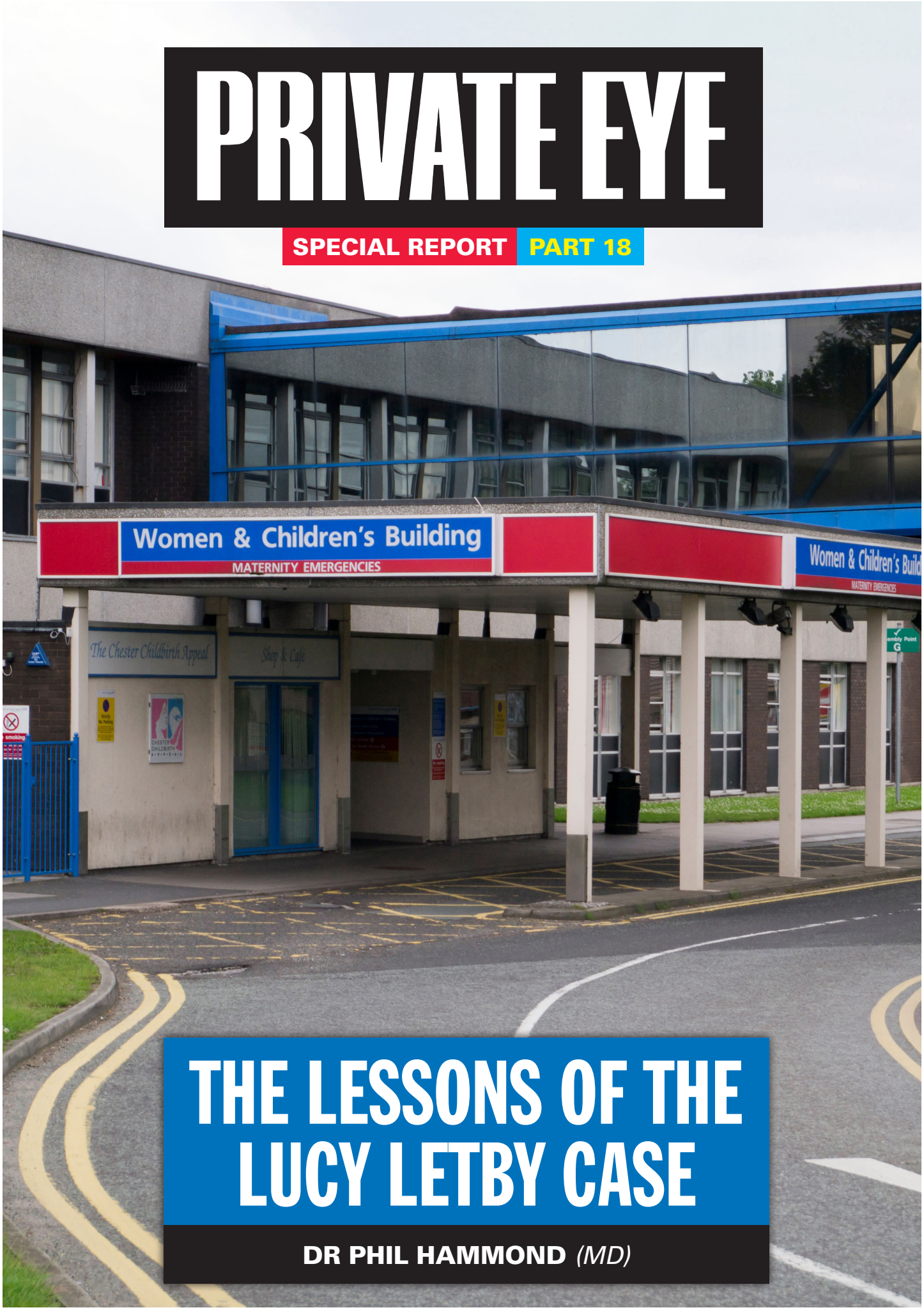
PRIVATE EYE

SPECIAL REPORT PART 18



THE LESSONS OF THE LUCY LETBY CASE

DR PHIL HAMMOND *(MD)*

THE LUCY LETBY CASE: PART 18

Thirlwall marches on

FORMER supreme court judge Jonathan Sumption believes Lucy Letby is "probably innocent" and deserves an appeal, he told the *Sunday Times* last weekend. But Lady Justice Thirlwall is writing her report now into what happened at the Countess of Chester hospital, dismissing legal arguments that if Letby turns out *not* to be a murderer, her inquiry's recommendations to stop future NHS murderers might completely miss the point (that an innocent nurse was blamed for dangerously substandard NHS care).

Thirlwall's challenge is to deduce recommendations that make NHS maternity and neonatal care safer for the most vulnerable babies, irrespective of whether Letby's verdict is later overturned on appeal (which would require a further inquiry to determine how the legal process got it so wrong).

Lawyers acting for a group of bereaved parents have written to Thirlwall arguing that the international experts supporting Letby have made serious errors in their press-conferenced summary reports. The lawyers have been offered the full expert reports but have so far declined. Seven of the experts have said publicly they would give evidence under oath, if asked, and have stated they were "struck by the lack of expertise" of the witnesses at Letby's original trial.

Doctors in the dock

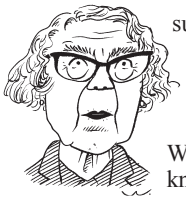
THIRLWALL's overriding conclusion is obvious: if you truly suspect one of your work colleagues is murdering babies, you must tell the police immediately. The safeguarding duty of saving babies' lives trumps everything, including pissing off your managers. Thirlwall's report will centre on the delay in reporting such serious allegations. The police will then decide whether failure to act, or act sooner, by any individuals might constitute gross negligence manslaughter alongside the threatened corporate manslaughter charge against the hospital.

The insulin hinge

PROSECUTION experts at the Letby trial stated under oath that the **only** explanation for the blood results for Babies F and L was that they had been given exogenous insulin. Defence experts argue that this was a clear and serious factual error and there are alternative, plausible explanations, because the immunoassay test used is notoriously prone to interference. We now know that the Liverpool lab where it was processed was also experiencing severe calibration errors, grossly overmeasuring insulin and undermeasuring C peptide (UnHerd, 29 March). However, the jurors were told by judge Mr Justice Gross: "There is no reason to doubt the reliability of the tests." There certainly is now, and this alone should warrant an appeal.

What next?

THIRLWALL may recommend a whistleblower hotline for all hospitals but must be wary that feuding staff could use false accusations to settle scores. She may suggest CCTV cameras in all neonatal units, or even throughout hospitals, which might have the added advantage of spotting assaults on staff and providing evidence for both sides in negligence cases. But it would be expensive and legally complex to implement, monitor and store highly confidential CCTV footage: patients might not consent; trade unions might object; and the NHS is already driven by fear. A surveillance culture would make it an even less attractive place to work.



An alternative might be covert surveillance of the member of staff under suspicion, but on a neonatal unit that means using babies as bait and getting parental consent: "We think your baby's nurse might be a murderer. We're secretly filming her, but let us know if you spot anything suspicious."

Cameras in cupboards might spot staff spiking feed bags with insulin; and insulin may become a controlled drug, kept under lock and key with strict monitoring and mandatory reporting to the police of any test results suggesting poisoning. Perhaps every neonate with documented hypoglycaemia will have a blood test sent to a specialist laboratory in Guildford for the definitive exogenous insulin test. But this would be prohibitively expensive, and the tests take time.

CT scans could be done at all post-mortem examinations to pick up air emboli. Large amounts of gut gas on a baby's x-ray could have deliberate injection ruled out. There would likely be an increase in false accusations – but then Letby was suspected of deliberate harm at times when she wasn't even on duty.

The bigger picture

MEDICAL murders are very rare; death by substandard care is much more common. In trying to make the former even less likely, Thirlwall must not increase the chances of the latter (by putting nurses off a neonatal career, say). Imposing oppressive and expensive murder safeguards on a cash-strapped service where too many staff are angry and overworked could do more harm than good. Thirlwall has heard ample evidence that Letby's unit was dangerously short-staffed and accepting babies beyond its competence. Addressing these issues would improve outcomes across the NHS.

Another key point from this and every other NHS disaster is that a hospital must not be left to investigate its own serious failures. The temptation to protect reputations, cover up and avoid litigation is too great; but the royal colleges and Care Quality Commission aren't currently up to the task of a thorough, independent safety investigation. So who might be?

MD's recommendations

IN THE 25 years since the Bristol Inquiry promised to protect babies from avoidable harm, and all the maternity inquiries since, it is clear what Thirlwall needs to recommend and health secretary Wes Streeting needs to do…

- There should be a single, trusted, properly resourced and powerful healthcare investigation organisation, independent of the NHS but present in every region, continuously monitoring data and serious safety concerns, investigating promptly and publishing findings in full. This would also weed out vexatious and erroneous complaints.
- This "go to" patient safety body could be funded by merging the current mess of safety organisations and stopping routine inspections by the CQC, which are expensive, time-consuming and of doubtful value. Instead, resources would be focused on safety investigation experts working in regional health investigation teams (HITs).
- The duty of candour for NHS staff must extend beyond reporting concerns in their own institution. Every serious staff, patient or relative concern or incident must be copied to the regional HIT, with an audit trail of the issues raised and action taken.
- Patients and relatives would have full access to HIT reports, whose findings would be discussed with them, along with changes to be made to prevent future recurrences. This reduces litigation markedly.
- If patients still wish to litigate, or police wish to investigate, HIT reports would be available as expert evidence, and those who compiled them as witnesses. The police habit of hand-picking long-retired medical experts to analyse dozens of complex cases alone must end. Proper safety investigation is a complex team effort.

The abolition of NHS England will now put huge power in the hands of the health secretary, so it is more important than ever to have an independent health investigation body to hold government and health services to account, and prevent cover-ups and the suppression of bad news (particularly in the run-up to elections).

Most avoidable harm in healthcare, from cradle to grave, is down to providers not having enough staff or expertise to cope safely with the complexity and volume of the workload. The government must therefore commit to mandatory safe staffing and skill-mix levels and a safe working environment, starting in maternity and neonatal care. If we had these, hundreds more babies and dozens more mothers would live each year, and the government would save a fortune on investigations, inquiries and litigation. Over to Thirlwall…

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