PRIVATE EYE

SPECIAL REPORT PART 24

THE LESSONS OF THE LUCY LETBY CASE

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THE LUCY LETBY CASE: PART 24

MD ON THE DEATH OF 'BABY O'

Arrested development

CHESHIRE police have arrested and bailed three former senior managers at the Countess of Chester hospital (CoCH). Any manslaughter charges could relate to not stopping the convicted baby killer Lucy Letby sooner, or not downgrading the struggling neonatal unit sooner, which, had it been in Canada, "it would have been shut down", according to defence expert Dr Shoo Lee. Letby may face further charges too. But what about the doctors?

Wilful blindness

IN DECEMBER 2024, it was alleged at a press conference organised by Lucy Letby's barrister Mark McDonald that Baby O had died avoidably as a result of serious clinical errors. This was based on a detailed report by neonatologists Dr Neil Aiton and Dr Svilena Dimitrova, whose expertise is in complex "Level 3" neonatology. McDonald offered to share the report with parents and the police to determine whether gross negligence manslaughter had occurred. Six months on, the police have not investigated. Why not?

The parents' view

BABY O was one of triplets born prematurely by Caesarean section at the CoCH, though their mother had been booked into Liverpool Women's hospital. Their father told the Thirlwall Inquiry: "The state of the theatres looked like something out of a horror film. It was very cold and unhygienic."

Their mother said that when one of the babies collapsed: "We were confronted by a scene of complete chaos." When a second triplet collapsed: "I was confronted with the same chaos as the day before." Her husband observed it was "absolute pandemonium… I saw a nurse Googling a procedure, a lung drain. There was an image of a person with an arrow where the incision should be… I remember other staff coming over to the computer to have a look… It looked like they were following a tutorial rather than they actually knew what they were doing." Two of the triplets, O and P, died.

The hospital's view

A ROOT cause analysis (RCA) by the Chester hospital of Baby O's death was released at the Thirlwall Inquiry. It determined that a subcapsular haematoma of the liver – which can occur naturally in premature babies – had ruptured. There had also been "significant suboptimal care that may have been relevant to the outcome, failures in care to recognise problems and failure to act appropriately".

There was no use of vasopressor drugs, which increase blood pressure, and no changes to airway support or ventilator settings. The paediatric medical team omitted to keep contemporaneous records or, in some instances, any documentation at all. There was no record of a consultant being present to help intubation; and the on-call team was not in the neonatal unit despite Baby O needing intensive care. This led to a delay in starting the care required when the infant began to deteriorate. It was not until 39 minutes after a crash call for help that a consultant arrived, despite it being daytime when they should have been in the unit within five minutes.

Meanwhile, with Baby O receiving a significant step up to intensive care provision, the hospital registrar left a ward "to attend to clinical commitments elsewhere, resulting in a delay in attendance at [the] sudden unexpected collapse." This was clearly a medico-legal nightmare.

The prosecution's view

WITHIN ten minutes of seeing photographs of Baby O's ruptured subcapsular haematoma, lead prosecution expert Dr Dewi Evans was certain this was inflicted harm, even though no one had observed this. At Letby's trial, it was pointed out that one of the consultants, Dr Stephen Brearey, had put a needle into the right side of the abdomen and drawn back blood. Prosecution pathologist Dr Andreas Marnerides conceded that the needle could have gone into the liver, and this could have caused a haemorrhage, but he felt trauma a more likely cause. Letby was duly convicted of murder by causing trauma to Baby O's liver and injecting air into a vein, which was also never observed and has no forensic proof. Evans, who had not resuscitated a neonate for years, said the resuscitation skills of the doctors were of a high standard.

The defence experts' view

DOCTORS Aiton and Dimitrova examined Baby O's records in detail and found no evidence Letby was doing anything other than providing a good standard of nursing care. They concluded Baby O died avoidably, for the following reasons:

- Excessive lung ventilation pressures were used, meaning the heart couldn't function properly, leading to the baby's progressive deterioration.
- An X-ray clearly shows the liver was pushed downwards by the excessive pressures, to the anatomical location where Dr Brearey is documented to have inserted the needle.
- The resuscitation sheet details a stable haemoglobin level of 197.9 g/L at 13.20.
- At 17.25, it was recorded that Dr Brearey put a "cannula in abdomen" which was on the right side and drew back blood.
- At 17.43, the haemoglobin had fallen by more than half to 86 g/L.

Drs Aiton and Dimitrova reported that the sudden drop in haemoglobin was most likely caused by Dr Brearey accidentally puncturing the outer layer of the liver (the liver capsule). This had been holding back the pocket of blood in the haematoma. Once the layer was punctured, the bleeding from the liver remained unopposed and continued freely into the abdomen. This likely caused a major internal bleed that was never recognised or corrected.

If the harmfully high ventilation pressures had been reduced and the acute bleed had been recognised and corrected, Aiton and Dimitrova believe Baby O would have recovered. They attribute the cause of death to clinical failures in resuscitation, very similar to the hospital's initial but more guarded assessment, but completely at odds with the trial findings.

The legal authorities

THE Criminal Cases Review Commission (CCRC) and court of appeal (CoA) could argue – for years – that the needle in the liver was discussed at trial and so isn't new evidence. After the needle was put in, the next haemoglobin measurement shows a life-threatening fall, and Dimitrova believes the significance of this wasn't spotted by the doctors at the time, as demonstrated by the fact that resuscitation was discontinued without a blood transfusion. She also argues that, even without the bleed, the baby may have died because of the excessive ventilation pressures.

This information has been passed by Dr Dimitrova to Cheshire police, the Cheshire coroner and the General Medical Council. Whether they will take action is unclear, but Dimitrova has fulfilled her duty as a doctor to report what she believes was grossly negligent care. Neither the needle in the abdomen nor the excessive ventilation pressure was reported to the coroner at the time. In one document submitted to the Thirlwall Inquiry, Brearey states he "wasn't directly involved in the triplets' deaths". MD approached the CoCH and Dr Brearey for comment and they declined.

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