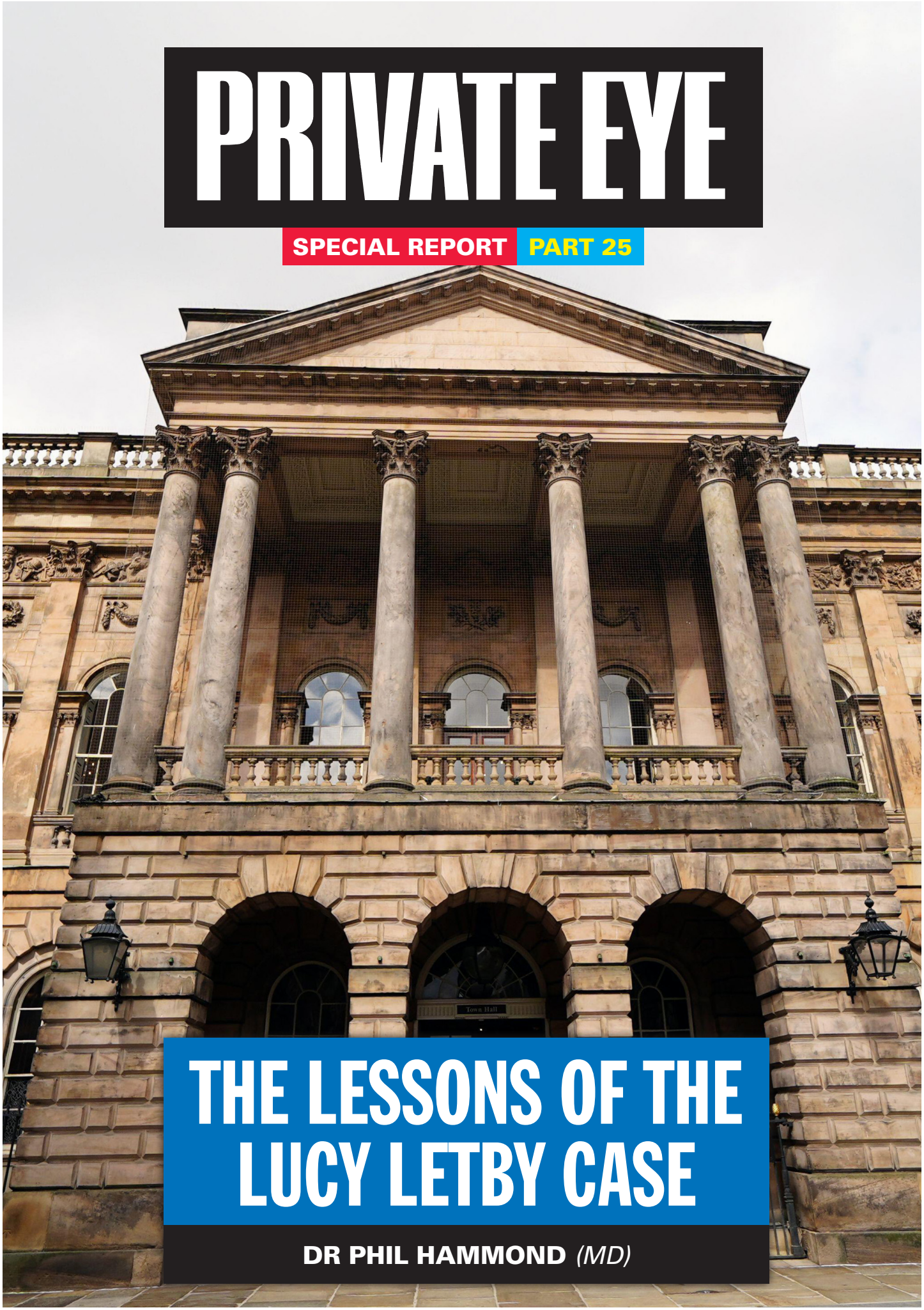
PRIVATE EYE

SPECIAL REPORT PART 25



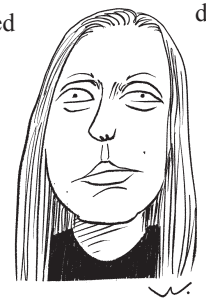

# THE LESSONS OF THE LUCY LETBY CASE

DR PHIL HAMMOND *(MD)*

# THE LUCY LETBY CASE: PART 25

## Coronial disputes

AS THE Criminal Cases Review Commission struggles to digest thousands of pages of reports to determine whether to refer neonatal nurse Lucy Letby's convictions for murder and attempted murder back to the appeal court, a key question remains: how did prosecution experts find clear evidence of deliberate harm, new defence experts find clear evidence of accidental harm, and yet the coroner found neither?



## Missing deliberate harm

CORONERS can only act on information given to them. Nicholas Rheinberg, former senior coroner for Cheshire, told the Thirlwall Inquiry into events at the Countess of Chester Hospital (CoCH) he was "horribly disappointed" that not a single consultant or manager had passed on suspicions of foul play for any of the babies Letby was later convicted of murdering.

Nor did doctors tell the coroner about highly unusual skin changes they observed which were later used to support the convictions of death by venous air embolism, based on the misinterpretation of a research paper by Professor Shoo Lee. When consultant Dr Ravi Jayaram was asked in court why he hadn't reported these to the coroner, he argued that he hadn't yet found the paper linking skin changes to embolism, so he didn't realise the significance. Prof Lee has since published research to show you get no such skin changes with venous air embolism. The evidence used to convict Letby was wrong.

## Missing accidental harm

RHEINBERG was well aware of shortcomings on CoCH's neonatal unit after a 2015 inquest into the death of baby Noah Robinson found doctors had put a breathing tube in the oesophagus and then ignored repeated warnings of the error. Similarly, defence experts believe triplets Baby O and P died in quick succession after resuscitation errors, most notably that the ventilation pressures were far too high, severely restricting cardiac function and circulation. But this was not reported to the coroner, probably because the doctors themselves failed to spot it.

The terminal event for Baby O (see last *Eye*) was a haemorrhage, as evidenced by a halving of the haemoglobin in a sample recorded shortly before death and shortly after consultant Stephen Brearey inserted a needle in the right side of the abdomen, where an X-ray suggested the liver was, and pulled back blood. Brearey has said he was "nowhere near the liver" but he still had a duty to report the procedure followed by the drop in haemoglobin to the coroner's office, to inform the pathologist before the post-mortem examination.

Stephanie Davies, a senior coroner's officer at the time, has gone on record to say this didn't happen. In an interview with the *Guardian* and Channel 4, she stated that had the coroner had the full picture, an inquest would have followed that would likely have found the terminal event was a medical procedure. Certainly, this theory has a better-documented evidence base than Letby somehow secretly traumatising the liver on a busy unit.

Four months after Baby O's post-mortem, in preparation for an inquest that never happened, a doctor did finally tell the coroner about the needle in the abdomen withdrawing blood, but not the precipitous fall in haemoglobin afterwards, nor the perilously high ventilation pressures (which were also missed in the court hearings). Having heard the explanations of the defence experts, Davies now believes there has been a miscarriage of justice.

## Police response

A CHESHIRE police statement dismissed Davies as having "an administrative role within the Cheshire coroner's office" and said she was "neither formally medically, nor legally trained". In fact, Davies had undertaken specialist investigative training and was promoted to senior coroner's officer in March 2017, a role which required considerable expertise.

In a statement to Thirlwall, Davies said that in early May 2017 she was asked to attend a "Gold Group" meeting of senior Cheshire police officers, when they were considering whether to investigate concerns raised by hospital doctors about Letby. Assistant chief constable Darren Martland asked her to review all the post-mortems and records for the babies who had died, and provide an opinion. This seems an odd request if you believe someone is an unqualified administrator. Davies reported she could find no evidence of deliberate harm but there were clearly bits of the jigsaw missing. This encouraged the police to pursue deliberate harm, completely missing the far more obvious accidental harm.

## Challenging events

DAVIES lost her job at Cheshire police in 2023 after a different review she conducted challenged the outcomes of two murder investigations. She consulted a small number of experts to further her research, and her report was leaked to the press, but not by her. Cheshire police pursued Davies for gross misconduct, alleging she breached duties of confidentiality when she sent details to the experts. She resigned from the force before her disciplinary hearing.

## Thirlwall accounts

THE total expenditure for the Thirlwall Inquiry in the last financial year is £13,098,000, with the chair trousering £452,000, other legal costs of £8,634,000, IT costs of £601,000 and "media services and monitoring" at £226,000. If Letby's case turns out to be a miscarriage of justice, it will be an expensive one, with some very rich lawyers rewarded for their failures by us.


*This report originally featured in Private Eye issue 1654.*

To read parts 1-24 please visit
**www.private-eye.co.uk/specialreports**