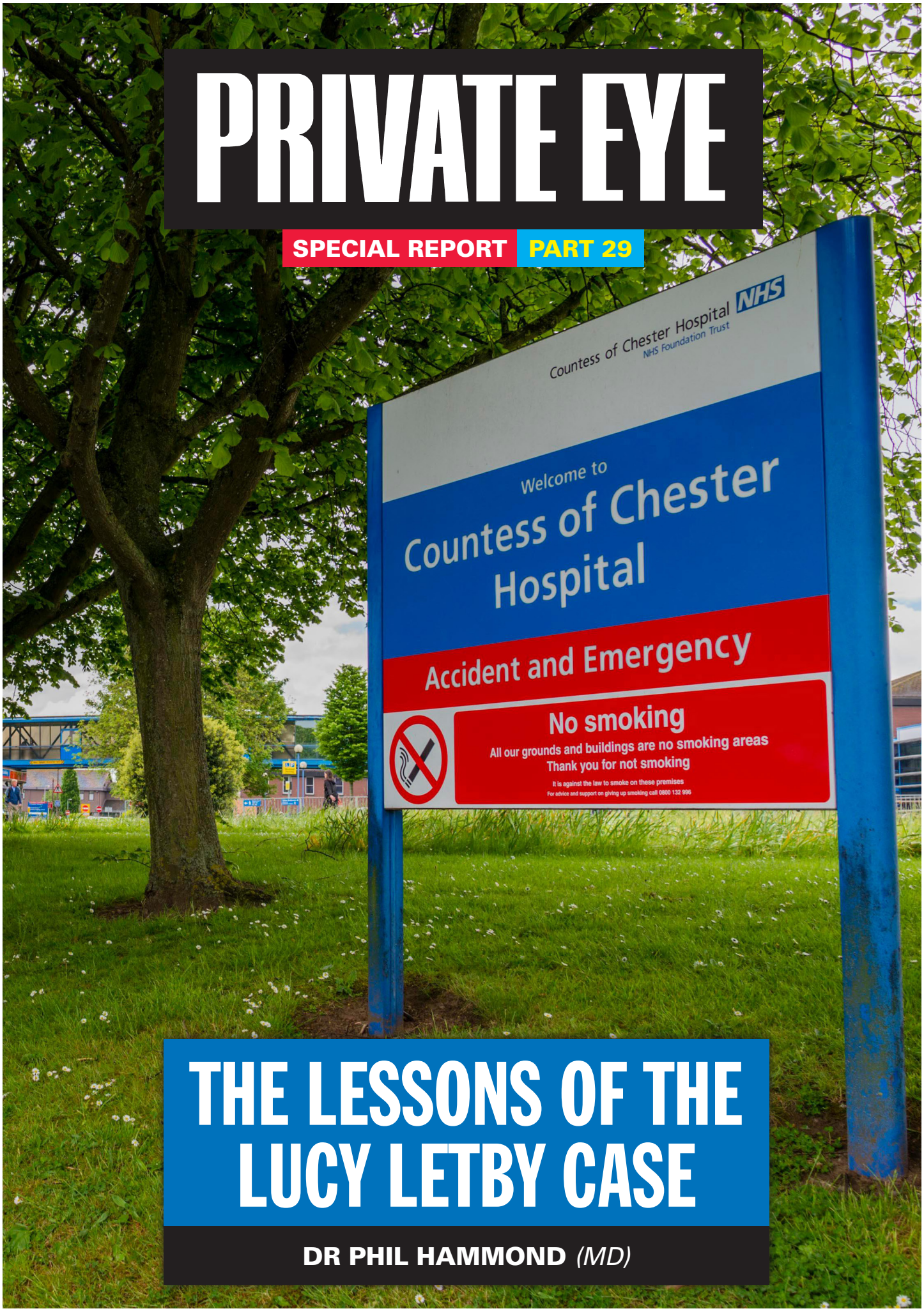
PRIVATE EYE

SPECIAL REPORT PART 29



THE LESSONS OF THE LUCY LETBY CASE

DR PHIL HAMMOND *(MD)*

THE LUCY LETBY CASE: PART 29

Dewi Evans unleashed

TWO-PART documentary *Lucy Letby – Murder or Mistake?* (Channel 4, 29 September) was pretty much the Dewi Evans show. The lead prosecution expert declared the neonatal nurse to be "evil" and "guilty as sin", and demonstrated how she killed babies with air injections, using red wine as a visual alternative. He dismissed the *Eye* ("that well know scientific journal") as being part of the "great metropolitan elite" and "God's most entitled". The international experts who challenge his findings are "hired guns" and – even worse – "Americans and Canadians".

MD's view remains that the science and statistics presented to the jury were incomplete and erroneous, neither independent nor impartial, and on that basis she should have an appeal. Had there been better expert analysis at the beginning of the investigation, it would likely not have made it past the police, let alone to court.

Framing the problem

HOW was Cheshire police persuaded by consultants at the Countess of Chester Hospital (COCH) to investigate whether a spike of neonatal deaths on their unit was murder?

In May 2017, Dr Stephen Brearey invited his colleagues to comment on a draft document, "Reasons for concerns regarding a possible criminal cause for increased neonatal mortality at the Countess of Chester Hospital NHS Foundation Trust, June 2015-July 2016". He argued the spike in deaths was both unexpected and unexplained, and "nurse L" was more often than not present when something happened. She was never observed doing anything untoward, but her presence was enough to warrant investigation. In addition, the spike in deaths stopped when Letby left the unit, although that also coincided with the unit being downgraded to level 1.

Brearey argues: "The redesignation [to level 1] cannot be considered to be a significant reason why there have been no deaths or sudden unexplained deteriorations of babies on the unit since July 2016." Fellow consultant Dr John Gibbs was not so sure: "I don't think we can claim that the altered designation of our NNU [neonatal unit] has not had any impact on the likelihood of neonates dying because we now care for fewer patients and these fewer patients are at lower risk of death (because they are of a higher average gestation)."

Gibbs' comments illustrate how much uncertainty surrounded some of the deaths: "Don't we need (like the other cases) to briefly explain why we feel this neonate suffered an unexpected or unexplained death? To an outsider reading this brief summary, especially a non-medic, there seem to be enough reasons (serious heart disorder, infection) to explain death… Are we able to say that the streptococcus was unlikely to be the cause of death (if so, what are the grounds for claiming this)?"

Safe staffing?

ON 4 May 2017, Brearey emailed his colleagues detailing tweaks to the document, including: "I've added a paragraph saying acuity and staffing is irrelevant." MD has not been able to find a neonatologist or paediatrician to agree that those factors were irrelevant to these cases.

The consultants argue that the babies' collapses were "unexpected and unexplained" and they died despite receiving "appropriate timely interventions". But on an overloaded unit short of staff and light on expertise, deteriorations are more likely to be missed, interventions more likely to be untimely and inappropriate, and deaths more likely to be explained by poor care. This is what neonatal experts reviewing the notes for the defence have now found. But the Chester consultants were allowed to investigate themselves and point the finger elsewhere for the police to follow.

Killer rash

THE report states that "an unexplained rash was observed for at least three babies" and "this is highly unusual and may indicate a possible unnatural cause of death". COCH consultant paediatrician Dr Ravi Jayaram suggests: "Should we say 'for example air embolism'. The review paper attached describes such rashes in air embolism." This interpretation has since been shown to be wrong – the attached paper by neonatologist Shoo Lee, professor emeritus at the University of Toronto, applied to arterial not venous embolism. Dewi Evans discovered exactly the same paper independently and made exactly the same error of interpretation.

Loose tubes

FOR Baby K, the email chain includes the statement from Jayaram that "staff nurse Letby at incubator and called Dr Jayaram to inform of low saturations". He later told the court Letby had definitely not asked him for help, which may have made her appear guilty to the jury. This alone should warrant an appeal. Jayaram argues for strategies to "pique police interest" and signs off with a jaunty: "Those are my ones, over to you!"

Intubation difficulties

BEFORE the spike in deaths, an avoidable death happened on the unit that definitely had nothing to do with Letby. In 2015, an inquest into the death of baby Noah Robinson found COCH doctors had wrongly intubated the oesophagus, twice, and clear signs the tube was misplaced were ignored (*Eyes passim*).

Intubation difficulties also caused harm during the spike, according to Dr Tariq Ali, a paediatric intensive care consultant and anaesthetist. He spotted a pattern of multiple failed and repeated intubations documented for some babies with concerns they were not adequately oxygenated in between the failed attempts, as evidenced by repeated oxygen desaturation readings and signs of oxygen deprivation at some post-mortem examinations.

A failing unit

HALFWAY through the spike in deaths, a consultant blew the whistle not on Letby, but on the unit. In December 2015, Dr Alison Timmis emailed Tony Chambers, the hospital's chief executive, reporting that staff were in tears because they were being forced to look after more babies than the unit could safely accommodate.

"Over the past few weeks I have seen several medical and nursing colleagues in tears… they get upset as they know that the care they are providing falls below their high standards." Staff were "chronically overworked" and "no one is listening": "This is not an exceptionally busy week. This is now our normal working pattern and it is not safe. Things are stretched thinner and thinner and are at breaking point. When things snap, the casualties will either be children's lives or the mental and physical health of our staff."

Timmis's two-page email, copied to medical director Ian Harvey and other managers, was sent after she'd worked a 21-hour shift over a Friday and Saturday. She said another colleague worked 23 hours in a row the same weekend. The neonatal unit was forced to close repeatedly and had three or four babies more than its "maximum capacity". A midwife had to come from the labour ward to help check emergency resuscitation drugs as there were not enough trained nursing staff. "At several points we ran out of vital equipment such as incubators… At one stage a baby had to be intubated in the middle of a room as there were no free bed spaces."

MD believes the unit should have been temporarily shut down or downgraded then, pending recruitment of more staff. Instead, it was allowed to accept premature triplets at high risk of complications as they shared the same placenta – the last thing you need when short-staffed. Two died and the third, who survived, was transferred out of COCH for ongoing care.

Insulin tests

THE Letby case probably only made it to trial because of the insulin results, uncovered on a retrospective notes trawl by Dr Brearey. The concession by defence

experts at a pre-trial meeting that two babies Letby was accused of murdering had indeed been given exogenous insulin (see last *Eye*) meant the defence had no experts to argue that the tests aren't always accurate in neonates and there were far more plausible explanations for the low blood sugars. Experts have since come forward to challenge the "insulin poisoning theory", but why were they absent from her trial?

Mary Prior KC, chair of the Criminal Bar Association, recently observed: "It is becoming increasingly difficult to instruct an expert on behalf of the defence in a criminal trial. There are fewer professionals with expertise who are willing to provide reports for the fees that the Legal Aid Agency will pay… The prosecution has its own budget and can therefore afford to pay more than the defence…. Where experts are only willing to be instructed by the prosecution, it is a growing concern that their evidence, whether consciously or subconsciously fails to be impartial. We are all aware of appeals against conviction based on errors in expert evidence."

An insulin expert for the defence would certainly have argued there are other explanations for the test results. Indeed, the Liverpool lab that processed the tests states that the "Low C-peptide, raised insulin" results that doomed Letby either mean "insulin administration or insulin receptor antibodies (IR-A)". Forensic confirmation was needed but never happened.

Meanwhile Letby – "the syringe killer" – was never observed by anyone on a crowded unit with a syringe in her hand injecting air into veins, air into nasogastric tubes or insulin into feed bags. There were no "trophy syringes" found at her home. Was it somehow easier to believe one rogue nurse was to blame, rather than repeated cases of clinical negligence? If the conviction was wrongful, it may also have saved the NHS a fortune…

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