

PRIVATE EYE

SPECIAL REPORT **PARTS 40-43**

THE LESSONS OF THE LUCY LETBY CASE

DR PHIL HAMMOND *(MD)*

THE LUCY LETBY CASE: PARTS 40-43

PART 40

No further charges (again)

THE Special Crime and Counter Terrorism Division (SCCTD) of the Crown Prosecution Service (CPS) has made a "final decision" to uphold its January ruling that Lucy Letby should not face any further charges of murder and attempted murder put forward by Cheshire Police. The evidence for each one of the 11 cases was not reliable or credible enough to pass "the evidential test".



Families of six of the nine babies involved asked for the decision to be reconsidered, but after an extensive independent review, the evidence again failed at the first hurdle. This raises the question of whether the original evidence against Letby was equally poor and, had it been the SCCTD making the original decision as it is now obliged to in such cases (rather than the local CPS), would the case ever have gone to court?

If the CPS had known what experts have since stated about the serious statistical and clinical errors and omissions in the first trial, surely it would not have proceeded with prosecution. It would have been hard for the Criminal Cases Review Commission (CCRC) to refer the original cases back to the Court of Appeal if further charges were being prosecuted. Now there is no reason not to, particularly as the chief constable of Cheshire Police, Mark Roberts, has taken early retirement.

Insulin doubts

IN MD's view, the CCRC should refer back to the appeal court because of the insulin poisoning convictions. These were decided firstly and unanimously, and cross-admissibility allowed the jury to use the guilty verdicts to shape other verdicts, where the evidence was even weaker. If the insulin cases fall, everything falls.

The tests used to "prove" insulin poisoning are considered so unreliable they can't be used to stand up doping allegations, never mind attempted murder. Definitive testing could and should have been done, but wasn't. The lead expert prosecution witness knew antibody interference was a plausible alternative explanation, particularly in neonates, but didn't declare it. New evidence has confirmed this. The lead expert witness was under investigation for serious clinical failings by his employer but only declared this when severe restrictions were placed on his practice by the General Medical Council. He believed Letby had poisoned a baby while not on duty by spiking supposedly tamper-proof infusion bags. Many experts have looked at the clinical records of both babies, and although they don't agree on every detail, they all agree there is no evidence of insulin poisoning.

Obstetric omission

CHESHIRE Police was obliged "to pursue all reasonable lines of inquiry, whether they pointed towards or away from the suspect". It was negligent not to ask an obstetric expert to examine the obstetric records to determine whether pregnancy or childbirth risks could have accounted for any of the collapses or deaths, as the National Crime Agency had advised it to. If BBC Radio 4's *File on 4 Investigates* (see last *Eye*) is correct in asserting that the defence was refused access to obstetric records after requesting them, that alone could be grounds for referral.

Statistical omission

THERE is statistical evidence that the "unexpected" spike in deaths at the Countess of Chester's neonatal ward was not unexpected, given the increase in the number of babies the overstretched unit was dealing with, and their prematurity. Alas, no statistician gave evidence and – as in the case of Sally Clark, who was wrongfully convicted in 1999 of murdering her two infant sons – non-statisticians butchered the statistics, presenting an incriminating spreadsheet where all the unexpected collapses and deaths that didn't involve Letby were removed, to make it appear she was always on shift when something unexpected happened. Ben Myers KC, Letby's original defence lawyer, quite properly asked for disclosure of the material used to construct the shift chart, presumably to get a proper statistical analysis, but Judge Goss rejected his application.

Expert overreach

MD has read a number of the new expert defence reports prepared for Letby's CCRC application, and – despite going into great detail – they have been unable to find any evidence Letby harmed a baby. I have also read a number of the expert prosecution reports prepared for her trial. These are much briefer, very dogmatic and less convincing. As with Sally Clark, prosecution experts grossly overstated the probability of murder and ignored more plausible alternatives.



Conflict of interest

THE alternative and more likely explanation for the unit's excess deaths was poor care overseen by the consultants who were pointing the finger at Letby. External and internal reviews commissioned by the hospital found no evidence Letby was deliberately harming babies, and neither did any post-mortem. But they did document that Letby had been subjected to bullying, and that malicious rumours about her had been spread within the unit.

That the consultants had also been forced to apologise to her was kept from the jury. The consultants may have had a grudge against Letby, and yet the police trusted their opinions, even when they were clearly wrong.

Baby K

PREMATURE babies often dislodge their breathing tubes spontaneously, as is well documented in the literature and by any competent neonatologist or neonatal nurse. It took four attempts to intubate Baby K, who weighed just 625g, and her tube came out three times. All the defence experts examining the records thought the dislodgements were spontaneous, and even Dr Dewi Evans did not initially flag the case as suspicious.

Baby K was flagged as suspicious when one of the consultants, Dr Ravi Jayaram, stated – a year after the event – that he had walked in on Letby at 3.50am just after she had deliberately dislodged the tube. He swore she was alone and hadn't called for help. He was prepared to testify that the *only* possible explanation was deliberate dislodgement, though he had neither documented this nor raised concerns at the time. Evans came into line, but the jury was unconvinced and the case was not proven at the original trial. However, Letby was convicted unanimously at retrial when – if the jurors weren't already aware – prosecution barrister Nick Johnson KC repeatedly reminded them she was already a convicted serial killer.

Jayaram doubts

DURING the retrial, the CPS admitted it had got the swipe card data for the unit the wrong way round, with staff leaving when police thought they were entering, and vice versa. Letby had not been alone with Baby K when Jayaram had documented her collapse in the notes (at 3.50am).

Jayaram then changed the timing to 3.14am, to fit the corrected data, and still convinced the jury and the Court of Appeal, which at least observed: "Legitimate criticism can be made of [Dr Jayaram's] evidence… although he believed that Letby had deliberately dislodged the endotracheal tube, he said nothing about it at the time, nor for many months thereafter. There was an inconsistency between his evidence and the contemporaneous records."

After the appeal, the Thirlwall Inquiry published an email from 4 May 2017 where Jayaram told his colleagues Letby had in fact "called Dr Jayaram to inform of low saturations". And yet Jayaram had sworn she had not asked for help. David Davis MP promptly asked Cheshire Police to investigate Jayaram for perjury. The police accelerated their expensive trawl of 4,000 notes spanning Letby's nursing career to try to make other "deliberate extubation" charges stack up. They have now failed twice.

Group error

JAYARAM was also certain Baby A had died from venous air embolism, having discovered a 1989 paper about highly unusual skin changes and air embolism that

sounded similar to those he recalled observing on the baby, although again he forgot to document it in the notes. Evans then came on board with the theory. Alas, both misinterpreted the paper, which applied to arterial, not venous embolism, and there was no definitive pathological evidence of air embolism for any of the six babies deemed to have died this way.

Evans had volunteered to be an expert witness, which raises something of a red flag, and very quickly declared that Baby O had suffered from an inflicted liver injury, partly based on bruising over the liver. When it transpired the bruise had disappeared, it became the fleeting and now discredited rash of venous air embolism.

As for air in the stomach as a murder weapon, Evans withdrew that theory post-trial, even though the appeal court documents three babies dying from that method. Just as well Judge Goss instructed the jury they didn't need to understand the mechanisms of death. The prosecution experts and Chester consultants clearly didn't either. But they were all certain it was murder.

PART 41

Thirlwall time

ON 15 September, Lady Justice Thirlwall will publish her public inquiry report, predicated on Lucy Letby's guilt, before the Criminal Cases Review Commission has decided whether to refer the convictions back to the Court of Appeal.

The report is likely to be shorter than first imagined, as it was asked to explore what was known about Letby's previous work as a nurse when she began employment at the Countess of Chester Hospital. Insinuations were made in evidence at the inquiry that Letby would face further charges, notably in relation to deliberate breathing tube displacement, without her being granted permission to defend herself.

Letby then became the most scrutinised neonatal nurse in NHS history, with Cheshire Police trawling through 4,000 sets of notes throughout her career. And yet the Crown Prosecution Service's Special Crime and Counter Terrorism Division (SCCTD) has twice determined that none of the further 11 charges the police proposed meet the evidential standard (see *Eye* 1673).

According to the law, for which Thirlwall is a stickler, Letby suddenly became a serial killer at the precise moment the overloaded and understaffed neonatal unit received an influx of sicker babies. What are the chances of that? Why did other babies collapse and die when Letby was not present? And why did the local CPS determine all of the original charges met the evidential standard when the national CPS SSCTD twice determined none of the new charges did? Don't expect any answers from Lady Thirlwall.

Lessons not learned

THIRLWALL was asked to determine whether the recommendations of previous inquiries to prevent avoidable harm have been effectively implemented. The answer is a resounding no. In 2001, the Bristol Inquiry recommended continuous independent external surveillance of clinical outcomes and mortality rates across the NHS, with prompt action and investigation after a single unsuspected death. The theory was that you shouldn't need to wait for a spike in deaths to act if a single death showed a unit was failing.

Missed opportunities

HAD the Bristol recommendations been properly implemented, the Chester neonatal unit should have been downgraded from level 2 (ie able to handle complex cases) to level 1, pending further investigations, after the death of Noah Robinson in 2014. An inquest found that a doctor had intubated the oesophagus, rather than the trachea, and then multiple members of staff – including a consultant who later accused Letby – failed to recognise the error despite clear evidence the tube was misplaced. This showed the unit didn't have the staff or expertise to cope with very small, premature babies and it should have remained at level 1 while appropriate retraining and recruitment took place.

In June 2015, with Chester still a level 2 unit, there was another huge red safety flag. Three neonatal deaths occurred in two weeks, compared to a historical average of 2.5 deaths a year.

This was a clear statistical spike which again should have led to a downgrading of the unit, or a temporary suspension, until a thorough, independent investigation had ascertained the causes and ongoing risks. Parents should have been fully involved and informed.

The downgrade to level 1 finally occurred in July 2016, after 13 babies had died on the unit and three after passing through it since June 2015. The death rate then went down, either because it was less busy and received fewer sick babies, or because Letby had left it. Either way, Thirlwall should spot those missed opportunities to save lives that swift action would have brought. She should also recognise that it is entirely inappropriate for doctors working on a unit to investigate causes of death, and steer a police investigation, when they themselves may be implicated.

Candour conundrum

THIRLWALL made a serious error at the start of her inquiry, criticising experts who were speaking up in defence of Letby and fulfilling their duty of candour. She must also consider if parents have a right to know immediately if doctors suspect a nurse is trying to murder their babies. And who else should be told?

At trial,the jury was told the *only* explanation for all the deaths and collapses was deliberate harm by Letby, even when she wasn't there, and Thirwall accepted this. This makes everyone who failed to spot it at the time, or at least raise timely concerns, negligent, incompetent or both.

How could a consultant be so certain Letby pulled out an endotracheal tube at trial, telling the media it was the *only* possible explanation, and yet they didn't say anything at the time and stayed quiet about the attempted murder for more than a year? How did no one pick up and act on the blood tests at the time, which the jury were told could *only* have been insulin poisoning? Why did none of the pathologists detect any of the obvious deliberate harm at postmortem? Or the coroner? How did none of the external and internal reviews pick it up? How have none of the myriad new defence experts picked up such obvious murders? Over to Thirlwall…

Obstetric omission

BBC Radio 4's *File on 4 Investigates* (21 July) reported that vital obstetric records of the babies Lucy Letby was convicted of harming were obtained by Cheshire Police, ignored by the prosecution experts and denied to the defence, who quite rightly demanded to see them.

Why a baby collapses or dies in the first few days or weeks of life can critically depend on what happened to them in the previous months in the womb or during birth. Countless maternity inquiries have shown that obstetric care and neonatal outcomes can be inextricably linked. In a murder trial with no direct evidence of deliberate harm and a high degree of uncertainly, it would be negligent not to explore the obstetric history in detail, to determine all the plausible causes of collapse and death.

The National Crime Agency (NCA) recognised this at the outset and advised Cheshire Police to engage "an obstetrician to review the medical histories, tests results, hospital notes/reports/scans, medication, etc." It chose to ignore the NCA, instead relying on the views of a long-retired paediatrician, Dewi Evans, who told *File on 4* he didn't think the obstetric records were relevant and that he never saw them. *File on 4* then interviewed Phil Bennett, professor of obstetrics and gynaecology at Imperial College London, who argued that the records were highly relevant and that Baby O had most likely died as a result of a well-recognised liver injury picked up at birth, and not from the deliberate trauma and venous air embolism Evans suggested, which has no evidence.

MD has further discovered that the police have refused to pass the obstetric records to Letby's new defence team, who tried to obtain them more than 18 months ago. It is surely absurd that the police and Crown Prosecution Service decide what unused prosecution material might be relevant to a trial or an appeal, particularly obstetric records that the NCA advised were relevant, the defence asked for and no obstetric expert has reviewed. Only the Criminal Cases Review Commission can now access the obstetric records and get an expert view. It must do so immediately.

PART 42

Thirwall fudge

THE challenge of chairing a public inquiry into the very rare occurrence of a nurse murdering babies, which may yet turn out to be a miscarriage of justice, is to produce sensible recommendations that will improve neonatal care across the NHS whatever the eventual outcome, and justify the exorbitant public cost (£20m). In MD's view, Lady Justice Thirlwall has failed.

Thirlwall argues that "the move towards a 'no blame' culture in the NHS, starting in 2000, was a mistake. The focus on system faults rather than the failings of individuals, coupled with a learning culture that omitted acknowledging responsibility or blame, meant difficult conversations about conduct were avoided. This undermined patient safety."

This "no blame culture" never took off (look at the spiralling NHS litigation bill), but to move away from attempts at "a just culture" would be very harmful. If Lucy Letby is an ingenious serial baby killer who was never observed causing harm, left no solid evidence of it and has fooled a large number of neonatal defence experts from home and abroad, she deserves all the blame she has already received. If not, then blaming her and everyone for not stopping her sooner – particularly the hospital managers – will turn out to be catastrophic.

Gross negligence and deliberate harm should rightly attract blame, but the vast majority of NHS harm is unintended, and staff should be rewarded for owning up to it and being open and honest with patients, who usually don't sue if they are fairly compensated and given a swift explanation and apology. The system failures – usually a lack of expert staff and training, or capacity shortages – that facilitate avoidable harm can then be fixed. To revert to a blame culture, particularly in such uncertain cases as Letby's, will just lead to more defensive medicine and cover-ups and an even higher legal bill when the truth finally comes out.

Disappearing livestream

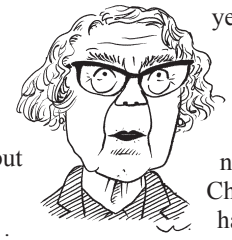
THE debate about Letby may never be resolved because she was never caught in the act of doing anything wrong. Thirlwall's first recommendation is that "cots and incubators in all neonatal units should be fitted with in-cot cameras with live streaming video, so that parents may observe the baby remotely at any time" and harm, deliberate or accidental, may be captured.

This might provide parents with reassuring footage of their baby when they can't be cot-side, and might deter a future baby murderer, although it would need to be extended across maternity and children's services too. However, Thirlwall does not recommend that the stream should be recorded and kept, and so can't be used in evidence to either convict or exonerate anyone. This places unfair pressure on parents to spot harm in real time and may lead to a mountain of calls and concerns around the clock for staff to deal with, and legions of sleep-deprived and fearful parents glued to their never-ending yet transient baby feed. It could also make staff less willing to work on neonatal units if they alone have been singled out for scrutiny, or make them far more defensive in their care.

Independent investigation

THIRLWALL has recommended the Department of Health and Social Care (DHSC) "should convene a panel of independent experts from all specialties to be called upon in situations where there are emerging concerns about an individual and harm to a patient or patients".

MD first advocated an independent medical inspectorate after the Bristol Inquiry reported in 2001. When serious harm, a spike in deaths or serious whistleblower concern occurs, for whatever suspected reason, the hospital involved should not lead the investigation and certainly not steer the police. A fair, independent expert report is needed with an obligation for the NHS and government to swiftly act on the findings, and not wait for a public inquiry 11 years after the events.



As MD has stated, such an investigation after the avoidable death of baby Noah Robinson in 2014, or the spike in three neonatal deaths at the Countess of Chester Hospital in 2015, may well have saved lives and a vast amount of money and harm (see last *Eye*). The expert panels could also contribute evidence to any future court cases, removing the absurdity of expert witnesses paid for by the prosecution or the defence. Any such panel would be most unlikely to include the pair whose opinions were crucial to Letby's conviction: Dewi Evans, a long-retired paediatrician who spotted intended harm within ten minutes, and Peter Hindmarsh, an endocrinologist who was facing multiple patient complaints and had severe restrictions placed on his practice by the General Medical Council. Until we resolve who gives expert evidence in court, and how they are paid, the risk of miscarriages of justice in adversarial trials will remain high.

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PAGE 94

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What now?

DR JOHN GIBBS, one of the consultants who accused Letby, told *Channel 4 News* that there needed to be clear guidance for frontline staff and managers on what to do when deliberate harm is suspected, but also stated the CCRC must seriously consider the views of all the eminent defence experts who can find no evidence of deliberate harm. And vascular surgeon Colin Ferguson has challenged Dewi Evans and stated there is no evidence for any of the deaths by venous air embolism (see *Lucy Letby Scapegoat? Channel 5, September 21*).

PART 43

Heated debate

IS IT safe to convict someone for causing multiple deaths by venous air embolism (VAE) when there is no evidence any death was caused by VAE? It's a vital question that ideally would have been debated by experts in front of the jury at Lucy Letby's trial, but the defence put up no experts so instead we've had to wait more than three years after her convictions for the privilege, courtesy of the *Sun* and Channel 5.

In C5's *Lucy Letby: Scapegoat?* on 21 September, reporter Rob Pattinson oversaw an argument between Dr Dewi Evans, lead expert for the prosecution and a retired paediatrician, and Mr Colin Ferguson, a former vascular surgeon and director of professional affairs in Wales for the Royal College of Surgeons. Evans argued that the air Letby had injected (unobserved) into the veins of seven babies had caused sudden death and collapse by an embolic blockage in the right side of the heart, but then the air emboli had somehow completely dissipated around the body, leaving not a trace of air found in any of the hearts at the six postmortems. Ferguson argued that this was utter nonsense. If the emboli were truly big enough to cause cardiac arrest, some air should have been found in the hearts of babies by the expert neonatal pathologists at postmortem, as air is largely nitrogen, which does not dissipate into the tissues as Evans suggested.

Follow the research

FERGUSON asked Evans if he was aware of any documented case of death by VAE that hadn't shown air in or around the heart at postmortem, and Evans said "no". Evans said it was impossible to be sure whether air would still be present in the heart because there were no published cases in the scientific literature of premature babies dying of VAE. Ferguson said he had found eight published cases of death by VAE in neonates, and "in every single case there is air in the right side of the heart or the proximal large veins or the pulmonary arteries… the real-world data is clear that in order for a neonate to die of venous air embolism, you have to have these features".

Evans was adamant the babies had died from this method without air found in the heart, even if the research said otherwise. Ferguson was adamant they had not. What was doubtless a much longer interview was

cut down to a few minutes and ended with Evans taking off his microphone and walking out. If the jury had at least witnessed the substance of this exchange, they would likely not have found Letby guilty beyond reasonable doubt by this method. And this is now the only method of murder Evans is supporting, having withdrawn his support for murder by air in the stomach after the trial, even though Letby is locked up for life for killing three babies using this equally unevidenced method.

Welsh connection

NEITHER Ferguson nor Evans can strictly be considered an expert in death by VAE in neonates, as it is so rare. One acknowledged global expert in researching vascular emboli in neonates, Dr Shoo Lee, has stated categorically having reviewed all the records with expert colleagues that there is no evidence of death by VAE, nor any other deliberate harm in any case, and that his research used by Evans (and Chester consultants) to support a diagnosis of VAE had been wrongly applied.

The *Sun* may yet bring us the Evans v Lee showdown, but we had to be content with Ferguson, who knows more about vasculature and blood flow, vs Evans, who knows more about babies. They also know a lot about each other, as they worked in the same Swansea hospital. Ferguson is not an instructed defence expert but spoke up because he felt it was his professional duty to do so. Evans looked very uncomfortable under pressure from a fellow Swansea consultant who pointedly called him David, rather than use his stage name Dewi, and offered to continue the discussion at any time in the future.

In MD's view, and the view of every expert I've spoken to, the standard of proof to safely convict on this method of murder definitely was not met.

Mountain of doubt

PATTINSON spent a year trying to confirm Letby was "a baby-killing monster" and ended up full of doubt. There were three new revelations. An anonymous whistleblowing consultant working at the Countess of Chester hospital declared that the evidence that Letby had done anything wrong was "extremely poor", and that she was likely a scapegoat for the unit's failings. A mother whose baby had died after Letby left said it was due to faecal contamination. And blood results showing normal sugar levels for the babies allegedly poisoned by extremely high levels of insulin had not been disclosed to the defence.

The rest of the documentary was well known, laying out the many flaws in the case with which readers will be familiar.

Retrial support

DR JOHN Gibbs, one of the consultants who accused Letby of murder, did not contribute to the documentary but told the *Sun* afterwards that it would be "appalling" if she had been jailed for crimes she had not committed, that he held "a very small concern there may not have been any deliberate harm done", and that a retrial "might be the most appropriate thing for everyone". If Gibbs' modest U-turn spreads to other troubled Chester consultants and prosecution experts, it may yet make a difference.

Coronial view

MD HAS been contacted by a former coroner who trained as a doctor, and who also does not believe the standard of proof for death by venous air embolism was high enough to convict. However, the coroner who will oversee the inquests into the Chester babies' deaths is obliged to agree with the court findings, even if he doesn't personally agree with them.

The Court of Appeal is the only place where the verdicts can be challenged, and it is essential that the Criminal Cases Review Commission makes a decision on referral before the inquests take place. If not, parents who have already suffered unimaginably may face the further harm of having the inquest findings reversed after an appeal.



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