SUSHRUTA JOURNAL OF HEALTH POLICY & OPINION

The Case of Nurse Letby: Systems Failure in Safeguarding Patients

Indranil Chakravorty MBE

University of Hertfordshire, Hatfield, UK

Abstract

The case of nurse Lucy Letby killing innocent babies in a neonatal unit has yet again shaken the confidence of society in healthcare professionals and forced many professionals themselves to reflect on what impact this may have on their practice. Like in wider society, there are professionals who cause harm to others deliberately, and in some cases demonstrate attributes of serial killers. This is not new and sadly is highly unlikely to be ever eradicated. What has shaken the healthcare professions more, is the abject failure of leadership to heed concerns raised (whistleblowing) and actions that may be considered collusive or protectionism, towards Nurse Letby, who apparently did not have the 'face of a killer'.

'Letby was the epitome of ordinary. She appeared conventional in every way.'[1]

It appears that established systems for raising concerns were blatantly defeated by the actions of leaders. There is also an additional concern that the 'conventional' profile of the perpetrator may have played a role in how the leaders reacted to protect her. There are contrasts being drawn by analysts to cases where professionals with different personal attributes (protected characteristics such as colour, race, religion) were treated differently, both while raising concerns or when concerns were raised about them. This case highlights the other elephant in the room, the differential treatment of people in society, as well as in healthcare based on their race or protected characteristics.

What can the profession and society learn from this and similar gruesome incidents? How should leadership accountability be established? What recourse do patients and professionals have to expect their concerns to be taken seriously before harm occurs? What is the implication of the proposed 'Martha's rule' to healthcare?

Keywords
Whistleblowing, Martha's Rule, Raising concerns.

Cite as: Chakravorty, I. (2023) The case of nurse Letby: Systems failure in safeguarding patients. Sushruta J Health Pol vol 15; Issue 3: 1-8 DOI 10.38192/15.3.4

Article information
Submitted 9 Sep 23
Revised 10 Sep 23
Published 6 Oct 23

Background

Rogue professionals who cause deliberate harm to patients under their care and sometimes do so with impunity, remaining undetected over time, avoiding established systems of protection, shake the confidence of society - the crucial tenet on which healthcare relies. Such heinous acts shake the resolve of most professionals who uphold their Hippocratic Oath and serve with dedication and compassion. Several high-profile cases underscore the gravity of this issue and illuminate the proactive steps taken by society and regulators to mitigate the risks and protect the public.

One of the most notorious cases is that of Harold Shipman, an English general practitioner, who was responsible for the deaths of at least 218 patients over decades.[2] This chilling case sent shockwaves through the medical community and society at large, revealing the potential for unimaginable harm when a rogue healthcare professional goes unchecked.[3] Regulators were forced to reevaluate their oversight mechanisms to prevent such atrocities from occurring again.[4]

'...all doctors, and not general practitioners alone, share responsibility for creating the circumstances that enabled Shipman to be so successful a killer. We must accept that responsibility and embark on a process of professional renewal in which the principle of patient-centredness is given greater force by the addition of the idea of the patient as the source of control.' Richard Baker, JRSM

In response to such incidents, governments and regulatory bodies around the world have undertaken comprehensive reforms. Mandatory background checks, thorough screening processes, and enhanced reporting systems have been implemented to identify potential red flags early. Moreover, mandatory peer evaluations and regular performance assessments now ensure continuous monitoring of professionals' conduct and competence. However, more needs to be done as it is becoming recognised by a series of reviews that professional misconduct has a greater chance of occurring when there are design faults and operational failings at different levels from the individual to the organisation and finally in wider society. [5]

The case of nurse Charles Cullen in the United States[6] further fuelled the urgency for reform. His calculated administration of lethal doses of medications to patients in multiple hospitals raised concerns about cross-institutional accountability and the sharing of critical information. As a result, new inter-institutional databases were established to facilitate the exchange of data and information, aiding regulators in tracking a healthcare professional's history across different healthcare facilities.

Why is it difficult to detect when deliberate harm occurs in a healthcare setting?

There are several factors including the complexity of decision-making which is both collaborative and distributive in most settings, and that patients or their families often receive inadequate information or are unempowered. Collaboration has been standard practice ever since the specialisation of the medical profession began requiring a shared cognitive approach to diagnosis and treatment.[7] The shared goal—correctly diagnosing and properly treating patients—has become such an overly complex process that it can only be achieved by splitting the medical professions into specialisations and bringing them back in a multidisciplinary team (MDT) decision-making matrix. However, there are inherent weaknesses in this system, such as patients have little to contribute directly to the MDT process in most settings and are only presented a heavily redacted, sanitised version of the complexity of decisions. Often patients are not provided the evidence supporting the decisions, nor the tools to understand the implications.[8]

Healthcare systems depend on assumption of good self-governance of such MDT processes, the integrity of individual clinicians to provide

an evidence-based diagnosis or treatment. There are recognised weaknesses in such systems such as power imbalance, communication, paucity of facts presented and other human factors including differential empowerment of members. Decisions in primary care or community settings are based on individual observations and are rarely subject to the rigour of an MDT-hence potentially remain vulnerable to the actions of rogue professionals, such as Dr Shipman.

The introduction of advanced data analytics and artificial intelligence may offer a role in bolstering decision-making, providing transparency in outcomes for individuals, teams or institutions - thus offering a level of protection of the public.[9] These technologies can enable the identification of unusual patterns and behaviours, facilitating early intervention before significant harm occurs.[10]

Patient or Family Empowerment

Martha Mills died in 2021 a few days short of her 14th birthday, just after an August bank holiday weekend. She had been on a paediatric ward at King's College Hospital in London, one of three national centres for the care of children with pancreatic trauma, after injuring her pancreas in a bicycle accident. She was showing signs of sepsis, and her parents raised this possibility with staff, but by the time she was transferred to paediatric intensive care days later, it was too late. [11] The proposed implementation of 'Martha's Rule offers patients, families or next of kin the opportunity to raise concerns directly and independently demanding a clinical review.

A similar measure, called *Ryan's rule*,[12] had been introduced in Queensland. It was named after Ryan Saunders, who died in 2007 from an undiagnosed streptococcal infection, which led to toxic shock syndrome. When Ryan's parents were worried, he was getting worse, they did not feel their concerns were acted on in time. Ryan's rule allows a next of kin to demand a clinical review (not technically a second opinion) if they remain unsatisfied with the current review or the speed with which clinicians may be acting on their concerns. An evaluation of the use of Ryan's rule activations in Australia demonstrated that communication issues were central to more than half the activations, 35% of cases required no clinical intervention. While clinicians doubted the appropriateness of activators' use of the escalation tool, 15% of patients were transferred to receive a higher level of care.[13] Whether this transfer to higher care would lead to better outcomes and cervical is yet to be seen.

In the UK, there are systems for escalation using evidence-based early warning scores based on clinical parameters, many organisations have critical care outreach teams to attend to clinical escalations with agreed timelines and minimum standards of seniority required. Patients and next-of-kin have access to a liaison service for raising concerns which is independent of the managing clinical team. Patients also have a right to demand a second opinion if there is a disagreement or lack of trust in the clinical decisions. In extreme cases, there are systems for judicial review of clinical decisions.

However, the automatic right to a second clinical review when patients, next of kin or carers (as proposed in Martha's rule) have concerns or are dissatisfied with the level of care is new. In the review of activation of Ryan's rule, clinicians labelled activations as a 'complaint' as opposed to a 'concern' and reasoned that a 'complaint' did not justify a full review of the consumer's perspective for the activation. While most clinicians would understand and accommodate or seek a second clinical opinion in cases of uncertainty or complexity - the automatic activation of a mandatory clinical review by next of kin may lead to confusion, disruption of patient-professional relationships, and trust and pose challenges in the provision of senior opinion makers in out-of-hours situations.

Measures of effectiveness of implementation of Ryan's Rule have mainly focused on policy and process without first understanding barriers or facilitators through engagement with stakeholders and environmental assessment. There is also a need to assess the impact on

families, particularly within a diverse cultural mix. Without a systematic evidence informed knowledge translation approach, progress in implementing family initiated deterioration of condition processes is more about appearance and optics – ticking the box – than genuine engagement with families.[14] It would thus be prudent through a period of consultation and piloting to understand the positive and negative impact of such an introduction.

Raising Concerns

Whistleblowing refers to when a worker makes a disclosure of information which they reasonably believe shows wrongdoing or someone covering up wrongdoing, and are entitled to protections, through the Public Interest Disclosure Act 1998 (PIDA). Whistleblowing has a tortured history in the NHS although it has been recognised as making an important contribution to patient safety. Institutions remain largely unsupportive of whistleblowing, with many staff fearful about the consequences of going outside official channels to bring unsafe care to light. [15–17]

In his summary, Sir Robert Francis wrote, *'Speaking up is essential in any sector where safety is an issue. Without a shared culture of openness and honesty in which the raising of concerns is welcomed, and the staff who raise them are valued, the barriers to speaking up identified in this Review will persist and flourish.'*[18]

However, whistle-blower protection laws have been strengthened, encouraging healthcare staff to report suspicions without fear of retribution. In many countries whistle-blower protection laws fail to meet international standards and fall significantly short of best practice. Lacking strong legal protections, employees who report potential wrongdoing to their managers or to regulators can face dismissal, harassment and other forms of retribution and the wrongdoing may continue with impunity, as was illustrated by Nurse Letby's case. [20] Whereas most governmental whistleblowing agencies have investigative tasks, a comparative study found that in Belgium and the Netherlands, worryingly investigations are done within the same department.[21] Other agencies have separated these tasks to avoid conflict of interest or because different expertise is claimed to be needed for both.

Institutional Accountability & Silencing

What was illustrated in the case of nurse Letby was the abject collusion or failure of the institutional leadership in responding to concerns raised through whistleblowing, repeatedly and attempts to threaten or silence the whistle-blowers. In studies with whistle-blowers, many reported being ignored, threatened, harassed, or not given any feedback on the actions taken, thus discouraging them from further reporting. [22] Silencing can be the hidden exercise of power, using institutional mechanisms, communication hierarchies and informal rules to control channels of communication and information flows. By distracting from or delaying redress of malpractice and undermining employees' right to recognise and report wrongdoing by minimising, wrongdoing is normalised and responsibility to act is avoided. [23] Sometimes whistle-blowers can become the focus and victim of raising concerns and speaking up[24] and may be persecuted by powerful organisations- such cases were illustrated by the handling of junior doctor Chris Day[25], cardiologist Usha Prasad[26] in London and another Coventry cardiologist Raj Mattu[27] to name a few where NHS Trusts have persecuted whistleblowers at great public expense and devastating consequences to the whistleblowers. An NHS England review into the behaviour of high-profile senior leaders who took over a Midlands trust concluded that the interim chief executive "behaved poorly and inappropriately" while its chair was "complicit with" and failed to address problems [28] highlighted by paediatrician David Drew. [29,30]

Retribution & Differential Treatment

It is well recognised that differential treatment of individuals and groups of people (although deemed illegal) exists in society, including within institutions based on protected or

unprotected (such as immigration status) characteristics. Institutional bias such as racism leads to structural disadvantage which is persistent and often such practices drive disparities in employment, recruitment, and education. Discrimination or bias can be expressed through bullying and harassment,[31] perceptions of job performance[32] and rewards, poor work-life balance, and experiences of harmful interpersonal interactions.[33] So it is unsurprising that such differential treatment may also be a factor in how whistleblowers are treated, and has an adverse impact on employee confidence in leaders and their ability to effectively address and mitigate concerns raised.[34]

Does retaliation against a whistleblower qualify as discrimination or an infringement of freedom of expression?

In France, whistleblowing legislation has built whistleblower protection on the model of discrimination. The transposition of the European Directive 2019/1937 of 23 October 2019 on the protection of persons who report breaches of EU law, reinforced by domestic case law, shifted the balance towards freedom of expression. Standing between discrimination and freedom of expression, the protection of whistleblowers is in urgent need of conceptual clarification.[35] Retaliation towards internal whistleblowers can in turn negatively relate to relationships with the leaders and decisions to blow the whistle again, using external channels. Following the events at Mid Staffordshire NHS Foundation Trust, Sir Robert Francis found that staff had tried to speak up about their concerns, but that they had been ignored, or victimised as a result. This experience was not confined to Mid Staffordshire and the *Freedom to Speak Up* report recommended the appointment of Freedom to speak up guardians in NHS trusts and foundation trusts and a national guardian to lead this network, undertake case reviews and provide support and challenge to the system.[36] An internal review of the NHS Freedom to Speak Up (FTSU) Guardian role in 2022, demonstrated that there was a decline in the confidence to speak up, especially in frontline or community services and overall. [37] There is also the issue of persistent inconsistencies in the way in which regulatory agencies handle concerns, based on protected characteristics of the individuals involved. [38]

In the case of Nurse Letby, numerous instances of whistleblowing were ignored, and silenced with the threat of adverse consequences for those raising concerns, demonstrating an abject failure of leadership and concerns that the profile of the perpetrator when compared to those raising concerns may be a factor.

Conclusion

The menace posed by rogue healthcare professionals demands unwavering vigilance and adaptability from the industry and its stakeholders. Through the implementation of stringent vetting processes, cross-institutional data sharing, and the integration of advanced technologies, a renewed commitment to patient safety is needed. By learning from the mistakes of the past, we can move forward with the shared goal of ensuring that the trust placed in healthcare professionals is well-founded and that the care provided remains a beacon of hope and healing.

The world had taken a step back from when Time Magazine declared it to be the year of "Whistleblowers" in 2002.[39] Even if the best legislation is in place, the status of a whistleblower will inevitably receive a hard blow. While employers can't retaliate directly, there is no check on unfair appraisal and deliberate over-burdening. There is a lack of protection due to the restrictive nature of the definition of a whistleblower and the complicated process of "whistleblowing" that dissuades whistleblowers from coming forward. [40] The UN Whistleblower Policy 2017, addresses similar issues but faces the same pitfall of a restricted approach. It defines reports and cooperation as "protected activities" if they are made as soon as possible, in good faith and not later than six years and rarely may be extended to individuals who

report through external mechanisms.[41] Herein lies the weakness, when protection is rarely offered for external reporting such as through Monitor in UK Healthservice.[42]

Stringent regulations and reforms in healthcare systems have contributed to saving lives and preventing harm caused by rogue healthcare professionals. While these measures cannot eliminate the risk of rogue healthcare professionals, they have undoubtedly contributed to minimizing the potential for harm and protecting patients. By learning from past cases and implementing proactive reforms, healthcare systems have taken significant steps towards ensuring patient safety and maintaining the integrity of the profession.

There is also evidence to suggest that whistleblowers from minority backgrounds may experience differential treatment compared to their white counterparts. Addressing these disparities requires a multi-faceted approach that involves creating inclusive and supportive organisational cultures, promoting diversity in leadership, ensuring fair treatment and protection for all whistleblowers, and raising awareness about the importance of whistleblowing regardless of one's background. It's essential to recognise that achieving equality in treatment for whistleblowers from minority backgrounds is a critical aspect of ensuring ethical conduct and accountability within organisations.

References

1. Halliday, J. & Grierson, J. Lucy Letby, the 'beige' and 'average' nurse who turned into a baby killer. *The Guardian* (2023).
2. Jackson, T. & Smith, R. Harold Shipman. *BMJ* **328**, 231 (2004).
3. Baker, R. & Hurwitz, B. Intentionally harmful violations and patient safety: the example of Harold Shipman. *J. R. Soc. Med.* **102**, 223–227 (2009).
4. Baker, R. Patient-centred care after Shipman. *J. R. Soc. Med.* **97**, 161–165 (2004).
5. Mannion, R. *et al.* Healthcare scandals and the failings of doctors. *J. Health Organ. Manag.* **33**, 221–240 (2019).
6. Charles Cullen: The true story of a hospital killer and 'The Good Nurse' who brought him to justice. *Sky News* https://news.sky.com/story/the-good-nurse-the-true-story-of-killer-charles-cullen-and-the-colleague-who-brought-him-to-justice-12729287.
7. Kempt, H. & Nagel, S. K. Responsibility, second opinions and peer-disagreement: ethical and epistemological challenges of using AI in clinical diagnostic contexts. *J. Med. Ethics* **48**, 222–229 (2022).
8. Hamilton, D. W., Heaven, B., Thomson, R. G., Wilson, J. A. & Exley, C. Multidisciplinary team decision-making in cancer and the absent patient: a qualitative study. *BMJ Open* **6**, e012559 (2016).
9. Supporting open data and transparency. *NHS Digital* https://digital.nhs.uk/services/supporting-open-data-and-transparency.
10. Batko, K. & Ślęzak, A. The use of Big Data Analytics in healthcare. *J. Big Data* **9**, 3 (2022).
11. Dyer, C. Martha's rule: What could the proposed changes mean for doctors? *BMJ* **382**, p2067 (2023).
12. Ryan's Rule. *Clinical Excellence Queensland | Queensland Health* https://clinicalexcellence.qld.gov.au/priority-areas/safety-and-quality/ryans-rule.
13. Dwyer, T. A., Flenady, T., Kahl, J. & Quinney, L. Evaluation of a patient and family activated escalation system: Ryan's Rule. *Aust. Crit. Care* **33**, 39–46 (2020).
14. Gill, F. J., Leslie, G. D. & Marshall, A. P. Family initiated escalation of care for the deteriorating patient in hospital: Family centred care or just "box ticking". *Aust. Crit. Care* **29**, 195–200 (2016).
15. Bolsin, S., Pal, R., Wilmshurst, P. & Pena, M. Whistleblowing and patient safety: the patient's or the profession's interests at stake? *J. R. Soc. Med.* **104**, 278–282 (2011).
16. Re: Whistleblower was unfairly dismissed in case lasting 12 years, tribunal rules. g2881 (2021).
17. Cooper, B. 'I was left to fight alone for NHS whistleblowing protection' | Benedict Cooper. *The Guardian* (2018).
18. Freedom to Speak Up.
19. Whistleblowing for employees. *GOV.UK* https://www.gov.uk/whistleblowing.
20. Wolfe, S., Worth, M., Dreyfus, S. & Brown, A. J. *Breaking the silence: strengths and weaknesses in G20 whistleblower protection laws.* https://apo.org.au/node/41246

(2014).
21. Loyens, K. & Vandekerckhove, W. Whistleblowing from an International Perspective: A Comparative Analysis of Institutional Arrangements. *Adm. Sci.* **8**, 30 (2018).
22. Bjørkelo, B., Einarsen, S., Nielsen, M. B. & Matthiesen, S. B. Silence is golden? Characteristics and experiences of self-reported whistleblowers. *Eur. J. Work Organ. Psychol.* **20**, 206–238 (2011).
23. Tiitinen, L. The power of silence: silencing as a method of preventing whistleblowing. *Eur. J. Soc. Work* **23**, 68–79 (2020).
24. Waring, J. When Whistle-blowers Become the Story: The Problem of the 'Third Victim'. *Int. J. Health Policy Manag.* **5**, 133–135 (2015).
25. davidhencke. Tribunal of the Absurd: My Verdict on the Dr Chris Day whistleblower case. *Westminster Confidential* https://davidhencke.com/2022/11/19/tribunal-of-the-absurd-my-verdict-on-the-dr-chris-day-whistleblower-case/ (2022).
26. davidhencke. Judge adjourns £180,000 costs hearing case against whistleblower consultant Dr Usha Prasad. *Westminster Confidential* https://davidhencke.com/2023/08/23/judge-adjourns-180000-costs-hearing-case-against-whistleblower-consultant-dr-usha-prasad/ (2023).
27. Dyer, C. Whistleblower was unfairly dismissed in case lasting 12 years, tribunal rules. *BMJ* **348**, g2881 (2014).
28. Trust CEO 'behaved poorly' and chair was 'complicit', NHS England review concludes. *Patient Safety Learning - the hub* https://www.pslhub.org/blogs/entry/3216-trust-ceo-%E2%80%98behaved-poorly%E2%80%99-and-chair-was-%E2%80%98complicit%E2%80%99-nhs-england-review-concludes/ (2022).
29. Whistleblower's book lifts lid on fight against Walsall Manor Hospital chiefs. https://www.expressandstar.com/news/2014/06/04/whistleblowers-book-lifts-lid-on-fight-against-walsall-manor-hospital-chiefs/ (2014).
30. CRC0018 - Evidence on Complaints and Raising Concerns. https://committees.parliament.uk/writtenevidence/49243/html/.
31. Bahji, A. & Altomare, J. Prevalence of intimidation, harassment, and discrimination among resident physicians: a systematic review and meta-analysis. *Can. Med. Educ. J.* **11**, e97–e123 (2020).
32. Chakravorty, I. *et al.* Bridging the Gap 2021-Summary Report: *Sushruta J. Health Policy Opin.* 1–52 (2021) doi:10.38192/btg21.1.
33. Bhui, K. Ethnic inequalities in health: The interplay of racism and COVID-19 in syndemics. *EClinicalMedicine* **36**, 100953 (2021).
34. Pavithra, A., Sunderland, N., Callen, J. & Westbrook, J. Unprofessional behaviours experienced by hospital staff: qualitative analysis of narrative comments in a longitudinal survey across seven hospitals in Australia. *BMC Health Serv. Res.* **22**, 410 (2022).
35. Leclerc, O. Overarmed or underdressed? whistleblowers between anti-discrimination law and freedom of expression. *Int. J. Discrim. Law* 13582291231154160 (2023) doi:10.1177/13582291231154161.
36. Freedom to Speak Up: guidance for NHS trust and NHS foundation trust boards | NHS Improvement. https://improvement.nhs.uk/resources/freedom-speak-guidance-nhs-trust-and-nhs-foundation-trust-boards/.
37. Review finds decrease in workforce confidence to speak up | NHS Employers. https://www.nhsemployers.org/news/review-finds-decrease-workforce-confidence-speak.
38. Savage, A. & Hyde, R. The response to whistleblowing by regulators: a practical perspective. *Leg. Stud.* **35**, 408–429 (2015).
39. The Whistleblowers: 100 Women of the Year. *Time* https://time.com/5793757/the-whistleblowers-100-women-of-the-year/ (2020).
40. Mathur, A. & Ramesh, V. Need of the Hour: Reformation in the Scope of Whistleblower Policies and Protection. SSRN Scholarly Paper at https://doi.org/10.2139/ssrn.3521142 (2020).
41. UN Ethics Office. https://www.un.org/en/ethics/protection-against-retaliation/index.shtml.
42. External_Whistleblowing_Policy_-_October_2013__1___1_.pdf.