

Lucy Letby: child murder case highlights need to regulate managers and improve whistleblowing procedures

LEWIS, Robin

Available from Sheffield Hallam University Research Archive (SHURA) at:

<https://shura.shu.ac.uk/33403/>

This document is the Published Version [VoR]

Citation:

LEWIS, Robin (2023). Lucy Letby: child murder case highlights need to regulate managers and improve whistleblowing procedures. *The Conversation*. [Article]

Copyright and re-use policy

See <http://shura.shu.ac.uk/information.html>

Lucy Letby: child murder case highlights need to regulate managers and improve whistleblowing procedures

Published: August 25, 2023 4.09pm BST

Robin Lewis

Senior Lecturer in Healthcare, Sheffield Hallam University

Repeated complaints were made about Letby's presence during unexplained infant deaths. PA Images / Alamy Stock Photo

The recent conviction of Lucy Letby, the neonatal nurse who murdered seven infants and attempted to murder six others while working at the Countess of Chester Hospital between 2015-2016, has raised fundamental questions about how something like this could have happened – and why it took so long to stop her.

The fact is attempts were made to stop her. Two medical consultants, Dr Stephen Brearey and Dr Ravi Jayaram, both raised concerns about unexplained infant deaths as early as July 2015. By October 2015, both brought specific concerns about Letby, who had been on duty during each of the deaths, to the senior director of nursing.

But both have related how they were rebuffed by hospital management at each stage of the process. Dr Jayaram even revealed he was told by management “not to make a fuss”. It wasn't until June 2016, after repeated complaints, that Letby was finally removed from her clinical duties.

Common sense would dictate that if a senior doctor raised concerns with managers, even informally, it would be taken seriously. This apparently wasn't the case – nor is it the first time an NHS doctor's concerns have been ignored by senior management. This highlights an urgent need to change the structure of the NHS to ensure managers and executives are held to account for the decisions they make.

Refusal to act

The NHS is an inherently hierarchical organisation, with many layers of management.

Clinical managers are typically clinicians (such as nurses) with managerial responsibilities. These middle managers oversee operations in their own clinical areas.

There are also senior managers, who often have no clinical experience. These managers have little or no contact with ward staff. They manage the hospital at the executive level, looking at finances, human resources and the hospital's reputation.

In hospitals such as the Countess of Chester, most routine decisions are made by middle management. If there's problems with staff on the ward, it's normally up to the unit manager to decide whether or not these concerns are escalated to senior management.

Hospital management was notified on multiple occasions of the senior doctors' concerns. PA Images / Alamy Stock Photo

The unit manager in this case presumably would have known Letby personally – and given that the evidence against Letby was largely circumstantial, it would have been very difficult to suspend or even investigate Letby at first.

Even once the unit manager and senior clinicians brought their concerns again to the attention of more senior management, evidence shared as part of the trial shows hospital executives pushed back – refusing to meet with them, shutting down suggestions that police needed to be involved and even ordering them to write an apology to Letby for raising concerns about her.

Brearey and Jayaram suggested that executives were attempting to minimise any reputational damage to the unit and, by extension, the hospital. The decisions of hospital executives will be investigated as part of a public inquiry.

Freedom to Speak Up

There's a long history in the NHS of lone whistleblowers being pilloried for trying to raise concerns about failings in patient care. This is what led to the Freedom to Speak Up review, which investigated how organisations dealt with concerns raised by NHS staff. Ironically, the report was published in 2015.

The review found NHS employees were often afraid of raising concerns out of fear of victimisation or the worry they wouldn't be listened to. Many also faced isolation and bullying when they did speak up.

The results of the report led to the Freedom to Speak Up policy, which provides guidance for NHS staff on how they can raise patient safety concerns. A Freedom to Speak Up Guardian is also now present in every NHS Trust to ensure issues raised are responded to.

At the time Brearey and Jayaram raised their concerns about Letby, this policy didn't exist. It's clear from what has been reported so far that this policy may have made a big difference – and could have prevented lives being lost.

But the role that management plays in cases such as this cannot be ignored. Unfortunately, this isn't the first time that preventing reputational damage has been placed ahead of patient safety. Inquiries into various NHS scandals, such as at the Bristol Children's hospital, highlighted management attempts to cover up failings in patient care and avoid negative publicity.

Even with the Freedom to Speak Up Policy, the British Medical Association reports that staff are still being victimised for raising concerns. Staff who raise concerns are often dismissed under the "some other substantial reason" (SOSR) clause which enables organisations, not just the NHS, to sack employees without needing to prove misconduct or incompetence. Clearly, the policy needs to be improved and legislation passed that would protect staff from dismissal if they do speak up.

In the aftermath of the Letby case, Brearey and Jayaram have both called for hospital managers to be regulated. Regulation would ensure that managers would need to be registered to practise in the same way as health professionals are. This would ensure that managers are held to account for their decisions and that action is taken if they're found not to be acting in the interests of patient safety.

This will need a significant philosophical shift in the way the NHS is managed. Focus needs to be moved away from managing hospitals as businesses to putting patient safety first. Holding NHS managers to account for their decisions may well be the best way to do this.

Jane Tomkinson, Acting Chief Executive Officer at the Countess of Chester Hospital NHS Foundation Trust, said:

Following the trial of former neonatal nurse Lucy Letby, the Trust welcomes the announcement of an independent inquiry by the Department of Health and Social Care. In addition, the trust will be supporting the ongoing investigation by Cheshire Police. Due to ongoing legal considerations, it would not be appropriate for the Trust to make any further comment at this time.