# The Letby Murders –

## Individual and institutional pathologies

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The shocking infant murders by nurse Lucy Letby represent a mercifully rare (we think) class of event. These remain extremely difficult to understand, predict or prevent, much as we must try. This is not true of the failure of our institutional responses to such events.

What does that mean?

**August 2023.** After many months of trial, and then many days of jury deliberation, a previously very popular and personable thirty-three-year-old neonatal nurse is found guilty of the murder of at least seven babies.

Earlier images of her look like recruitment posters for the nursing profession: an open-faced, directly-gazed, warm and kindly smile while on duty; joyfully partying and salsa dancing with friends in recreation. In her long trial she, by accounts, inevitably lost that sparkle to reveal an unrevealing softly-spoken blandness – opaque, wan and inscrutable.

Clearly Lucy Letby did not previously present as the kind of person who harboured great harm. An only child to two proud and doting parents, warmly sociable and friendly with nursing and medical colleagues, familiar to and with management … she seemed an ideal team player. In this way Letby seems different from previous UK healthcare killers, for example Dr Harold Shipman and Nurse Beverley Allitt, who did not share Letby's apparent easy warmth and attractive, friendly sociability.

So, many years after these pioneering and much publicised healthcare killers' crimes had been exposed and painfully ruminated upon, the *possibility* of these kind of heinous acts had become part of our communal consciousness. Before then – before Shipman – they had seemed unthinkable, all but impossible.

Yet despite several years of an unmistakable and otherwise unaccountable (though much clinically investigated) increase in neonatal deaths at the Countess of Chester Hospital, and despite the circumstantial evidence linking these to Letby, it took some years for the pattern to become clear enough for management to agree to a

police forensic investigation. Shortly before that an uncomfortably bewildered senior consultant said: '*It can't be Lucy, not nice Lucy*'. But the evidence was compelling; the consultants' view consolidated – Letby looked dangerously suspect. They asked management to immediately suspend her and urgently call in the police.

Management did not do this. They listened more to Letby's distressed protests of innocence. She was, she said, being scapegoated for other sources of poor competence, and physical and employment conditions that imperilled her delicate and exacting work. The consultants persisted in their evidence-stacked demands, but management now resisted this even more vigorously, sharply instructing them to sign a letter apologising to Letby for the distress to her caused by their 'unfounded' suspicion and allegations.

Eventually, as we now know, the consultants prevailed and were proved correct in their grave suspicions. This has since led to an angry backlash of doctors against their managers, alleging managers' bullying and incompetent control within matters that should remain, they say, more autonomously professional. This is a longstanding and cumulative grievance. More pragmatically, the doctors now suggest that managers should be subject to the same kind of governance as the medical profession: ie inspection, regulation, license and possible discipline or dismissal for serious incompetence or failure of integrity.

This represents a long-gestated campaign to change the balance of power in healthcare decision-making. The last thirty years of successive neoliberal reforms to the NHS have incrementally deprived practitioners of their ability to act from their clinical, vocational or human sense. Instead they must conform to instructions

concocted in often distant management boardrooms.

This is widely recognised in the profession – and by other analysts – as being a primary source of inefficiency and unhappiness amongst our 'Service Providers' … our practitioners.

At the time of writing, the doctors' request of government – to substantially increase the accountability and management of managers – looks like it may, at last, be heeded.

In the meantime how may we understand those managers' purblindness?

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First, a near-universal problem: it is often difficult to see, or even to imagine, someone doing something that makes no sense to us and may lie far outside our fantasies. Our minds tend to default to *it cannot be*; we screen-out the perception, or contort a more familiar (and benign) explanation. This seems to have been the case for many years with our blindness about Shipman, a difficult-though-diligent and prickly, circumspect man. It was not that the truth about him was deliberately covered up: it was that that truth was so incompatible with what (then) seemed both possible and sensical. This was not professional collusion, it was the blindness of cognitive bias.[1]

How much more likely such unsightedness was with Lucy Letby, a seemingly model nurse: industrious, proactive, friendly, cooperative, attractive, empathic. 'It can't be

Lucy, not nice Lucy', as the senior investigating consultant said as he struggled to overcome his own cognitive bias. Such is the difficulty in seeing 'evil-in-our-midst'.

And we need to consider how the very concept of evil-in-our-midst is beset with frighteningly destructive possibilities and so requires our most challenging discriminations. It is double-edged in its potency. The dangers of misapplication are quite as great as those of denial: the former leads to our grossest scapegoatings, racisms, and frenzied mass blood-lusts; the latter leads to Letby, Jimmy Saville and the Magdalene Laundries. To example how we can err either way, consider this last month of August in the Crown Courts: close in time to the eventual conviction of Letby was the long-delayed exoneration of Andrew Malkinson. He had been wrongfully imprisoned for seventeen years for a false charge of rape. His steadfast protests of innocence were disregarded until the review of post-trial evidence solidly proved his veracity.

So we can – at least partially – understand the hospital managers' reluctance or resistance to accusing 'nice Lucy': unfounded accusations can be catastrophically life-changing, even life-ending, for the individual. For a difficult-to-staff workforce it can add to a sense of mistrust, endogenous hazard and wary dispiritedness. But a persistently unexpected and unexplained increase in neonatal death is a troubling yet unconjectured fact: for a while it remains far less explosively controversial or divisive. In a highly stressed and beleaguered organisation, that unsolved problem is the more manageable option: that is the one to stay with, for as long as possible…

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Such are the more general difficulties in attempting to accurately identify or eliminate the most rare and grave concealed heinous acts amongst us. Even more generally we cannot know with certainty the internal world, the motivation or intent of another. Mostly our guesses are good enough, that is how we get along. But serious errors – even between the long-familiar – are common: the divorced together with their lawyers provide ample and easy evidence of this

This conundrum becomes yet more difficult the longer the chain of response and responsibility. So with Letby we had the individual practitioner (A), her clinical team (B), and the hospital management responsible overall (C). So we have C having responsibility to identify and decode behaviour by A which has been deliberately and stealthily concealed and encrypted.

Little wonder this is so easy to get wrong; why cognitive bias can be such an expedient refuge.

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Yet there are current and important systemic issues that contribute strongly to such cognitive bias, and then its even more entrenched confirmation bias.

The last three decades of neoliberal reforms to the NHS have spawned a network of fiefdom-like autarkies whose operation has been modelled on competitive manufacturing industries producing consumer objects. This (mis)managed evolution has inevitably jettisoned the possibilities of cooperation, trust and practitioner judgement that used to guide and fuel our pre-reformed and pre-commercially-

industrialised Welfare services.

The intention to hierarchically and tightly manage all clinicians was boosted, more than twenty years ago, by the Shipman Inquiry. The presiding Judge there concluded that Shipman killed largely because he was irresponsibly unaccountable and unmanaged: more micromanaged accountability should be mandatory.

And so it became.

While there was some truth in this Judge's view, she could not see – by definition – her own cognitive bias, the way her crude assertion was also *not* true. For many years since, this deficit has been evident and documented.[1]

Due largely to that watershed judgement, the hierarchical management network of the NHS, with all its devices of surveillance and regulation, has grown ever-greater and denser. Amidst all this we have (unironically named) Trusts whose commanding regimes have become, so often, mistrustful and mistrusted. The culture generated has become a Darwinian struggle for survival: camouflage, concealments, aggression-displays, covert parasitism, sleights of illusion are all commonplace. Forty years ago they were much rarer – though, of course, there were other problems.

This is the edgy, precarious and insecure culture in which often highly-paid managers must handle their poisoned chalice. In this business-modelled service, maintaining a confident and positive public image and reputation are seen as crucial to the marketing or survival of the Trust, the department, one's own career. Such

organisational personas are easier to manipulate than, by definition, our unshowcased issues of underlying integrity. Such expediencies become cultural, eventually they gain slickness via their unconscious tenacity.

Many fear that such defensive expedience is what largely explains the obdurate resistance of management to look at, and into, what was becoming increasingly clear and difficult on Letby's unit.

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And what of Lucy Letby herself, the vivacious murderess? How do we best understand her motivation? We learned little to help us from her trial. This probably augurs for future opacity: like most serial killers she will probably resist any candid dialogue of disclosure. We currently know little of any personal troubles, trauma and distress. In her writings she describes the problem of being an only child to retired and ageing parents whose adulating love is difficult to separate from: a toxic-glue-guilt syndrome that is not uncommon. That glue may be very adhesive: she writes, 'I will never get married or have children …'. But at work and socially her behaviour, until the grave allegations against her, seemed very positive and well-adjusted. Any forensic psychiatry or forensic psychology remains impotent in the face of such an enigma: they can offer academically interesting speculation (philosophy), but neither can help us with prior identification, accurate prediction or effective prevention (applied science).

So, what to do? Yes, we can increase some safety procedures and regulations – for example, make sure all injections and intravenous administrations are performed by

two practitioners and then double-signed for. But how could we possibly implement that with an already-depleted workforce?

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Amidst all these riddles and uncertainties there is one that is much more remediable and better understood: our commercially corporatised healthcare culture, and how that so alienates us from one another that difficult tasks that require our ready cooperation become ever-more impossible.

Lucy Letby's grotesque perversion of care will, rightly, generate shock-horror headlines, but our institutional human disconnections create far more extensive, if insidious, damage.

The greater tragedy is we become accustomed to this: it endures as cultural landscape.

There are no headlines about landscapes.

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**Reference**

1: Zigmond, D. 'Harold Shipman, Serial Killer: Mad, Bad or What?', *British Journal of General Practice*, 8/12/20. Also available as Article 132 on David Zigmond Home Page Archive.

Interested? Many articles exploring similar themes are available on David

Zigmond's Home Page (http://www.marco-learningsystems.com/pages/david-zigmond/david-zigmond.html).