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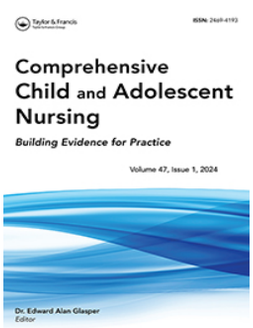

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EDITORIAL

Child Killers in Our Midst: Why the Lessons Learned About Safeguarding Shortfalls in the Care of Sick Children Must Not Be Confined to the Trash Can of History

Emeritus Professor Alan Glasper from the University of Southampton and Senior Lecturer Dr Debbie Fallon from the University of Manchester discuss how lessons can be learned after the criminal conviction of Lucy Letby, an English children's and young people's nurse for the multiple murders of babies in August 2023.

Although murders committed by health care professionals are not well understood, they are becoming increasingly identified and brought to our attention in the media, perhaps as a reflection of whistle blowing acceptability and the overall adoption and embracement of the duty of candor worldwide.

Throughout history, both doctors and nurses have been found guilty of murdering the very people they were supposed to be caring for. Indeed, Yorker et al. (2006) accurately chronicle the catalog of health care professionals who have murdered or attempted to murder their patients since the 1970s and the majority of the 94 worldwide health care worker offenders cited in this research have been nurses.

The reasons behind the higher percentage of nurses engaging in such heinous crimes are unknown, but health care professionals have the same foibles as any other human being, and in line with the general population, it is likely that some may have symptoms, experiences or tendencies that fit diagnostic criteria for personality disorders including antisocial personality disorder. We can speculate that nurses with intentions to cause harm are able to do so because they have more unobserved close personal contact with their patients and therefore more opportunities to commit such crimes when compared to doctors in hospital settings. Unobserved contact was also a key feature of the case of Harold Shipman, a family physician in the UK, who was eventually convicted in 1999 of

murdering 15 elderly patients during community visits in the English city of Manchester, though it is widely believed that he had killed as many as 250 people in his care. Shipman committed suicide in prison in 2004.

In terms of nursing, in the USA, one of the most notorious health care serial killers was a nurse called Charles Cullen. Cullen was convicted of murdering 29 patients, although the number of deaths was potentially more than 400 committed over a 16-year period (Yardley & Wilson, 2016). Cullen will never be released from prison as his criminal sentence amounted to 11 consecutive life terms, totaling 397 years. In 2022, British actor Eddie Redmayne portrayed the nurse Charles Cullen in a Netflix biographical crime drama entitled "The Good Nurse."

It is the murder of children in hospital by those nurses who care for them which is particularly concerning for the children's and young people's workforce.

In the USA, the so-called baby killer Genene Jones was jailed for life in 1984 for murdering a child in her care at a San Antonio hospital and for administering an overdose to a second child. As with Cullen, the true number of her child murders may never be known (Staglin, 2020).

Nearly a decade later, Beverly Allitt, a nurse who worked with sick children at a hospital in the English county of Lincolnshire, was convicted of murdering four children and the attempted murder of three others. She was sentenced to life imprisonment in 1993. It is still not clear after all these years why Beverly Allitt committed these crimes, although it has been theorized within in the medical press that she suffered from Munchausen syndrome by proxy, now known of as "Factitious Disorder" (Biography.com Editors, 2020).

However, such crimes are not a modern phenomenon; indeed, Grey (2015) highlights the case of Eva Grace Thompson, a nurse who murdered a number of children at a pediatric facility in London during World War I. During her trial, Thompson was found to be "guilty, but insane", highlighting, as with Allitt, how the mental health of the perpetrators is often brought into question. No such conclusions were drawn about Letby at her sentencing.

In the aftermath of the Allitt case, the nursing profession went through a prolonged period of reflection on what steps to take to prevent this tragedy from ever happening again. One of the primary findings of the subsequent inquiry following the conviction of Beverly Allitt was the revelation that the number of qualified children's nurses on the ward where she worked was significantly lower than the standard recommended by the Royal College of Nursing, i.e. two qualified children's and young people's nurses to be available at all times. These minimum standards are now enshrined in RCN policy and went some way to address the notion of unobserved interactions (Royal College of Nursing, 2015).

There were also calls for an overhaul of the occupational health strategy of the UK's National Health service, addressing the need for closer scrutiny at recruitment to prevent the subsequent recruitment of another Allitt (Parliament, 1994).

At the time, we were senior nurse educators in the field of children's and young people's nursing in the period that followed the 1984 Clothier inquiry into the Allitt case (Parliament, 1994).

This meant that we were involved in many debates on how to improve the way in which student nurses were recruited and subsequently monitored throughout their training. Consequently, significant steps were taken by regulated nurse training institutions to mitigate against people who were deemed unfit for whatever reason to register as nurses, which included implementing strategies to monitor and scrutinize when and where

necessary the progress of students through the introduction of "fitness for practice" panels. These are a special type of disciplinary panel for nursing students, and their appearances before such panels are often prompted by concerns raised in clinical placement environments by supervisors or assessors.

The trial and conviction of Letby provided little insight into how our profession might avoid such cases in the future. Therefore, despite the post Allitt implementation of more rigorous procedures in both recruitment and monitoring of student nurses throughout their training, the faith of the nursing profession in its ability to safeguard and protect health service users is shattered. Like her predecessor Beverly Allitt, Lucy Letby was sentenced to life imprisonment and suspended from the NMC register. Following her conviction for murder, the regulator will take additional regulatory action, to strike her off the register (Nursing & Midwifery Council, 2023; O'Donoghue, 2023).

How did this unthinkable event happen?

Education

In terms of entry into the profession, Letby qualified as a children's nurse at the UK's University of Chester in 2011 and successfully applied for a staff nurse position in the neonatal unit of the Countess of Chester Hospital in 2012. We now know that from June 2015, she fatally attacked and killed babies in her care.

Undetected by post Allitt student recruitment and monitored procedures, Letby was able to complete the theory and supervised practise required to complete a degree in children's nursing which enabled her to register as a trained nurse with the UK's Nursing and Midwifery regulator, the Nursing and Midwifery Council (NMC). Whilst students are monitoring in the educational setting, those settings are all approved nurse training institutions and are closely monitored by the NMC as part of their quality assurance processes. The NMC also monitors the ability of the institutional practice learning partners, e.g., hospital wards and departments, to continue to offer appropriate clinical learning environments for nursing and midwifery students. In the context of such processes, Letby's criminal intent remained undetected. The complexities of detecting potential patient murderers and efforts to compile psychological profiles to identify such individuals are highlighted in a Lancet editorial about the Letby case which points out that Letby appeared to be a model nurse with none of these traits (The Lancet, 2023).

It may be that approved educational institutions offering nursing courses leading to state registration in the UK will have to work with the regulator in future to determine what additional processes need to be implemented to mitigate against people with the potential to be a danger to others entering the registered nurse work force.

Clinical environment

Once qualified, safeguarding measures rest with the clinical setting. Dean (2015) highlights that previous nurse serial killers have exhibited so-called "red flag" markers such as unexplained high levels of patient deaths during their periods of duty and/or raising anxiety levels among their coworkers, both of which were reported in the Letby case. The Countess of Chester neonatal unit also had regular

morbidity and mortality meetings in place designed to reflect on adverse incidents with a view to improving clinical care but again this failed to specifically indict Letby.

The value of whistle blowers in safeguarding patients is highlighted in the Lancet Editorial, but whistle blowers often fear retribution. We now know that whistle blowers concerns and reports to managers about Letby were ignored and in several cases her colleagues who had raised concerns about her in relation to the series of unexplained deaths were forced to make an apology to her. The lead medical neonatologist had also on one occasion specifically requested that Letby be relieved of duty following the unexplained deaths of two triplets on June 24, 2016. However, this request was not upheld by the duty executive. Again, potential safety net measures failed to protect the public.

The Letby case has therefore shone some light on the potential role of health care management in safeguarding the public. Following the police investigation, the NMC has confirmed it will proceed with a fitness to practise investigation into her former nurse manager who has subsequently been suspended from her current role following concerns about her handling of neonatal clinicians' concerns at the time of the infant deaths in Chester.

It is now up to the nursing profession and its regulator the NMC to contemplate the steps necessary to prevent further cases arising. This is vital as yet another children's nurse is currently being criminally investigated after the death of a baby at the UK's Birmingham children's hospital (FP Staff, 2023; Halliday et al., 2023).

Undoubtedly, the trauma and horror of the Lucy Letby case will force the issue of selection of prospective nurses back to the top of the agenda for nursing schools, the nursing regulator, and others. As yet there appears to be no known processes for identifying serial killer nurses, but the role of nursing regulators such as the NMC is to engage with the profession to highlight that not all nurses are angels and that some are capable of harming patients in their care. However, detecting and preventing an individual nurse from engaging in malicious acts is complicated as is identifying warning signs to detect individuals who might pose a risk to the patients in their care (Tilley et al., 2019).

Clearly after the Letby conviction, there will be another review, similar to that following the conviction of Beverly Allitt, although details of this are yet to be made public. The English Department of Health has stated that the inquiry review aims to provide answers to the victims' parents and examine how clinicians' concerns were handled and importantly to ensure that lessons are learnt (Baker, 2023).

One of the areas being openly debated is the implementation of similar strategies to that used in the airline industry. Here, Pilot Psychological Assessments in the form of Pilot Aptitude Tests prior to commencing training or during an assessment process for employment are used. These aptitude tests are a form of psychometric testing that provide an insight into an individual's suitability for a particular role. This testing reveals cognitive abilities, personality traits, operational and professional competencies and social competencies and may be a blueprint for similar testing among future and current health care professionals (Akhurst, 2021).

However, despite being utilized for decades, these psychological testing mechanisms to determine if a pilot is fit to fly have been questioned in the light of the Germanwings Airbus 320 crash when Andreas Lubritz, the copilot of the plane, intentionally crashed it into

French Alps, killing all the people on the flight. With the current system, a pilot who does not raise any obvious red flags will be allowed to keep flying. This is because the system relies on pilots self-declaration, and unless that pilot is scrupulously honest about a problem involving mental health issues, there is no guarantee that an underlying problem would be recognized. It is now believed that the industry should adopt a more stringent psychological testing of pilots which is perhaps a lesson for the Letby review (Ortiz & Jamieson, 2015).

Whatever the Letby review reveals, there are lessons to be learned which will affect children's and young people's nurses across the globe, who work hard every day to ensure the optimum health of their child patients and whose "raison d'etre" is "The child first and always." It will be important that these lessons are not confined to the trash can of history!

References

Akhurst, E. (2021, July). Pilot psychological assessment- what is it all about? *Airside Magazine*. https://airside.testcloud.cae.com/magazine/articles/pilot-psychological-assessment-what-is-it-all-about

Baker, G. (2023). Lucy Letby: What happens next with inquiry, prison and police review. *BBC News*. https://www.bbc.com/news/explainers-66573845

Biography.com Editors. (2020). Beverly Allitt. *Biography.com*. https://www.biography.com/crime/beverley-allitt

Dean, E. (2015). How to spot a nurse killer. *Nursing Standard*, *29*(21), 20. https://doi.org/10.7748/ns.29.32.20.s22

FP Staff. (2023, August). After Lucy Letby, another British nurse under investigation for baby's death. *Firstpost*. https://www.firstpost.com/world/after-lucy-letby-another-british-nurse-under-investigation-for-babys-death-13050472.html

Grey, D. (2015). Murder, mental illness, and the question of nursing "character" in Early Twentieth Century England. *History Workshop Journal*, *80*(1), 183–200. https://doi.org/10.1093/hwj/dbv021

The Lancet. (2023, September). The Lucy Letby case: Lessons for health systems. *The Lancet*. https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(23)01839-1/fulltext

Nursing & Midwifery Council. (2023, August). NMC responds to verdict in Lucy Letby trial. *Nursing & Midwifery. Council*.https://www.nmc.org.uk/news/news-and-updates/nmc-responds-to-verdict-in-lucy-letby-trial/#:~:text=%E2%80%9CThis%20has%20been%20a%20long%2C%20complex%20criminal%20investigation.,action%2C%20seeking%20to%20strike%20her%20off%20the%20register.%E2%80%9D

O'Donoghue, D. (2023, August). Lucy Letby: What did the nurse do to babies in her care? *BBC News*. https://www.bbc.com/news/uk-england-merseyside-65176260

Ortiz, E., & Jamieson, A. (2015, March). After germanwings crash, testing of pilots' mental health in spotlight. *NBC News*. https://www.nbcnews.com/storyline/german-plane-crash/after-germanwings-crash-pilots-mental-health-testing-question-n330831

Parliament. (1994). Beverly Allitt (report). *Parliament*. https://api.parliament.uk/historic-hansard/commons/1994/feb/11/beverly-allitt-report#:~:text=The%20Clothier%20report%20identifies%20and%20criticises,first%20evidence%20of%20possible%20foul%20play.&text=The%20Clothier%20report%20identifies,of%20possible%20foul%20play.&text=report%20identifies%20and%20criticises,first%20evidence%20of%20possible

Royal College of Nursing. (2015). Mandatory nurse staffing levels. *Royal College of Nursing*. https://www.rcn.org.uk/about-us/our-influencing-work/policy-briefings/pol-0312

Staglin, D. (2020, January 7). She was suspected of killing dozens of children. Now, woman dubbed 'killer nurse' gets life sentence. *USA Today*. https://www.usatoday.com/story/news/nation/2020/01/17/texas-killer-nurse-genene-jones-guilty-infant-death/4499258002/

Tilley, E., Devion, C., Coghlan, A. L., & McCarthy, K. (2019). A regulatory response to healthcare serial killing. *Journal of Nursing Regulation*, *10*(1), 4–14. https://doi.org/10.1016/S2155-8256(19)30077-8

Halliday, J., Blight, G., Fischer, H., & Kirk, A. (2023, August). Timeline of Lucy Letby's attacks on babies and when alarm was raise. *The Guardian*. https://www.theguardian.com/uk-news/ng-interactive/2023/aug/18/lucy-letby-timeline-attacks-babies-when-alarm-raised

Yardley, E., & Wilson, D. (2016). In search of the 'angels of death': Conceptualising the Contemporary Nurse Healthcare Serial Killer. *Journal of Investigative Psychology & Offender Profiling*, *13*(1), 39–55. https://doi.org/10.1002/jip.1434

Yorker, B. C., Kizer, K. W., Lampe, P., Forrest, A. R. W., Lannan, J. M., & Russell, D. A. (2006). Serial murder by healthcare professionals. *Journal of Forensic Sciences*, *51*(6), 1362–1371. https://doi.org/10.1111/j.1556-4029.2006.00273.x

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