

A REPORTER AT LARGE

A BRITISH NURSE WAS FOUND GUILTY OF KILLING SEVEN BABIES. DID SHE DO IT?

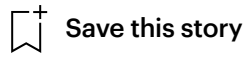
Colleagues reportedly called Lucy Letby an “angel of death,” and the Prime Minister condemned her. But, in the rush to judgment, serious questions about the evidence were ignored.

By Rachel Aviv

May 13, 2024



The case against Letby gathered force on the basis of a single diagram shared by the police, which circulated widely in the media. Illustration by Vartika Sharma



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Last August, Lucy Letby, a thirty-three-year-old British nurse, was convicted of killing seven newborn babies and attempting to kill six others. Her murder trial, one of the longest in English history, lasted more than ten months and captivated the United Kingdom. The *Guardian*, which published more than a hundred stories about the case, called her “one of the most notorious female murderers of the last century.” The collective acceptance of her guilt was absolute. “She has thrown open the door to Hell,” the *Daily Mail* wrote, “and the stench of evil overwhelms us all.”

The case galvanized the British government. The Health Secretary immediately announced an inquiry to examine how Letby’s hospital had failed to protect babies. After Letby refused to attend her sentencing hearing, the Justice Secretary said that he’d work to change the law so that defendants would be required to go to court to be sentenced. Rishi Sunak, the Prime Minister, said, “It’s cowardly that people who commit such horrendous crimes do not face their victims.”

The public conversation rushed forward without much curiosity about an incongruous aspect of the story: Letby appeared to have been a psychologically healthy and happy person. She had many close friends. Her nursing colleagues spoke highly of her care and dedication. A detective with the Cheshire police, which led the investigation, said, “This is completely unprecedented in that there doesn’t seem to be anything to say” about why Letby would kill babies.

“There isn’t really anything we have found in her background that’s anything other than normal.”

The judge in her case, James Goss, acknowledged that Letby appeared to have been a “very conscientious, hard working, knowledgeable, confident and professional nurse.” But he also said that she had embarked on a “calculated and cynical campaign of child murder,” and he sentenced her to life, making her only the fourth woman in U.K. history condemned to die in prison. Although her punishment can’t be increased, she will face a second trial, this June, on an attempted-murder charge for which the jury could not reach a verdict.

Letby had worked on a struggling neonatal unit at the Countess of Chester Hospital, run by the National Health Service, in the West of England, near Wales. The case centered on a cluster of seven deaths, between June, 2015, and June, 2016. All but one of the babies were premature; three of them weighed less than three pounds. No one ever saw Letby harming a child, and the coroner did not find foul play in any of the deaths. (Since her arrest, Letby has not made any public comments, and a court order has prohibited most reporting on her case. To describe her experiences, I drew from more than seven thousand pages of court transcripts, which included police interviews and text messages, and from internal hospital records that were leaked to me.)

The case against her gathered force on the basis of a single diagram shared by the police, which circulated widely in the media. On the vertical axis were twenty-four “suspicious events,” which included the deaths of the seven newborns and seventeen other instances of babies suddenly deteriorating. On the horizontal axis were the names of thirty-eight nurses who had worked on the unit during that time, with X’s next to each suspicious event that occurred when they were on shift. Letby was the only nurse with an uninterrupted line of X’s below her name. She was the “one common denominator,” the “constant malevolent presence when things took a turn for the worse,” one of the prosecutors, Nick Johnson, told the jury in his opening statement. “If you look at the table overall the picture is, we suggest, self-evidently obvious. It’s a process of elimination.”

But the chart didn't account for any other factors influencing the mortality rate on the unit. Letby had become the country's most reviled woman—"the unexpected face of evil," as the British magazine *Prospect* put it—largely because of that unbroken line. It gave an impression of mathematical clarity and coherence, distracting from another possibility: that there had never been any crimes at all.

Since Letby was a teen-ager, she had wanted to be a nurse. "She'd had a difficult birth herself, and she was very grateful for being alive to the nurses that would have helped save her life," her friend Dawn Howe told the BBC. An only child, Letby grew up in Hereford, a city north of Bristol. In high school, she had a group of close friends who called themselves the "miss-match family": they were dorky and liked to play games such as Cranium and Twister. Howe described Letby as the "most kind, gentle, soft friend." Another friend said that she was "joyful and peaceful."

Letby was the first person in her family to go to college. She got a nursing degree from the University of Chester, in 2011, and began working on the neonatal unit at the Countess of Chester Hospital, where she had trained as a student nurse. Chester was a hundred miles from Hereford, and her parents didn't like her being so far away. "I feel very guilty for staying here sometimes but it's what I want," she told a colleague in a text message. She described the nursing team at the Countess as "like a little family." She spent her free time with other nurses from the unit, often appearing in pictures on Facebook in flowery outfits and lip gloss, with sparkling wine in her hand and a guileless smile. She had straight blond hair, the color washing out as she aged, and she was unassumingly pretty.

The unit for newborns was built in 1974, and it was outdated and cramped. In 2012, the Countess launched a campaign to raise money to build a new one, a process that ended up taking nine years. "Neonatal intensive care has improved in recent years but requires more equipment which we have very little space for," Stephen Brearey, the head of the unit, told the *Chester Standard*. "The

risks of infection for the babies is greater, the closer they are to each other.” There were also problems with the drainage system: the pipes in both the neonatal ward and the maternity ward often leaked or were blocked, and sewage occasionally backed up into the toilets and sinks.

The staff were also overtaxed. Seven senior pediatricians, called consultants, did rounds on the unit, but only one was a neonatologist—a specialist in the care of newborns. An inquest for a newborn who died in 2014, a year before the deaths for which Letby was charged, found that doctors had inserted a breathing tube into the baby’s esophagus rather than his trachea, ignoring several indications that the tube was misplaced. “I find it surprising these signs were not realised,” the coroner said, according to the *Daily Express*. The boy’s mother told the paper that “staff shortages meant blood tests and X-rays were not assessed for seven hours and there was one doctor on duty who was splitting his time between the neonatal ward and the children’s ward.”

The N.H.S. has a totemic status in the British psyche—it’s the “closest thing the English have to a religion,” as one politician has put it. One of the last remnants of the postwar social contract, it inspires loyalty and awe even as it has increasingly broken down, partly as a result of years of underfunding. In 2015, the infant-mortality rate in England and Wales rose for the first time in a century. A survey found that two-thirds of the country’s neonatal units did not have enough medical and nursing staff. That year, the Countess treated more babies than it had in previous years, and they had, on average, lower birth weights and more complex medical needs. Letby, who lived in staff housing on the hospital grounds, was twenty-five years old and had just finished a six-month course to become qualified in neonatal intensive care. She was one of only two junior nurses on the unit with that training. “We had massive staffing issues, where people were coming in and doing extra shifts,” a senior nurse on the unit said. “It was mainly Lucy that did a lot.” She was young, single, and saving to buy a house. That year, when a friend suggested that she take some time off, Letby texted her, “Work is always my priority.”

In June, 2015, three babies died at the Countess. First, a woman with antiphospholipid syndrome, a rare disorder that can cause blood clotting, was admitted to the hospital. She was thirty-one weeks pregnant with twins, and had planned to give birth in London, so that a specialist could monitor her and the babies, but her blood pressure had quickly risen, and she had to have an emergency C-section at the Countess. The next day, Letby was asked to cover a colleague's night shift. She was assigned one of the twins, a boy, who has been called Child A. (The court order forbade identifying the children, their parents, and some nurses and doctors.) A nursing note from the day shift said that the baby had had "no fluids running for a couple of hours," because his umbilical catheter, a tube that delivers fluids through the abdomen, had twice been placed in the wrong position, and "doctors busy." A junior doctor eventually put in a longline, a thin tube threaded through a vein, and Letby and another nurse gave the child fluid. Twenty minutes later, Letby and a third nurse, a few feet away, noticed that his oxygen levels were dropping and that his skin was mottled. The doctor who had inserted the longline worried that he had placed it too close to the child's heart, and he immediately took it out. But, less than ninety minutes after Letby started her shift, the baby was dead. "It was awful," she wrote to a colleague afterward. "He died very suddenly and unexpectedly just after handover."

A pathologist observed that the baby had "crossed pulmonary arteries," a structural anomaly, and there was also a "strong temporal relationship" between the insertion of the longline and the collapse. The pathologist described the cause of death as "unascertained."

Letby was on duty again the night after Child A's death. At around midnight, she helped the nurse who had been assigned to the surviving twin, a girl, set up her I.V. bag. About twenty-five minutes later, the baby's skin became purple and blotchy, and her heart rate dropped. She was resuscitated and recovered. Brearey, the unit's leader, told me that at the time he wondered if the twins had been more vulnerable because of the mother's disorder; antibodies for it can pass through the placenta.

The next day, a mother who had been diagnosed as having a dangerous placenta condition gave birth to a baby boy who weighed one pound, twelve ounces, which was on the edge of the weight threshold that the unit was certified to treat. Within four days, the baby developed acute pneumonia. Letby was not working in the intensive-care nursery, where the baby was treated, but after the child's oxygen alarm went off she came into the room to help. Yet the staff on the unit couldn't save the baby. A pathologist determined that he had died of natural causes.

Several days later, a woman came to the hospital after her water broke. She was sent home and told to wait. More than twenty-four hours later, she noticed that the baby was making fewer movements inside her. "I was concerned for infection because I hadn't been given any antibiotics," she said later. She returned to the hospital, but she still wasn't given antibiotics. She felt "forgotten by the staff, really," she said. Sixty hours after her water broke, she had a C-section. The baby, a girl who was dusky and limp when she was born, should have been treated with antibiotics immediately, doctors later acknowledged, but nearly four hours passed before she was given the medication. The next night, the baby's oxygen alarm went off. "Called Staff Nurse Letby to help," a nurse wrote. The baby continued to deteriorate throughout the night and could not be revived. A pathologist found pneumonia in the baby's lungs and wrote that the infection was likely present at birth.

"We lost [her]," Letby texted a close friend I'll call Margaret, a shift leader on the unit. Margaret had mentored Letby when she was a student training on the

ward.

“What!!!!!! But she was improving,” Margaret replied. “What happened? Wanna chat? I can’t believe you were on again. You’re having such a tough time.”

Letby told Margaret that the circumstances of the death might be investigated.

“What, the delay in treatment?”

“Just overall,” she said. “And reviewing what antibiotics she was on, etc., if it is sepsis.” Letby wrote that she was still in shock. “Feel a bit numb.”

“Oh hun, you need a break,” Margaret said. Reflecting on the first of the three deaths, Margaret told her that the baby’s parents would always grieve the loss of their child but that, because of the way Letby had cared for him, they’d hopefully have no regrets about the time they spent with their son. “Just trying to help you take the positives you deserve from tough times,” Margaret wrote. “Always here. Speak later. Sleep well xxx.”

A few days later, Letby couldn’t stop crying. “It’s all hit me,” she texted another friend from the unit. She wrote that two of the deaths seemed comprehensible (one was “tiny, obviously compromised in utero,” and the other seemed septic, she wrote), but “it’s [Child A] I can’t get my head around.”

The senior pediatricians met to review the deaths, to see if there were any patterns or mistakes. “One of the problems with neonatal deaths is that preterm babies can die suddenly and you don’t always get the answer immediately,” Brearey told me. A study of about a thousand infant deaths in southeast London, published in *The Journal of Maternal-Fetal & Neonatal Medicine*, found that the cause of mortality was unexplained for about half the newborns who had died unexpectedly, even after an autopsy. Brearey observed that Letby was involved in each of the deaths at the Countess, but “it didn’t sound to me like the odds were that extreme of having a nurse present for three of those cases,” he said. “Nobody had any concerns about her practice.”

The head of the pediatrics department, Ravi Jayaram, told me, “There was an element of ‘Thank God Lucy was on,’ because she’s really good in a crisis.” He described Letby as “very popular” among the nurses. To make sense of the events, Jayaram said, “you sort of think, Well, maybe the baby wasn’t as stable as we thought, and maybe that longline was in just a bit far, and it got into the heart and caused a heart-rhythm problem. You try and make things fit, because we like to have an explanation—for us and for the parents—and it’s much harder to say, ‘I’m sorry. I don’t know what went on.’ ”

Four months later, another baby died. She had been born at twenty-seven weeks, just past the age that the unit treated. At one point, she was transferred to another hospital, called Arrowe Park, for more specialized care—she had an infection and a small bleed in her brain—but after two nights she returned to the Countess, where her condition deteriorated. Brearey told me, “Senior nursing staff were blaming the neonatal unit that sent back the baby, saying that they hadn’t been entirely honest, that they were just trying to clear a space.” The baby’s mother worried that the staff at the Countess were too busy to pay proper attention to her daughter. She recalled that a nurse named Nicky was “sneezing and coughing whilst putting her hands in [the baby’s] incubator.” She added, “To top it off, whilst Nicky was in the room, the doctor, who was seeing another baby, asked Nicky if she was full of a cold, to which she said, ‘Yeah, I’ve been full of it for days.’ So even the doctors were aware and didn’t do anything.” In a survey the next year of more than a thousand staff members at the Countess, about two-thirds said that they had felt pressure to come to work even when they were ill. (None of the hospitals mentioned in this piece would comment, citing the court order.)

The staff tried to send the girl to a specialized unit at a different hospital, but, while they were waiting to confirm the transfer, she began struggling to breathe. Her designated nurse was not yet trained in intensive care, and she shouted for help. Letby, who had been assigned to a different baby, came into the room, followed by two doctors, but the baby continued to decline and could not be revived.

A doctor later saw Letby crying with another nurse. “It was very much on the gist of ‘It’s always me when it happens, my babies,’ ” the doctor said, adding that this seemed like a normal reaction. Letby texted Margaret that she had spoken with the neonatal-unit manager, Eirian Powell, who had encouraged her to “be confident in my role without feeling the need to prove myself, which I have felt recently.”

Three of the nurses on the ward attended the baby’s funeral, and Letby gave them a card addressed to the child’s parents. “It was a real privilege to care for [her] and to get to know you as a family, a family who always put [her] first and did everything possible for her,” she wrote. “She will always be a part of your lives and we will never forget her. Thinking of you today and always.”

Jayaram, who was on duty during the girl’s death, discussed the events with Brearey and another pediatrician. “ ‘You know what’s funny?’ ” he said that he told them. “ ‘It was Lucy Letby who was on.’ And we all looked at each other and said, ‘You know, it’s always Lucy, isn’t it?’ ”

They shared their concerns about the correlation with senior management, and Powell conducted an informal review. “I have devised a document to reflect the information clearly and it is unfortunate she was on,” she wrote to Brearey. “However each cause of death was different.”

The next month, Letby, who was in a salsa group, got out of class and saw three missed calls: the nurses on the unit had called her because they didn’t know how to give a baby intravenous immunoglobulin treatment. “Just can’t believe that some people were in a position when they don’t know how to give something, what equipment to use and not being supported by manager,” Letby texted her best friend, a nurse I’ll call Cheryl. “Staffing really needs looking at.” She described the unit as “chaos” and a “madhouse.”

One of the senior pediatricians, Alison Timmis, was similarly distressed. She e-mailed the hospital’s chief executive, Tony Chambers, to complain that staff on the unit were “chronically overworked” and “no one is listening.” She wrote,

“Over the past few weeks I have seen several medical and nursing colleagues in tears.” Doctors were working shifts that ran more than twenty hours, she explained, and the unit was so busy that “at several points we ran out of vital equipment such as incubators.” At another point, a midwife had to assist with a resuscitation, because there weren’t enough trained nurses. “This is now our normal working pattern and it is not safe,” Timmis wrote. “Things are stretched thinner and thinner and are at breaking point. When things snap, the casualties will either be children’s lives or the mental and physical health of our staff.”

At the end of January, 2016, the senior pediatricians met with a neonatologist at a nearby hospital, to review the ward’s mortality data. In 2013 and 2014, the unit had had two and three deaths, respectively. In 2015, there had been eight. At the meeting, “there were a few learning points, nothing particularly exciting,” Brearey recalled. Near the end, he asked the neonatologist what he thought about the fact that Letby was present for each death. “I can’t remember him suggesting anything, really,” Brearey said.

But Jayaram and Brearey were increasingly troubled by the link. “It was like staring at a Magic Eye picture,” Jayaram told me. “At first, it’s just a load of dots,” and the dots are incoherent. “But you stare at them, and all of a sudden the picture appears. And then, once you can see that picture, you see it every time you look, and you think, How the hell did I miss that?” By the spring of 2016, he said, he could not “unsee it.”

Many of the deaths had occurred at night, so Powell, the unit manager, shifted Letby primarily to day shifts, because there would be “more people about to be able to support her,” she said.

In June, 2016, three months after the change, Cheryl texted Letby before a shift, “I wouldn’t come in!”

“Oh, why?” Letby responded.

“Five admissions, 1 vent.”

“OMG,” Letby responded.

Cheryl added that a premature boy with hemophilia looked “like shit.” His oxygen levels had dropped during the night. Letby took over his care that morning, and doctors tried to intubate him, but they were unable to insert the tube, so they called two anesthesiologists, who couldn’t do it, either. The hospital didn’t have any factor VIII, an essential medicine for hemophiliacs. Finally, they asked a team from Alder Hey Children’s Hospital, which was thirty miles away, to come to the hospital with factor VIII. A doctor from Alder Hey intubated the child on the first try. “Sat having a quiet moment and want to cry,” Letby wrote to a junior doctor, whom I’ll call Taylor, who had become a close friend. “Just feel like I’ve been running around all day and not really achieved anything positive for him.”

A week later, a mother gave birth to identical triplet boys, born at thirty-three weeks. When she was pregnant, the mother said, she had been told that each baby would have his own nurse, but Letby, who had just returned from a short trip to Spain with friends, was assigned two of the triplets, as well as a third baby from a different family. She was also training a student nurse who was “glued to me,” she complained to Taylor. Seven hours into Letby’s shift, one of the triplet’s oxygen levels dropped precipitously, and he developed a rash on his chest. Letby called for help. After two rounds of CPR, the baby died.

The next day, Letby was the designated nurse for the two surviving triplets. The abdomen of one of them appeared distended, a possible sign of infection. When she told Taylor, he messaged her, “I wonder if they’ve all been exposed to a bug that benzylpenicillin and gentamicin didn’t account for? Are you okay?”

“I’m okay, just don’t want to be here really,” Letby replied. The student nurse was still with her, and Letby told Taylor, “I don’t feel I’m in the frame of mind to support her properly.”

A doctor came to check on the triplet with the distended abdomen, and, while he was in the room, the child’s oxygen levels dropped. The baby was put on a

ventilator, and the hospital asked for a transport team to take him to Liverpool Women's Hospital. As they were waiting, it was discovered that the baby had a collapsed lung, possibly a result of pressure from the ventilation, which was set unusually high. "There was an increasing sense of anxiety on the unit," Letby said later. "Nobody seemed to know what was happening and very much just wanted the transport team to come and offer their expertise." The triplets' mother said that she was alarmed when she saw a doctor sitting at a computer "Googling how to do what looked like a relatively simple medical procedure: inserting a line into the chest." She was also upset that one of the doctors who was resuscitating her son was "coughing and spluttering into her hands" without washing them. Shortly after the transport team arrived, the second triplet died. His mother recalled that Letby was "in pieces and almost as upset as we were."

While dressing the baby for his parents—a standard part of helping grieving families—Letby accidentally pricked her finger with a needle. She hadn't eaten or taken a break all day, and as she was waiting to get her finger checked she fainted. "The overall enormity of the last two days had sort of taken its toll," she said. "To imagine what those parents had gone through to lose two of their babies, it was harrowing."

The surviving triplet was taken to Liverpool Women's Hospital, and his mother felt that the clinical staff there were more competent and organized. "The two hospitals were as different as night and day," she said.

That night, Brearey called Karen Rees, the head of nursing for urgent care, and said that he did not want Letby returning until there was an investigation. The babies' deaths seemed to be following Letby from night to day. Rees discussed

the issue with Powell, and she said that Powell told her, “Lucy Letby does everything by the book. She follows policy and procedure to the letter.” Rees allowed Letby to keep working. “Just because a senior healthcare professional requests the removal of a nurse—there has to be sound reason,” Rees said later. The next day, Letby was assigned a baby boy, known as Child Q, who had a bowel infection. At one point, he was sent to Alder Hey, but he was transferred back within two days. Taylor texted Letby that Alder Hey was “so short of beds that they can only accommodate emergency patients. It’s not good holistic care, and it’s rubbish for his parents.”

Letby was also taking care of another newborn in a different room, and, while she was checking on that baby, Child Q vomited and his oxygen levels dropped. After he stabilized, John Gibbs, a senior pediatrician, asked another nurse which staff members had been present during the episode.

“Do I need to be worried about what Dr Gibbs was asking?” Letby texted Taylor after her shift.

“No,” he reassured her. “You can’t be with two babies in different nurseries at the same time, let alone predict when they’re going to crash.”

“I know, and I didn’t leave him on his own. They both knew I was leaving the room,” she said, referring to a nurse inside the room and one just outside.

“Nobody has accused you of neglecting a baby or causing a deterioration,” he said.

“I know. Just worry I haven’t done enough.”

“How?” he asked.

“We’ve lost two babies I was caring for and now this happened today. Makes you think am I missing something/good enough,” she said.

“Lucy, if anyone knows how hard you’ve worked over the last 3 days it’s me,” he wrote. “If anybody says anything to you about not being good enough or

performing adequately I want you to promise me that you'll give my details to provide a statement.”

“Well I sincerely hope I won't ever be needing a statement,” she said. “But thank you. I promise.”

Letby was supposed to work the next night, but at the last minute Powell called and told her not to come in. “I'm worried I'm in trouble or something,” Letby wrote to Cheryl.

“How can you be in trouble?” Cheryl replied. “You haven't done anything wrong.”

“I know but worrying in case they think I missed something or whatever,” Letby said. “Why leave it until now to ring?”

“It's very late, I agree,” Cheryl said. “Maybe she's getting pressure from elsewhere.”

“She was nice enough, I just worry,” Letby responded. “This job messes with your head.”

Letby worked three more day shifts and then had a two-week vacation. Brearey, Jayaram, and a few other pediatric consultants met to discuss the unexpected deaths. “We were trying to rack our brains,” Brearey said. A postmortem X-ray of one of the babies had shown gas near the skull, a finding that the pathologist did not consider particularly meaningful, since gas is often present after death. Jayaram remembered learning in medical school about air embolisms—a rare, potentially catastrophic complication that can occur when air bubbles enter a person's veins or arteries, blocking blood supply. That night, he searched for literature about the phenomenon. He did not see any cases of murder by air embolism, but he forwarded his colleagues a four-page paper, from 1989, in the *Archives of Disease in Childhood*, about accidental air embolism. The authors of the paper could find only fifty-three cases in the world. All but four of the

infants had died immediately. In five cases, their skin became discolored. “I remember the physical chill that went down my spine,” Jayaram said. “It fitted with what we were seeing.”

Jayaram and another pediatrician met with the hospital’s executive board, as well as with the medical and nursing directors, and said that they were not comfortable working with Letby. They suggested calling the police. Jayaram said that the board members asked them, “ ‘What’s the evidence?’ And we said, ‘We haven’t got evidence, but we’ve got concerns.’ ” To relieve the general burden on the unit, the directors and the board decided to downgrade the ward from Level II to Level I: it would no longer provide intensive care, and women delivering before thirty-two weeks would now go to a different hospital. The board also agreed to commission a review by the Royal College of Paediatrics and Child Health, to explore what factors might explain the rise in mortality.

After Letby returned from vacation, she was called in for a meeting. The deputy director of nursing told her that she was the common element in the cluster of deaths, and that her clinical competence would need to be reassessed. “She was distraught,” Powell, the unit manager, who was also at the meeting, said. “We were both quite upset.” They walked straight from the meeting to human resources. “We were trying to get Lucy back on the unit, so we had to try and prove that the competency issue wasn’t the problem,” Powell said.

But Letby never returned to clinical duties. She was eventually moved to an administrative role in the hospital’s risk-and-safety office. Jayaram described the office as “almost an island of lost souls. If there was a nurse who wasn’t very good clinically, or a manager who they wanted to get out of the way, they’d move them to the risk-and-safety office.”

After she’d been away from clinical duties for more than a month, Letby texted Cheryl that she’d spoken with her union representative, who had advised her not to communicate with other staff, since they might be involved in reviewing her competence. “Feel a bit like I’m being shoved in a corner and forgotten about,” she wrote. “It’s my life and career.”

“I know it’s all so ridiculous,” Cheryl said.

“I can’t see where it will all end.”

“I’m sure this time after Christmas it’ll all be a distant memory,” Cheryl reassured her.

In September, 2016, Letby filed a grievance, saying that she’d been removed from her job without a clear explanation. “My whole world was stopped,” she said later. She was diagnosed with depression and anxiety and began taking medication. “From a self-confidence point of view it completely—well, it made me question everything about myself,” she said. “I just felt like I’d let everybody down, that I’d let myself down, that people were changing their opinion of me.”

That month, a team from the Royal College of Paediatrics and Child Health spent two days interviewing people at the Countess. They found that nursing- and medical-staffing levels were inadequate. They also noted that the increased mortality rate in 2015 was not restricted to the neonatal unit. Stillbirths on the maternity ward were elevated, too.

A redacted portion of the report, which was shared with me, described how staff on the unit were “very upset” that Letby had been removed from clinical duties. The Royal College team interviewed Letby and described her as “an enthusiastic, capable and committed nurse” who was “passionate about her career and keen to progress.” The redacted section concluded that the senior pediatricians had made allegations based on “simple correlation” and “gut feeling,” and that they had a “subjective view with no other evidence.” The Royal College could find no obvious factors linking the deaths; the report noted that the circumstances on the unit were “not materially different from those which might be found in many other neonatal units within the UK.” In a public statement, the hospital acknowledged that the review had revealed problems with “staffing, competencies, leadership, team working and culture.”

In November, Jayaram was interviewed by an administrator investigating Letby's grievance. There had been reports of pediatricians referring to an "angel of death" on the ward, and the interview focussed on whether Jayaram had made his suspicions publicly known.

"Did you hear any suggestion that Lucy had been deliberately harming babies?" the administrator asked Jayaram, according to minutes of the interview.

"No objective evidence to suggest this at all," Jayaram responded. "The only association was Lucy's presence on the unit at the time."

"So to clarify, was there any suggestion from any of the consultant team that Lucy had been deliberately harming babies?"

"We discussed a lot of possibilities in private," he responded.

"So that's not a yes or no?"

"We discussed a lot of possibilities in private," Jayaram repeated.

The hospital upheld Letby's grievance. At a board meeting in January, 2017, Chambers, the chief executive, who was formerly a nurse, told the members, "We are seeking an apology from the consultants for their behavior." He wanted Letby back on the unit as soon as possible. In a letter to the consultants, Chambers expressed concern about their susceptibility to "confirmation bias," which he defined as a "tendency to search for, interpret, favour, and recall

information in a way that confirms one's preexisting beliefs or hypotheses.”
(Chambers said that he could not comment, because of the court order.)

Jayaram agreed to meet with Letby for a mediation session in March, 2017. A lithe, handsome man with tight black curls, Jayaram appeared frequently on TV as a medical expert, on subjects ranging from hospital staffing to heart problems. When the cluster of deaths began, he was on the reality series “Born Naughty?,” in which he met eight children who had been captured on hidden cameras behaving unusually and then came up with diagnoses for them. Letby had prepared a statement for the meeting, and she read it aloud. “She said, ‘I’ve got evidence from my grievance process that you and Steve Brearey orchestrated a campaign to have me removed,’ ” Jayaram recalled. “ ‘I’ve got evidence that you were heard in the queue to the café accusing me of murdering babies.’ ” (Jayaram told me, “Now, I’ve got a big mouth, but I wouldn’t stand in a public place doing that.”) Letby asked if he would be willing to work with her. He felt obligated to say yes. “I came away from that meeting really angry, but I was not angry at her,” he said. “I was angry at the system.”

Jayaram and Brearey felt that they were being silenced by a hospital trying to protect its reputation. When I spoke with Brearey, he had recently watched a documentary about the explosion of the Challenger space shuttle, and he described the plight of an engineer who had tried to warn his superiors that the shuttle had potentially dangerous flaws. Brearey saw his own experiences in a similar light. He and Jayaram had spent months writing e-mails to the hospital’s management trying to justify why they wanted Letby out of the unit. They wrote with the confidence of people who feel that they are on the right side of history.

Serial-killer health professionals are extraordinarily rare, but they are also a kind of media phenomenon—a small universe of movies and shows has dramatized the scenario. In northwest England, this genre of crime has not been strictly limited to entertainment. Harold Shipman, one of the most prolific serial killers in the world, worked forty miles from Chester, as a physician for the N.H.S. He is thought to have murdered about two hundred and fifty patients in the span

of three decades, injecting many of them with lethal doses of a painkiller, before he was convicted, in 2000. The chair of a government inquiry into Shipman's crimes said that investigators should now be trained to "think dirty" about causes of death.

In April, 2017, with the permission of the Countess's leadership, Jayaram and another pediatrician met with a detective from the Cheshire police and shared their concerns. "Within ten minutes of us telling the story, the superintendent said, 'Well, we have to investigate this,' " Jayaram said. " 'It's a no-brainer.' "

In May, the police launched what they called Operation Hummingbird. A detective later said that Brearey and Jayaram provided the "golden thread of our investigation."

That month, Dewi Evans, a retired pediatrician from Wales, who had been the clinical director of the neonatal and children's department at his hospital, saw a newspaper article describing, in vague terms, a criminal investigation into the spike in deaths at the Countess. "If the Chester police had no-one in mind I'd be interested to help," he wrote in an e-mail to the National Crime Agency, which helps connect law enforcement with scientific experts. "Sounds like my kind of case."

That summer, Evans, who was sixty-seven and had worked as a paid court expert for more than twenty-five years, drove three and a half hours to Cheshire, to meet with the police. After reviewing records that the police gave him, he wrote a report proposing that Child A's death was "consistent with his receiving either a noxious substance such as potassium chloride or more probably that he suffered his collapse as a result of an air embolus." Later, when it became clear that there was no basis for suspecting a noxious chemical, Evans concluded that the cause of death was air embolism. "These are cases where your diagnosis is made by ruling out other factors," he said.

Evans had never seen a case of air embolism himself, but there had been one at his hospital about twenty years before. An anesthetist intended to inject air into

a baby's stomach, but he accidentally injected it into the bloodstream. The baby immediately collapsed and died. "It was extremely traumatic and left a big scar on all of us," Evans said. He searched for medical literature about air embolisms and came upon the same paper from 1989 that Jayaram had found. "There hasn't been a similar publication since then because this is such a rare event," Evans told me.

Evans relied heavily on the paper in other reports that he wrote about the Countess deaths, many of which he attributed to air embolism. Other babies, he said, had been harmed through another method: the intentional injection of too much air or fluid, or both, into their nasogastric tubes. "This naturally 'blows up' the stomach," he wrote to me. The stomach becomes so large, he said, that the lungs can't inflate normally, and the baby can't get enough oxygen. When I asked him if he could point me to any medical literature about this process, he responded, "There are no published papers regarding a phenomenon of this nature that I know of." (Several doctors I interviewed were baffled by this proposed method of murder and struggled to understand how it could be physiologically or logistically possible.)

Nearly a year after Operation Hummingbird began, a new method of harm was added to the list. In the last paragraph of a baby's discharge letter, Brearey, who had been helping the police by reviewing clinical records, noticed a mention of an abnormally high level of insulin. When insulin is produced naturally by the body, the level of C-peptide, a substance secreted by the pancreas, should also be high, but in this baby the C-peptide was undetectable, which suggested that insulin may have been administered to the child. The insulin test had been done at a Royal Liverpool University Hospital lab, and a biochemist there had called the Countess to recommend that the sample be verified by a more specialized lab. Guidelines on the Web site for the Royal Liverpool lab explicitly warn that its insulin test is "not suitable for the investigation" of whether synthetic insulin has been administered. Alan Wayne Jones, a forensic toxicologist at Linköping University, in Sweden, who has written about the use of insulin as a means of murder, told me that the test used at the Royal

Liverpool lab is “not sufficient for use as evidence in a criminal prosecution.” He said, “Insulin is not an easy substance to analyze, and you would need to analyze this at a forensic laboratory, where the routines are much more stringent regarding chain of custody, using modern forensic technology.” But the Countess never ordered a second test, because the child had already recovered.

Brearey also discovered that, eight months later, a biochemist at the lab had flagged a high level of insulin in the blood sample of another infant. The child had been discharged, and this blood sample was never retested, either.

According to Joseph Wolfsdorf, a professor at Harvard Medical School who specializes in pediatric hypoglycemia, the baby’s C-peptide level suggested the possibility of a testing irregularity, because, if insulin had been administered, the child’s C-peptide level should have been extremely low or undetectable, but it wasn’t.

The police consulted with an endocrinologist, who said that the babies theoretically could have received insulin through their I.V. bags. Evans said that, with the insulin cases, “at last one could find some kind of smoking gun.” But there was a problem: the blood sample for the first baby had been taken ten hours after Letby had left the hospital; any insulin delivered by her would no longer be detectable, especially since the tube for the first I.V. bag had fallen out of place, which meant that the baby had to be given a new one. To connect Letby to the insulin, one would have to believe that she had managed to inject insulin into a bag that a different nurse had randomly chosen from the unit’s refrigerator. If Letby had been successful at causing immediate death by air embolism, it seems odd that she would try this much less effective method.

In July, 2018, five months after the insulin discovery, a Cheshire police detective knocked on Letby’s door. Two years earlier, she had bought a home a mile from the hospital. A small birdhouse hung beside the entrance. It was 6 A.M., but she opened the door with a friendly expression. “Can I step in for two seconds?” the officer asked her, after showing his badge.

“Uh, yes,” she said, looking terrified.

Inside, she was told that she was under arrest for multiple counts of murder and attempted murder. She emerged from the house handcuffed, her face appearing almost gray.

The police spent the day searching her house. Inside, they found a note with the heading “NOT GOOD ENOUGH.” There were several phrases scrawled across the page at random angles and without punctuation: “There are no words”; “I can’t breathe”; “Slander Discrimination”; “I’ll never have children or marry I’ll never know what it’s like to have a family”; “WHY ME?”; “I haven’t done anything wrong”; “I killed them on purpose because I’m not good enough to care for them”; “I AM EVIL I DID THIS.”

On another scrap of paper, she had written, three times, “Everything is manageable,” a phrase that a colleague had said to her. At the bottom of the page, she had written, “I just want life to be as it was. I want to be happy in the job that I loved with a team who I felt a part of. Really, I don’t belong anywhere. I’m a problem to those who do know me.” On another piece of paper, found in her handbag, she had written, “I can’t do this any more. I want someone to help me but they can’t.” She also wrote, “We tried our best and it wasn’t enough.”

After spending all day in jail, Letby was asked why she had written the “not good enough” note. A police video shows her in the interrogation room with her hands in her lap, her shoulders hunched forward. She spoke quietly and deferentially, like a student facing an unexpectedly harsh exam. “It was just a way of me getting my feelings out onto paper,” she said. “It just helps me process.”

“In your own mind, had you done anything wrong at all?” an officer asked.

“No, not intentionally, but I was worried that they would find that my practice hadn’t been good,” she said, adding, “I thought maybe I had missed something, maybe I hadn’t acted quickly enough.”

“Give us an example.”

She proposed that perhaps she “hadn’t played my role in the team. I’d been on a lot of night shifts when doctors aren’t around. We have to call them. There are less people, and it just worried me that I hadn’t called them—quick enough.” She also worried that she might have given the wrong dose of a medication or used equipment improperly.

“And you felt evil?”

“Other people would perceive me as being evil, yes, if I had missed something.” She went on, “It’s how this situation made me feel.”

The detective said, “You put down there, Lucy, that you ‘killed them on purpose.’ ”

“I didn’t kill them on purpose.”

The detective asked, “So where’s this pressure that’s led to having these feelings come from?”

“I think it was just the panic of being redeployed and everything that happened,” she said. She had written the notes after she was removed from clinical duties, but later her clinical skills were reassessed and no concerns were raised, so she felt more secure about her abilities. She was “very career-focussed,” she said, and “it just all overwhelmed me at the time. It was hard to see how anything was ever going to be O.K. again.”

In an interview two days later, an officer asked why one of her notes had the word “hate” in bold letters, circled. “What’s the significance of that?”

“That I hate myself for having let everybody down and for not being good enough,” she said. “I’d just been removed from the job I loved, I was told that there might be issues with my practice, I wasn’t allowed to speak to people.” The officer asked again why she had written, “I killed them on purpose.”

“That’s how I was being made to feel,” she said. As her mental health deteriorated, her thoughts had spiralled. “If my practice hadn’t been good enough and I was linked with these deaths, then it was my fault,” she said.

“You’re being very hard on yourself there if you haven’t done anything wrong.”

“Well, I am very hard on myself,” she said.

After more than nine hours of interviews, Letby was released on bail, without being charged. She moved back to Hereford, to live with her parents. News of her arrest was published in papers throughout the U.K. “All I can say is my experience is that she was a great nurse,” a mother whose baby was treated at the Countess told the *Times* of London. Another mother told the *Guardian* that Letby had advocated for her and had told her “every step of the way what was happening.” She said, “I can’t say anything negative about her.” The *Guardian* also interviewed a mother who described the experience of giving birth at the Countess. “They had no staff and the care was just terrible,” she said. She’d developed “an infection which was due to negligence by a member of staff,” she explained. “We made a complaint at the time but it was brushed under the carpet.”

One of Letby’s childhood friends, who did not want me to use her name because her loyalty to Letby has already caused her social and professional problems, told me that she asked the Cheshire police if she could serve as a character reference for Letby. “They weren’t interested at all,” she said. Letby seemed to be in a state of “terror and complete confusion,” the friend said. “I

could tell from how she was acting that she just didn't know what to say about it, because it was such an alien concept to be accused of these things.”

Shortly after Letby's arrest, the pediatric consultants arranged a meeting for the hospital's medical staff, to broach the possibility of a vote of no confidence in Chambers, the hospital's chief executive, because of the way he'd handled their concerns. Chambers resigned before the meeting. A doctor named Susan Gilby, who took the side of the consultants, assumed his role. Gilby told me that the first time she met with Jayaram it was clear that he was suffering from the experience of not being believed by the hospital's management. “He was in tears, and bear in mind this is a mature, experienced clinician,” she said. “He described having issues with sleeping, and he felt he couldn't trust anyone. It was really distressing.” She was surprised that Ian Harvey, the hospital's medical director, still doubted the consultants' theory of how the babies had died. Harvey seemed more troubled by their behavior, she said, than by anything Letby had done. “In his mind, the issue seemed to be that they weren't as good as they thought they were,” Gilby told me. “It was ‘They think they're marvellous, but they need to look at themselves.’” (Harvey would not comment, citing the court order.)

The week of Letby's arrest, the police dug up her back garden and examined drains and vents, presumably to see if she had hidden anything incriminating. Four months later, while she remained out on bail without charges, the *Chester Standard* wrote, “The situation has caused many people to question both the ethics and legality of keeping someone linked to such serious allegations when seemingly there is not enough evidence to bring charges.” Letby was arrested a second time, in 2019, but, after being interviewed for another nine hours, she was released.

In November, 2020, more than two years after Letby's first arrest, an officer called Gilby to inform her that Letby was being charged with eight counts of murder and ten counts of attempted murder. (Later, one of the murder counts was dropped, and five attempted-murder charges were added.) She was arrested again, and this time she was denied bail. She would await trial in prison. As a

courtesy, Gilby called Chambers to let him know. She was taken aback when Chambers expressed concern for Letby. She said that he told her, “I’m just worried about a wrongful conviction.”

In September, 2022, a month before Letby’s trial began, the Royal Statistical Society published a report titled “Healthcare Serial Killer or Coincidence?” The report had been prompted in part by concerns about two recent cases, one in Italy and one in the Netherlands, in which nurses had been wrongly convicted of murder largely because of a striking association between their shift patterns and the deaths on their wards. The society sent the report to both the Letby prosecution and the defense team. It detailed the dangers of drawing causal conclusions from improbable clusters of events. In the trial of the Dutch nurse, Lucia de Berk, a criminologist had calculated that there was a one-in-three-hundred-and-forty-two-million chance that the deaths were coincidental. But his methodology was faulty; when statisticians looked at the data, they found that the chances were closer to one in fifty. According to Ton Derksen, a Dutch philosopher of science who wrote a book about the case, the belief that “such a coincidence cannot be a coincidence” became the driving force in the process of collecting evidence against de Berk. She was exonerated in 2010, and her case is now considered one of the worst miscarriages of justice in Dutch history. The Italian nurse, Daniela Poggiali, was exonerated in 2021, after statisticians reanalyzed her hospital’s mortality data and discovered several confounding factors that had been overlooked.

William C. Thompson, one of the authors of the Royal Statistical Society report and an emeritus professor of criminology, law, and psychology at the University of California, Irvine, told me that medical-murder cases are particularly prone to errors in statistical reasoning, because they “involve a choice between alternative theories, both of which are rather extraordinary.” He said, “One theory is that there was an unlikely coincidence. And the other theory is that someone like Lucy Letby, who was previously a fine and upstanding member of the community, suddenly decides she’s going to start killing people.”

Flawed statistical reasoning was at the heart of one of the most notorious wrongful convictions in the U.K.: a lawyer named Sally Clark was found guilty of murder, in 1999, after her two sons, both babies, died suddenly and without clear explanation. One of the prosecution's main experts, a pediatrician, argued that the chances of two sudden infant deaths in one family were one in seventy-three million. But his calculations were misleading: he'd treated the two deaths as independent events, ignoring the possibility that the same genetic or environmental factors had affected both boys.

In his book "Thinking, Fast and Slow" (2011), Daniel Kahneman, a winner of the Nobel Prize in Economics, argues that people do not have good intuitions when it comes to basic principles of statistics: "We easily think associatively, we think metaphorically, we think causally, but statistics requires thinking about many things at once," a task that is not spontaneous or innate. We tend to assume that irregular things happen because someone intentionally caused them. "Our predilection for causal thinking exposes us to serious mistakes in evaluating the randomness of truly random events," he writes.

Burkhard Schafer, a law professor at the University of Edinburgh who studies the intersection of law and science, said that it appeared as if the Letby prosecution had "learned the wrong lessons from previous miscarriages of justice." Instead of making sure that its statistical figures were accurate, the prosecution seems to have ignored statistics. "Looking for a responsible human—this is what the police are good at," Schafer told me. "What is not in the police's remit is finding a systemic problem in an organization like the National Health Service, after decades of underfunding, where you have overworked people cutting little corners with very vulnerable babies who are already in a risk category. It is much more satisfying to say there was a bad person, there was a criminal, than to deal with the outcome of government policy."

Schafer said that he became concerned about the case when he saw the diagram of suspicious events with the line of X's under Letby's name. He thought that it should have spanned a longer period of time and included all the deaths on the unit, not just the ones in the indictment. The diagram appeared to be a product

of the “Texas sharpshooter fallacy,” a common mistake in statistical reasoning which occurs when researchers have access to a large amount of data but focus on a smaller subset that fits a hypothesis. The term comes from the fable of a marksman who fires a gun multiple times at the side of a barn. Then he draws a bull’s-eye around the cluster where the most bullets landed.

For one baby, the diagram showed Letby working a night shift, but this was an error: she was working day shifts at the time, so there should not have been an X by her name. At trial, the prosecution argued that, though the baby had deteriorated overnight, the suspicious episode actually began three minutes after Letby arrived for her day shift. Nonetheless, the inaccurate diagram continued to be published, even by the Cheshire police.

Dewi Evans, the retired pediatrician, told me that he had picked which medical episodes rose to the level of “suspicious events.” When I asked what his criteria were, he said, “Unexpected, precipitous, anything that is out of the usual—something with which you are not familiar.” For one baby, the distinction between suspicious and not suspicious largely came down to how to define projectile vomiting.

Letby’s defense team said that it had found at least two other incidents that seemed to meet the same criteria of suspiciousness as the twenty-four on the diagram. But they happened when Letby wasn’t on duty. Evans identified events that may have been left out, too. He told me that, after Letby’s first arrest, he was given another batch of medical records to review, and that he had notified the police of twenty-five more cases that he thought the police should investigate. He didn’t know if Letby was present for them, and they didn’t end up being on the diagram, either. If some of these twenty-seven cases had been represented, the row of X’s under Letby’s name might have been much less compelling. (The Cheshire police and the prosecution did not respond to a request for comment, citing the court order.)

Among the new suspicious episodes that Evans said he flagged was another insulin case. Evans said that it had similar features as the first two: high insulin,

low C-peptide. He concluded that it was a clear case of poisoning. When I asked Michael Hall, a retired neonatologist at University Hospital Southampton who worked as an expert for Letby's defense, about Evans's third insulin case, he was surprised and disturbed to learn of it. He could imagine a few reasons that it might not have been part of the trial. One is that Letby wasn't working at the time. Another is that there was an alternative explanation for the test results—but then, presumably, such an explanation could be relevant for the other two insulin cases, too. “Whichever way you look at this, that third case is of interest,” Hall told me.

Ton Derksen, in his book about Lucia de Berk, used the analogy of a train. The “locomotives” were two cases in which there had been allegations of poisoning. Another eight cases, involving children who suddenly became ill on de Berk's shifts, were the “wagons,” trailing along because of a belief that all the deaths couldn't have occurred by chance.

The locomotives in the Letby prosecution were the insulin cases, which were charged as attempted murders. “The fact that there were two deliberate poisonings with insulin,” Nick Johnson, the prosecutor, said, “will help you when you are assessing whether the collapses and deaths of other children on the neonatal unit were because somebody was sabotaging them or whether these were just tragic coincidences.”

But not only were the circumstances of the poisonings speculative, the results were, too. If the aim was to kill, neither child came close to the intended consequences. The first baby recovered after a day. The second showed no symptoms and was discharged in good health.

On the first day of the trial, Letby's barrister, Benjamin Myers, told the judge that Letby was “incoherent, she can't speak properly.” She had been diagnosed as having post-traumatic stress disorder following her arrests. After two years in prison, she had recently been moved to a new facility, but she

hadn't brought her medication with her. Any psychological stability she'd achieved, Myers said, had been "blown away."

Letby, who now startled easily, was assessed by psychiatrists, and it was decided that she did not have to walk from the dock to the witness box and instead could be seated there before people came into the room. The *Guardian* said that in court Letby "cut an almost pitiable figure," her eyes darting "nervously towards any unexpected noise—a cough, a dropped pen, or when the female prison guard beside her shuffled in her seat." Her parents attended the entire trial, sometimes accompanied by a close friend of Letby's, a nurse from the unit who had recently retired.

Press coverage of the case repeatedly emphasized Letby's note in which she'd written that she was "evil" and "killed them on purpose." Media outlets magnified the images of those words without including her explanations to the police. Much was also made of a text that she'd sent about returning to work after her trip to Spain—"probably be back in with a bang lol"—and the fact that she'd searched on Facebook thirty-one times for parents whose children she was later accused of harming. During the year of the deaths, she had also searched for other people 2,287 times—colleagues, dancers in her salsa classes, people she had randomly encountered. "I was always on my phone," she later testified, explaining that she did the searches rapidly, out of "general curiosity and they've been on my mind." (Myers noted that her search history did not involve any references to "air embolism.")

The parents of the babies had been living in limbo for almost a decade. In court, they recalled how their grief had intensified when they were told that their children's deaths may have been deliberately caused by someone they'd trusted. "That's what confuses me the most," one mother said. "Lucy presented herself as kind, caring, and soft-spoken." They had stopped believing their own instincts. They described being consumed by guilt for not protecting their children.

Several months into the trial, Myers asked Judge Goss to strike evidence given by Evans and to stop him from returning to the witness box, but the request was denied. Myers had learned that a month before, in a different case, a judge on the Court of Appeal had described a medical report written by Evans as "worthless." "No court would have accepted a report of this quality," the judge had concluded. "The report has the hallmarks of an exercise in working out an explanation" and "ends with tendentious and partisan expressions of opinion that are outside Dr. Evans' professional competence." The judge also wrote that Evans "either knows what his professional colleagues have concluded and disregards it or he has not taken steps to inform himself of their views. Either approach amounts to a breach of proper professional conduct." (Evans said that he disagreed with the judgment.)

Evans had laid the medical foundation for the prosecution's case against Letby, submitting some eighty reports. There was a second pediatric expert, who provided what was called "peer review" for Evans, as well as experts in hematology, endocrinology, radiology, and pathology, and they had all been sent Evans's statements when they were invited to participate in the case. The six main prosecution experts, along with at least two defense experts who were also consulted, had all worked for the N.H.S. Evans wasn't aware if Letby's lawyers had sought opinions from outside the U.K., but he told me that, if he were them, he would have looked to North America or Australia. When I asked why, he said, "Because I would want them to look at it from a totally nonpartisan point of view."

In the five years leading up to the trial, some of the experts' opinions seemed to have collectively evolved. For one of the babies, Evans had originally written that the child had been "at great risk of unexpected collapse," owing to his fragility, and Evans couldn't "exclude the role of infection." The prosecution's pathologist, Andreas Marnerides, who worked at St. Thomas' Hospital in London, wrote that the child had died of natural causes, most likely of pneumonia. "I have not identified any suspicious findings," he concluded. But, three years later, Marnerides testified that, after reading more reports from the courts' experts, he thought that the baby had died "with pneumonia," not "from pneumonia." The likely cause of death, he said, was administration of air into his stomach through a nasogastric tube. When Evans testified, he said the same thing.

"What's the evidence?" Myers asked him.

"Baby collapsed, died," Evans responded.

"A baby may collapse for any number of reasons," Myers said. "What's the evidence that supports your assertion made today that it's because of air going down the NGT?"

"The baby collapsed and died."

"Do you rely upon one image of that?" Myers asked, referring to X-rays.

"This baby collapsed and died."

"What evidence is there that you can point to?"

Evans replied that he'd ruled out all natural causes, so the only other viable explanation would be another method of murder, like air injected into one of the baby's veins. "A baby collapsing and where resuscitation was unsuccessful—you know, that's consistent with my interpretation of what happened," he said.

The trial covered questions at the edge of scientific knowledge, and the material was dense and technical. For months, in discussions of the supposed air

embolisms, witnesses tried to pinpoint the precise shade of skin discoloration of some of the babies. In Myers's cross-examinations, he noted that witnesses' memories of the rashes had changed, becoming more specific and florid in the years since the deaths. But this debate seemed to distract from a more relevant objection: the concern with skin discoloration arose from the 1989 paper. An author of the paper, Shoo Lee, one of the most prominent neonatologists in Canada, has since reviewed summaries of each pattern of skin discoloration in the Letby case and said that none of the rashes were characteristic of air embolism. He also said that air embolism should never be a diagnosis that a doctor lands on just because other causes of sudden collapse have been ruled out: "That would be very wrong—that's a fundamental mistake of medicine."

Several months into the trial, Richard Gill, an emeritus professor of mathematics at Leiden University, in the Netherlands, began writing online about his concerns regarding the case. Gill was one of the authors of the Royal Statistical Society report, and in 2006 he had testified before a committee tasked with determining whether to reopen the case of Lucia de Berk. England has strict contempt-of-court laws that prevent the publication of any material that could prejudice legal proceedings. Gill posted a link to a Web site, created by Sarrita Adams, a scientific consultant in California, that detailed flaws in the prosecution's medical evidence. In July, a detective with the Cheshire police sent letters to Gill and Adams ordering them to stop writing about the case. "The publication of this material puts you at risk of 'serious consequences' (which include a sentence of imprisonment)," the letters said. "If you come within the jurisdiction of the court, you may be liable to arrest."

Letby is housed in a privately run prison west of London, the largest correctional facility for women in Europe. Letters to prisoners are screened, and I don't know if several letters that I sent ever reached her. One of her lawyers, Richard Thomas, who has represented her since early in the case, said that he would tell Letby that I had been in touch with him, but he ignored my request to share a message with her, instead reminding me of the contempt-of-court order. He told me, "I cannot give any comment on why you cannot

communicate” with Letby. Lawyers in England can be sanctioned for making remarks that would undermine confidence in the judicial system. I sent Myers, Letby’s barrister, several messages in the course of nine months, and he always responded with some version of an apology—“the brevity of this response is not intended to be rude in any way”—before saying that he could not talk to me.

Michael Hall, the defense expert, had expected to testify at the trial—he was prepared to point to flaws in the prosecution’s theory of air embolism and to undetected signs of illness in the babies—but he was never called. He was troubled that the trial largely excluded evidence about the treatment of the babies’ mothers; their medical care is inextricably linked to the health of their babies. In the past ten years, the U.K. has had four highly publicized maternity scandals, in which failures of care and supervision led to a large number of newborn deaths. A report about East Kent Hospitals, which found that forty-five babies might have lived if their treatment had been better, identified a “crucial truth about maternity and neonatal services”: “So much hangs on what happens in the minority of cases where things start to go wrong, because problems can very rapidly escalate to a devastatingly bad outcome.” The report warned, “It is too late to pretend that this is just another one-off, isolated failure, a freak event that *‘will never happen again.’*”

Hall thought about asking Letby’s lawyers why he had not been called to testify, but anything they said would be confidential, so he decided that he’d rather not know. He wondered if his testimony was seen as too much of a risk: “One of the questions they would have asked me is ‘Why did this baby die?’ And I would have had to say, ‘I’m not sure. I don’t know.’ That’s not to say that therefore the baby died of air embolism. Just because we don’t have an explanation doesn’t mean we are going to make one up.” The fact that the jury never heard another side “keeps me awake at night,” Hall told me.

After the prosecution finished presenting its case, Letby’s defense team submitted a motion arguing that the medical evidence about air embolism was so unreliable that there was “no case to answer” and the charges should be

dismissed. Though the motion was rejected, perhaps it had seemed that the prosecution's case was so weak that defense experts weren't necessary. The only witnesses Myers called were the hospital's plumber, who spoke about unsanitary conditions, and Letby, who testified for fourteen days.

She said she felt that there were systemic failures at the hospital, but that some of the senior pediatricians had "apportioned blame on to me." Johnson, the prosecutor, pushed her to come up with her own explanation for each baby's deterioration. Yet she wasn't qualified to provide them. "In general, I don't think a lot of the babies were cared for on the unit properly," she offered. "I'm not a medical professional to know exactly what should and shouldn't have happened with those babies."

"Do you agree that if certain combinations of these children were attacked then unless there was more than one person attacking them, you have to be the attacker?" Johnson asked at one point.

"No."

"You don't agree?"

"No. I've not attacked any children."

Johnson continued, "But if the jury conclude that a certain combination of children were actually attacked by someone, then the shift pattern gives us the answer as to who the attacker was, doesn't it?"

"No, I don't agree."

"You don't agree. Why don't you agree?"

"Because just because I was on shift doesn't mean that I have done anything."

"I'll use numbers, all right? I won't refer to specific cases. Let's say if baby 5, 8, 10 and 12 were all attacked, if the jury look at the medical evidence and say

they were all attacked by someone, and you're the only common feature, it would have to be, wouldn't it, that you're the attacker?"

"That's for them to decide."

"Well, of course it is, of course it is. But as a principle, do you agree with that?"

"No, I don't feel I can answer that."

After a few days of cross-examination, Letby seemed to shut down; she started frequently giving one-word answers, almost whispering. "I'm finding it quite hard to concentrate," she said.

Johnson repeatedly accused her of lying. "You are a very calculating woman, aren't you, Lucy Letby?" he said.

"No," she replied.

He asked, "The reason you tell lies is to try to get sympathy from people, isn't it?"

"No."

"You try to get attention from people, don't you?"

"No."

"In killing these children, you got quite a lot of attention, didn't you?"

“I didn’t kill the children.”

Toward the end of the trial, the court received an e-mail from someone who claimed to have overheard one of the jurors at a café saying that jurors had “already made up their minds about her case from the start.” Goss reviewed the complaint but ultimately allowed the juror to continue serving.

He instructed the twelve members of the jury that they could find Letby guilty even if they weren’t “sure of the precise harmful act” she’d committed. In one case, for instance, Evans had proposed that a baby had died of excessive air in her stomach from her nasogastric tube, and then, when it emerged that she might not have had a nasogastric tube, he proposed that she may have been smothered.

The jury deliberated for thirteen days but could not reach a unanimous decision. In early August, one juror dropped out. A few days later, Goss told the jury that he would accept a 10–1 majority verdict. Ten days later, it was announced that the jury had found Letby guilty of fourteen charges. The two insulin cases and one of the triplet charges were unanimous; the rest were majority verdicts. When the first set of verdicts was read, Letby sobbed. After the second set, her mother cried out, “You can’t be serious!” Letby was acquitted of two of the attempted-murder charges. There were also six attempted-murder charges in which the jury could not decide on a verdict.

Within a week, the Cheshire police announced that they had made an hour-long documentary film about the case with “exclusive access to the investigation team,” produced by its communications department. Fourteen members of Operation Hummingbird spoke about the investigation, accompanied by an emotional soundtrack. A few days later, the *Times* of London reported that a major British production company, competing against at least six studios, had won access to the police and the prosecutors to make a documentary, which potentially would be distributed by Netflix. Soon afterward, the Cheshire police revealed that they had launched an investigation into whether the Countess was

guilty of “corporate manslaughter.” The police also said that they were reviewing the records of four thousand babies who had been treated on units where Letby had worked in her career, to see if she had harmed other children.

The public conversation about the case seemed to treat details about poor care on the unit as if they were irrelevant. In his closing statement, Johnson had accused the defense of “gaslighting” the jury by suggesting that the problem was the hospital, not Letby. Defending himself against the accusation, Myers told the jury, “It’s important I make it plain that in no way is this case about the N.H.S. in general.” He assured the jury, “We all feel strongly about the N.H.S. and we are protective of it.” It seemed easier to accept the idea of a sadistic “angel of death” than to look squarely at the fact that families who had trusted the N.H.S. had been betrayed, their faith misplaced.

Since the verdicts, there has been almost no room for critical reflection. At the end of September, a little more than a month after the trial ended, the prosecution announced that it would retry Letby on one of the attempted-murder charges, and a new round of reporting restrictions was promptly put in place. The contempt-of-court rules are intended to preserve the integrity of the legal proceedings, but they also have the effect of suppressing commentary that questions the state’s decisions. In October, *The BMJ*, the country’s leading medical journal, published a comment from a retired British doctor cautioning against a “fixed view of certainty that justice has been done.” In light of the new reporting restrictions, the journal removed the comment from its Web site, “for legal reasons.” At least six other editorials and comments, which did not question Letby’s guilt, remain on the site.

Letby has applied to appeal her conviction, and she is waiting for three judges on the Court of Appeal to decide whether to allow her to proceed. If her application is denied, it will mark the end of her appeals process.

Her retrial in June concerns a baby girl whose breathing tube came out of place. She had been born at the Countess at twenty-five weeks, which is younger than the infants the hospital was supposed to treat. In a TV interview that aired after

the verdict but before the retrial was announced, Jayaram, the head of the pediatric ward, said that he had seen Letby next to the baby as the child's oxygen levels were dropping. "The only possibility was that that tube had to have been dislodged deliberately," he said. "She was just standing there." He recalled, "That is a night that is etched on my memory and will be in my nightmares forever."

Brearey, the head of the neonatal unit, told me that after Letby's first arrest, in 2018, a "significant cohort of nurses felt that she had done nothing wrong." But, in the past six years, many of them have retired or left. In an interview with a TV news program shortly after the verdict, Karen Rees, the former head of nursing for urgent care, seemed to be struggling to modify her beliefs. She routinely met with Letby in the two years after she was removed from the unit. "If I think back to all the times when I have seen her really, really upset—I wouldn't say hysterical but really upset—then I would think that . . ." She paused. The camera was focussed on her shirt, her face intentionally obscured. "How can somebody continually present themselves in that way on a near-weekly basis for two years?" Her voice trembled. "I find that really difficult, and I think, Oh, my gosh, would she have been that good at acting?"

Brearey told me that only one or two nurses still "can't fully come to terms" with Letby's guilt. The ward remains a Level I unit, accepting only babies older than thirty-two weeks, and it has added more consultants to its staff. The mortality rate is no longer high. The hospital has, however, seen a spike in adverse events on the maternity unit. During an eight-month period in 2021, five mothers had unplanned hysterectomies after losing more than two litres of blood. Following a whistle-blower complaint, an inspection by the U.K.'s Care Quality Commission warned that the unit was not keeping "women safe from avoidable harm." The commission discovered twenty-one incidents in which thirteen patients had been endangered, and it determined that in many cases the hospital had not sufficiently investigated the circumstances.

It was another cluster of unexpected, catastrophic events. But this time the story told about the events was much less colorful. The commission blamed a combination of factors that had been present in many of the previous maternity scandals, including staff and equipment shortages, a lack of training, a failure to follow national guidelines, poor recordkeeping, and a culture in which staff felt unsupported. It went unstated, but one can assume that there was another factor, too: a tragic string of bad luck.

Throughout the year of the deaths, Letby had occasionally reflected on the nature of chance, texting friends that she wanted to imagine there was a “reason for everything,” but it also felt like the “luck of [the] draw.” After the first three deaths, she wrote to Margaret, her mentor, “Sometimes I think how do such sick babies get through and others just die so suddenly and unexpectedly?”

“We just don’t have magic wands,” Margaret responded. “It’s important to remember that a death isn’t a fail.” She added, “You’re an excellent nurse, Lucy, don’t forget it.”

“I know and I don’t feel it’s a failure,” Letby responded, “more that it’s just very sad to know what families go through.” ♦

Published in the print edition of the May 20, 2024, issue, with the headline “Conviction.”

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