



MSc Public Health & Social
Care in Practice | Quality
Assurance and Service
Improvements (LCHS7006) |
Component 1 – Individual
Presentation



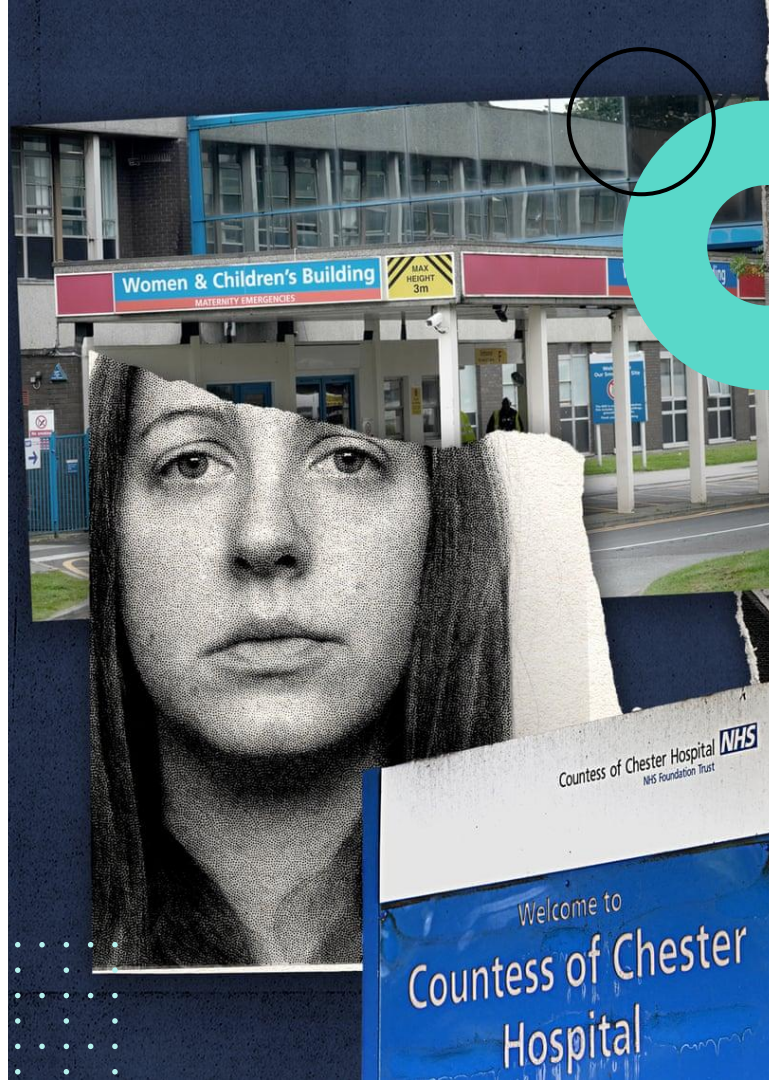
LUCY LETBY

CASE FAILURE IN CLINICAL GOVERNANCE

CASE STUDY

BISMA AMIN 2435002@student.uwtsd.ac.uk

Lecturer: Oluwadamilola Tayo



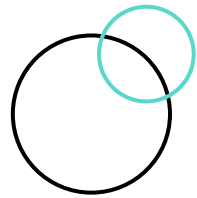


TABLE OF CONTENTS

This case highlights systemic failures rather than individual wrongdoing alone.

Introduction	Overview of the case and presentation objectives
Context	Background of the Lucy Letby case
Causes	Identification of root causes using safety models
Models	Application of quality improvement theories and frameworks
Policy	Analysis of policy issues affecting service delivery
Impact	Effects on quality, efficiency, and equity of care

CASE OVERVIEW

1.

**Neonatal nurse involved in
deaths of 7 infants +
attempted murders**

2.

**Occurred at Countess
of Chester Hospital
(2015–2016)**

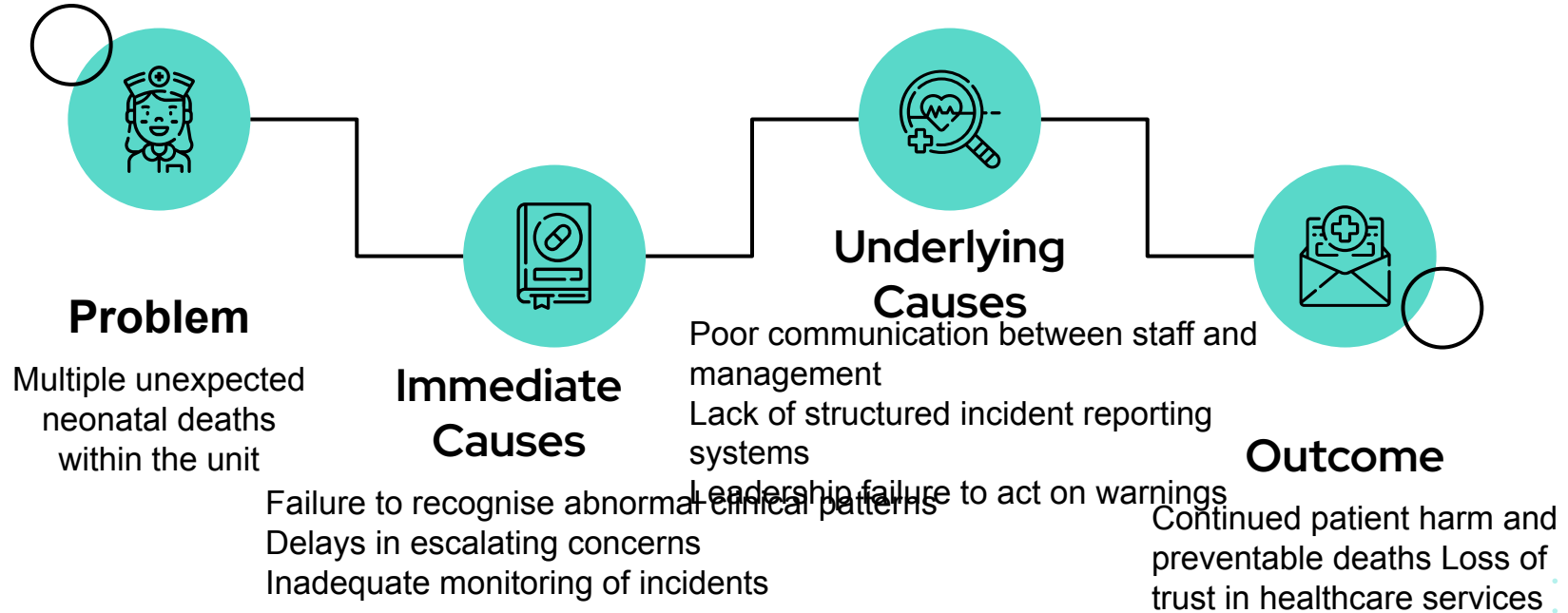
3.

**Repeated warnings
by consultants
were ignored**

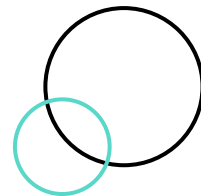
4.

**Delayed
investigation and
action**

ROOT CAUSE ANALYSIS (RCA)



Donabedian Model Application



Structure

- Staffing shortages
- Weak governance
- Lack of oversight



Process

- Poor reporting systems
- Ignored warnings
- Delayed investigation

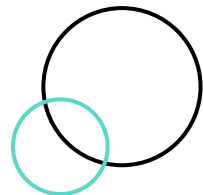


Outcome

- Infant deaths
- Patient harm
- Loss of trust



Policy Issues



Critical analysis:

Policies existed but
were **not**
implemented
effectively



Problems

1.

Ineffective
whistleblowing
policies



2.

Lack of
accountability
frameworks

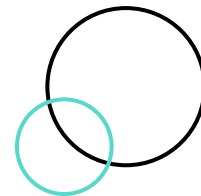


3.

Failure to escalate
to external bodies
(e.g., NHS
regulators)



Impact on Service Delivery



Critical analysis:

Policies existed but
were **not**
implemented
effectively



Problems

1.

Quality:

- Unsafe care environment
- Increased mortality



2.

Efficiency:

- Delayed response
- Increased harm
- Resource misuse



3.

Equity:

- Vulnerable neonatal patients disproportionately affected



Critical Perspectives



Perspective 1: System Failure

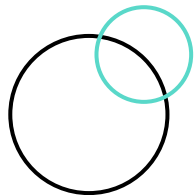
- Errors due to organisational weaknesses
- Supported by systems theory

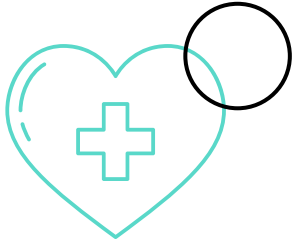
Perspective 2: Individual Responsibility

- Focus on Letby's actions
- Criminal accountability

Conclusion:

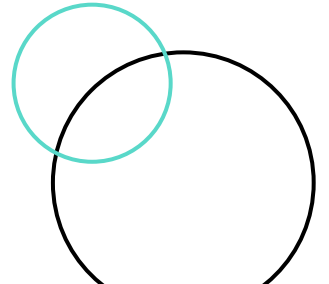
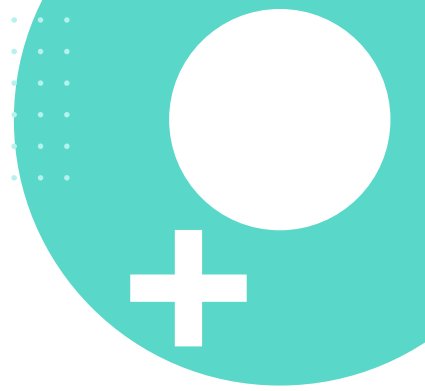
Both factors important, but **system failure** enabled harm

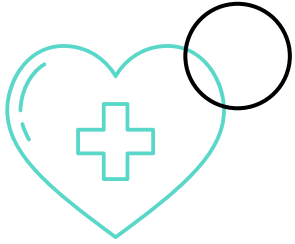




Recommendations

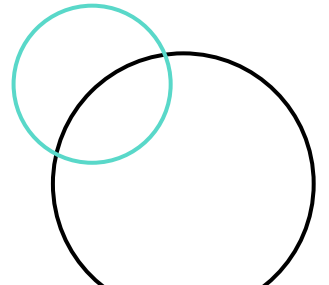
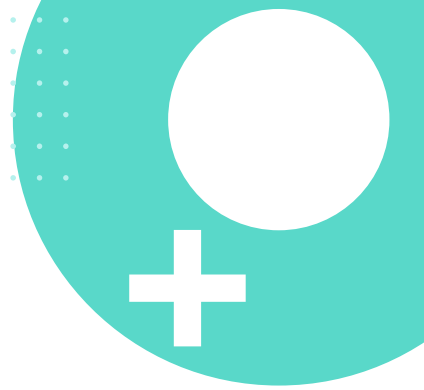
- Strengthen incident reporting systems
- Promote open safety culture
- Mandatory escalation protocols
- Regular external audits
- Staff training in patient safety





Implications for Practice

- Importance of **clinical governance frameworks**
- Need for **early intervention systems**
- Role of leadership in patient safety
- Integration of quality improvement models



Structure of Report (Component 2)

1. Introduction



5. Policy Analysis

2. Case Study Background



6. Impact on Service Delivery

3. Theoretical Frameworks



7. Recommendations



4. Root Cause Analysis



8. Conclusion

References

1. A. Donabedian. (1988) How can the quality of care be measured? American Medical Association Journal, 260(12), 1743–1748.
2. J. Reason. Models and management of human error (2000). 768–770 in British Medical Journal, 320(7237).
3. C. Vincent. Patient Safety, 2010. Edition 2. Wiley-Blackwell in Oxford.
4. Vincent, C. (2010) *Patient Safety*. 2nd edn. Oxford: Wiley-Blackwell.
5. The World Health Organization (2018) states that providing high-quality healthcare is a global necessity. WHO in Geneva.
6. The NHS Patient Safety Strategy: Safer systems, safer culture, safer patients (NHS England, 2019). NHS England in London.
7. Healthcare service regulation and inspection by the Care Quality Commission (CQC) (2022). CQC in London.
8. The Science of Improvement: How to Improve, Institute for Healthcare Improvement (IHI), 2020. IHI in Boston.
9. Investigation tools for Root Cause Analysis (National Patient Safety Agency, 2015). NPSA in London.
10. R. Francis. Mid Staffordshire NHS Foundation Trust Public Report (2013)
11. National Institute for Health and Care Excellence (NICE) (2021) *Clinical governance and quality standards*. London: NICE.
12. The Guardian (2024) *Failures at Lucy Letby's hospital revealed*. Available at: <https://www.theguardian.com> (Accessed: 20 March 2026).
13. Dixon-Woods, M. et al. (2014) *Culture and behaviour in the English National Health Service: Overview of lessons from a large multimethod study*. BMJ Quality & Safety, 23(2), pp. 106–115.
14. Walshe, K. and Smith, J. (2016) *Healthcare Management*. 3rd edn. Maidenhead: Open University Press.
15. Ovreteit, J. (2009) *Does improving quality save money?* London: The Health Foundation.
16. Braithwaite, J., Westbrook, J. and Travaglia, J. (2017) *Patient safety and health system reform*. Journal of Health Organization and Management, 31(1), pp. 1–9.

