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# **A SYSTEMS-BASED ANALYSIS OF QUALITY ASSURANCE FAILURES IN NEONATAL CARE: THE LUCY LETBY CASE AT THE COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST**



# INTRODUCTION AND CONTEXT



## OVERVIEW OF THE QUALITY PROBLEM

1

Repeated infant deaths and unexplained clinical collapses

2

Clinician concerns raised but not acted upon (Challacombe et al., 2024)

3

Weak incident reporting and escalation processes (Whiteing, 2024)

4

Evidence of organisational, not solely individual, failure (Buka and Truman, 2024)

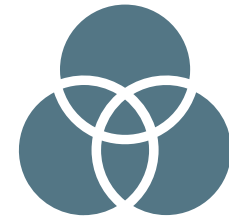
# Systems-Based Safety Perspective



Patient harm understood as a systems failure (Efstratiou, 2024)



Focus on latent organisational weaknesses



Swiss Cheese Model explains defence breakdowns (Chakravorty, 2023)



## ROOT CAUSE IDENTIFICATION USING THE SWISS CHEESE MODEL



Multiple organisational defence layers failed concurrently (Harrison, 2025).



Key failures identified across governance, reporting, leadership, and culture (Ellis and Ellis, 2023).



Incident reporting and escalation systems were ineffective (Johansen et al., 2021)

# IN-DEPTH QUALITY AND IMPROVEMENT MODELS APPLIED



Root Cause Analysis  
used to identify  
underlying system  
failures (Ishikura,  
2008).



Donabedian Model  
examines structure,  
process, and  
outcomes



Systems Theory  
supports analysis of  
complex  
organisational  
interactions (Raab,  
2006)



## CRITICAL APPLICATION OF MODELS TO THE CASE

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Structural failures in staffing, governance, and oversight (Mahase, 2025).

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Process failures in escalation, audit, and incident reporting

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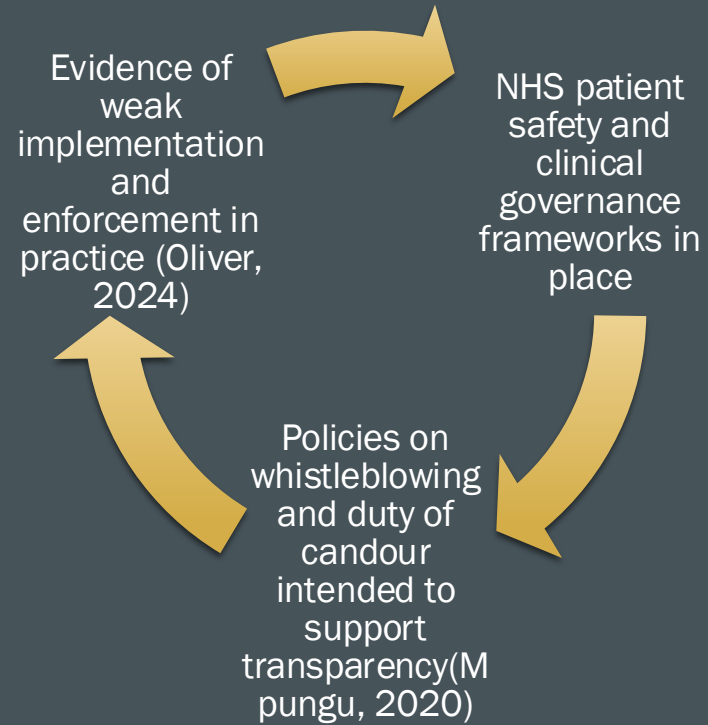
Harmful outcomes including infant deaths and loss of public trust (Manzanera et al., 2018)

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Models reveal systemic issues but have analytical limitations (Mathew, 2023).



# POLICY CONTEXT AND ISSUES



# Impact of Policy Failures on Service Delivery



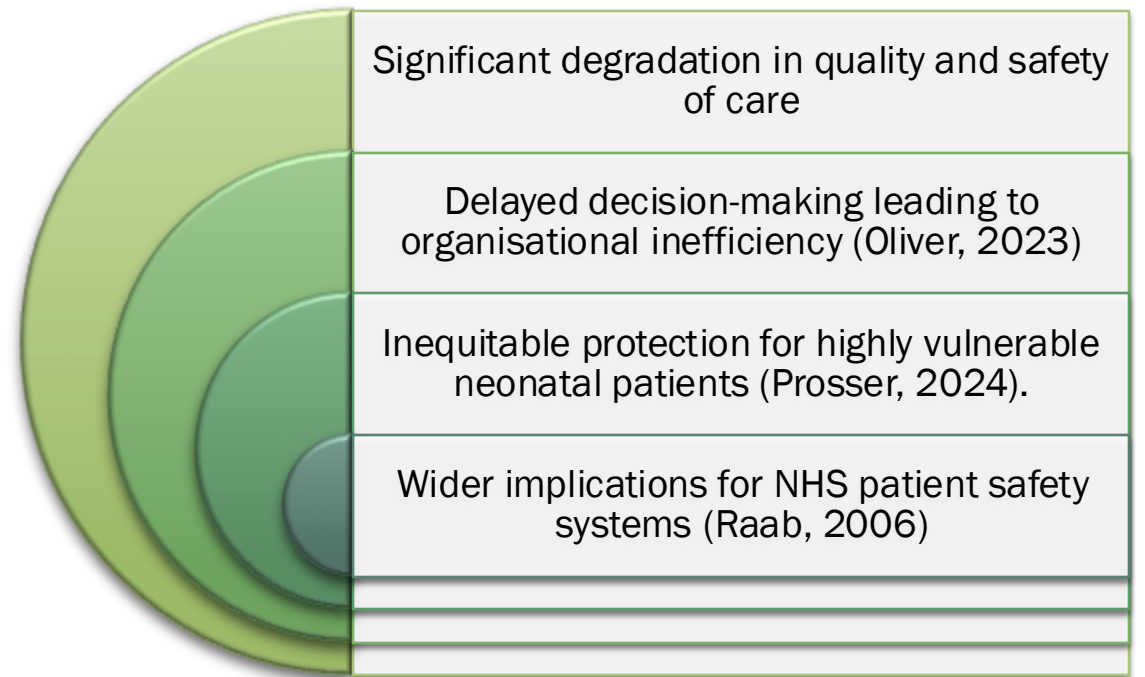
Policy weaknesses reduced quality and safety of neonatal care

Delayed and inefficient organisational responses to risk (Neville, 2023)

Increased vulnerability for high-risk neonatal patients (O'Dowd, 2023).

Significant harm to patients, families, and staff (Rimmer, 2023)

# Overall Impact on Quality, Efficiency, and Equity



# Key Lessons for Quality Assurance and Service Improvement



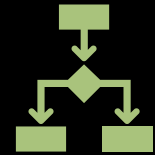
ORGANISATIONAL CULTURE  
STRONGLY INFLUENCES  
PATIENT SAFETY OUTCOMES



SAFETY SYSTEMS MUST BE  
RELIABLE AND ACTIVELY  
MONITORED

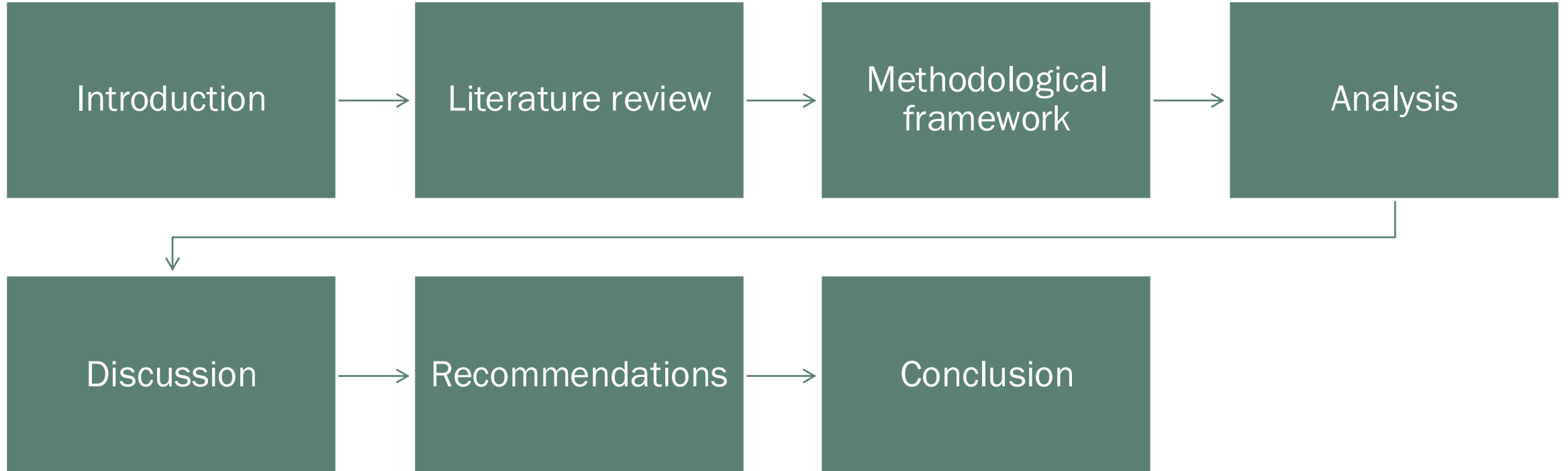


LEADERSHIP  
ACCOUNTABILITY IS CENTRAL  
TO QUALITY ASSURANCE



CLEAR IMPLICATIONS FOR  
STRENGTHENING FUTURE QA  
PRACTICE (HIGHTON, 2024)

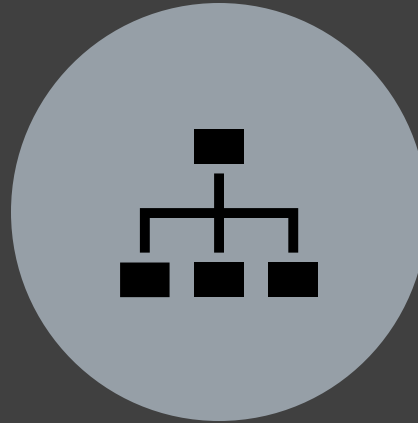
# Structure of Component 2



# Conclusion



CASE DEMONSTRATES SYSTEMIC  
QUALITY AND SAFETY FAILURES



HARM RESULTED FROM MULTIPLE  
ORGANISATIONAL WEAKNESSES, NOT  
INDIVIDUAL ACTION ALONE



ROBUST QUALITY ASSURANCE  
SYSTEMS ARE ESSENTIAL TO  
PROTECT PATIENTS

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