Notes on Independent inquiry relating to deaths and injuries on the children's ward at Grantham and Kesteven General Hospital during the period February to April 1991

Published February 1994, HMSO, ISBN 0 11 321714

The Allitt inquiry was commissioned by the then Secretary of State for Health, Virginia Bottomley, who made a statement about it in parliament.

The Allitt inquiry report is only available in hard copy as far as I can see, so I have made some notes for sharing.

The conduct of the inquiry caused controversy as families and some media felt it should have been a public inquiry. Nevertheless, the inquiry made some criticisms of what happened.

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1. The Allitt inquiry team comprised:

Sir Cecil Clothier, former Judge and Chair
Miss C Anne MacDonald, nurse

Professor David Shaw, doctor

2. Key conclusions about foul play and safeguarding

The inquiry acknowledged *"Civilised society has very little defence against the aimless malice of a deranged mind".*

Nevertheless, it made a concluding, overarching criticism that there was a failure to join the dots:

Page 121 *"We were struck throughout our inquiry by the way in which fragments of medical evidence, if assembled, would have pointed to Allitt as the malevolent cause of the collapses of children, lay neglected or were missed altogether. Taken in isolation, these fragments of medical evidence were not all very significant, nor was the failure to recognise them very culpable. But collectively they would have amounted to an unmistakable portrait of malevolence. The principal failure of those concerned lay in not collecting together those pieces of evidence. The initiative and the energy needed to do this was not forthcoming at GKGH. That is the true and ultimate criticism."*

As far as is known, Beverly Allitt began harming children on Ward Four on 24th February 1991.

The Allitt inquiry criticised a failure to proactively call a multidisciplinary conference by 30th March 1991, when a pattern of unexplained collapses had developed.

Page 50 "4.6.4 This was the seventh unusual and unexpected episode of collapse of a child on Ward Four within a period of about four weeks. There did not seem to be any clinical reason to make a connection between the previous collapses and that of Bradley Gibson. There was no suspicion of hypoglycaemia [low blood sugar] in respect of any of the children other than Paul Crampton. Yet the cumulative effect on a thinking person ought to have been, in our judgment, to force a close and anxious scrutiny of all seven episodes. Matters had progressed beyond the bounds of reasonable expectation. Indeed, Dr Porter was compelled by the collapse of Bradley Gibson to list for his personal recollection the collapses which had taken place in recent weeks.

4.6.5 We heard from many of our witnesses, and we agree, that the correct course of action would have been to call a case conference of all disciplines to consider each case individually and then to apply every mind available to thinking of all a connection, the identification of which would bring the series to a halt. ***There were some consistent factors among the various collapses which might have come to light at such a conference, not least the fact that the alarm was raised each time by Beverly Allitt.*** *[my highlight]*

4.6.6 No such decisive and commanding action was forthcoming. It is impossible to say now whether a conference of this kind would have been effective in saving further lives or suffering. But it might have done and it should have been attempted."

The inquiry concluded that there was a failure to act quickly enough when foul play first became clear with evidence of insulin poisoning:

Page 73 *"4.19.2 The first clear evidence of foul play emerged on Friday 12th April: the results which showed that Paul Crampton had been injected with exogenous insulin. We feel bound to record that in our judgment the delays between receipt of these results from Cardiff and the calling of the police, which ended Allitt's criminal course, cannot be justified. More prompt action might well have saved the life of Claire Peck and the sufferings of three other children."*

There were eighteen days between the test results of insulin being communicated to medical staff and the police being informed of possible deliberate harm to children on Ward Four.

The inquiry considered there was "feeble and indecisive" responses by senior clinical staff after they received the laboratory information on 12th April 1991 that Paul Crampton had been poisoned with insulin.

Two consultant paediatricians responsible for the ward in question departed for a conference during part of the interval. It was not until the 30th April that the police were asked to investigate, during which time more children had been harmed.

One of the consultants plucked up the courage to raise concerns with management and asked for support in the form of video surveillance on the ward. However, he was labelled as having "fanciful ideas", and the request was not supported.

The inquiry considered that "constant awareness" of the possibility of deliberate harm to children is essential when considering unexplained harm:

Page 74 *"4.19.6 The Grantham experience demonstrates the danger of assuming that there must be a natural explanation even when one cannot be found. We now know that child abuse and murder can be and have been perpetrated in hospital. However unlikely it may seem at the time, we conclude that when faced with a clinical history in a child that defies rational explanation, constant awareness of the possibility of unnatural events is essential".*

Balanced against the evidence of failure, there were two examples of good practice.

A night nurse manager who consistently raised concerns about unsafe staffing (which likely assisted Allitt's offending and delayed her detection) was posthumously praised by the inquiry.

There was also an example of professionalism by a professor of paediatrics at Nottingham who proactively ensured that his medical staff analysed cases of concern and joined up dots and who had a prominent role in ensuring that the police were informed of likely foul play.

3. The timeline and broad narrative

Beverly Allitt killed and injured her victims over a two month period. Three children died on Ward Four of Grantham and Kesteven General Hospital. A baby died at home not long after discharge. Nine other babies and children collapsed unexpectedly, some more than once. All of them but one had to be transferred to the special children's unit at Nottingham.

This is the timeline of events given in Appendix 4 of the inquiry report:

"February 1991

Tuesday 19th February	*Beverly Allitt began work as an enrolled nurse on Ward Four*
Saturday 24th February	*Liam Taylor collapsed and died*

March 1991

Tuesday 5th March	*Timothy Hardwick died suddenly*
Sunday 10th March	*Kayley Desmond collapsed twice and was transferred to Queen's Medical Centre, Nottingham (QMC)*
Saturday 23rd March	*Paul Crampton suffered his first hypoglycaemic episode*
Sunday 24th March	*Paul Cramptons's second hypoglycaemic episode*
Tuesday 28th March	*Paul Crampton's third hypoglycaemic episode, following which he was transferred to QMC*
Saturday 30th March	*Bradley Gibbon collapsed and was transferred to QMC*
Sunday 31st March	*Yik Hung Chan collapsed twice and was transferred to QMC*

April 1991

Tuesday 4th April	*Becky Phillips was discharged from Ward Four*
Friday 5th April	

	Becky Phillips collapsed at home in the early hours of the morning. She was dead on arrival at Grantham Hospital. Katie Phillips was admitted to Ward 4. She collapsed later in the day.
Sunday 7th April	*Katie Phillips collapsed twice and was transferred to QMC*
Tuesday 9th April	*Michael Davidson collapsed*
Friday 12th April	***Dr Nelson Porter was advised by telephone of the results of an insulin assay on a sample of Paul Crampton's blood taken during his third hypoglycaemic episode. The test results showed that Paul's blood contained insulin which had been administered by injection.*** *[my highlight]*
Saturday 13th April	*Christopher Peasgood collapsed twice and was transferred to QMC*
Sunday 14th April	*Christopher Peasgood collapsed*
Tuesday 16th April	*Christopher King collapsed three times and was transferred to QMC*
Thursday 18th April	*Patrick Elstone collapsed twice and was transferred to QMC*
Monday 22nd April	*Claire Peck collapsed twice and died during the second collapse*
Tuesday 30th April	***Concerns about the events on Ward Four were reported to the Grantham Police"*** *[my highlight]*

The number of sick children transferred from Ward Four to Queen's Medical Centre in Nottingham in March and April 1991 represented a sharp spike.

The inquiry reported that in contrast, only a handful had been transferred in 1989 and 1990:

Page 37 "*4.1.4 When children on Ward Four needed highly specialised treatment or intensive care, which the ward was neither staffed nor equipped to give them, they were transferred to one of the specialist children's units in Nottingham. This was not a frequent occurrence,*

and many of the transfers were planned for specific operations or investigations which could not be carried out in Grantham. Three children were transferred in the first four months of 1990, and in the equivalent period in 1989 there were only two transfers."

The inquiry noted:

Page 5 *"1.2 In many of the cases, it seemed to the doctors on Ward Four and in Nottingham that what had happened was unusual, but could be explained on the basis of each child's medical history. Nevertheless, as time went by and more children collapsed unexpectedly, medical and nursing staff in Grantham, bewildered by these events, grew deeply alarmed.*

1.3 Post mortem examinations were carried out on the children who died and tests to try to determine the cause of their collapse were carried out on each of the children who survived. Most of these tests proved negative. On 12th April, a blood test result showed that one of the children, whose blood sugar had fallen dramatically and inexplicably on three occasions, had been wrongly injected with insulin. During the weeks that followed, the possibility that this had happened accidentally was eliminated and, as more emergencies occurred on the ward, the suspicion grew that someone was deliberately harming the children. On 30th April 1991, the police were called to Ward Four to investigate.

1.4 The police investigation took several months. Gradually more children were added to the list of those whom the police suspected had been victims of criminal activity. As events were pieced together, a picture emerged of one person, Enrolled Nurse, Beverly Allitt as the likely culprit. She was first arrested and questioned on 21st May 1991, but it was not until November that the police had gathered enough evidence from the complex history of those months on Ward Four to charge her.

1.5 Arising from the events on Ward Four, Beverly Allitt was charged with four murders, nine attempted murders and nine counts of causing grievous bodily harm with intent to the same children. She was also charged with attempting to murder two adults elsewhere and with causing them grievous bodily harm with intent. On days between 13th and 17th May 1993 she was convicted of murdering Liam Taylor, Timothy Hardwick, Becky Phillips and Claire Peck. She was also convicted of attempting to murder Paul Crampton, Bradley Gibson and Katie Phillips, and of causing grievous bodily harm to Kayley Desmond, Yik Hung Chan, Michael Davidson, Christopher Peasgood, Christopher King and Patrick Elstone. She was sentenced to life imprisonment on every count. She was found not guilty of the charges relating to the two adults."

Allitt's development and mental health

The inquiry emphasised that Allitt was outwardly ordinary and in most people's eyes showed no clues of what was to come.

There were a few reports of Allitt's lack of emotion:

Page 88 *"5.7.3 A few of Allitt's colleagues noticed that she was unemotional, and that she didn't cry when children died, but they were in a minority. Some noticed too that she did not*

pick up babies just to cuddle them in the way that most nurses did. But as one of her colleagues remarked, "I just thought that this was her way of handling the stress we all felt". Lack of emotional expression is not unusual and some of us conceal our emotions under a mask of indifference."

The inquiry investigated Allitt's background including schooling, nurse training and medical history. It found a trail suggestive of abnormal illness behaviour dating back to school days when she *"…was often seen around the school wearing a bandage or with her arm in a sling".* The behaviours increased during pre-nursing college training, when her illnesses and injuries reportedly became more frequent. *"She often showed her injuries to her tutors, and appeared to be using them to draw attention to herself".* In her second year of training her sickness record became a matter of concern. She missed 52 out of 180 days and also additional sessions for medical appointments.

Allitt gained entrance to nursing college without a reference from her college, which hid her sickness record, and she passed an Occupational Health screen based on her self report:

Page 80 "5.5.1 Beverly Allitt was screened in the Occupational Health (OH) department at GKGH both when she was recruited to pupil nurse training, and when she was appointed to Ward Four. On both occasions she was passed fit for employment as a nurse".

As a pupil nurse, Allitt also had a high sickness record, missing 126 days of a 110 week course.

The inquiry criticised the fact that no referral was made to Occupational Health, but Allitt referred herself on fifteen occasions. She had abdominal and urinary complaints for which she was investigated. Occupational Health relied on Allitt for information and had no corroborating information from other sources which might alert the service to any psychiatric disorder or the presence of self-inflicted injuries. Occupational Health did not inform the School of Nursing about Allitts self referrals. A physiotherapist who saw Allitt wondered if she might be making her injuries worse, but stopped short of concluding that her injuries were self-inflicted.

A senior physiotherapist became concerned that she was not mature enough to be a nurse:

Page 86 *"5.6.3….The Superintendent Physiotherapist decided that she should mention Allitt's repeated attendances to the Nurse adviser. Her concerns were not specific, but she felt that Allitt lacked the maturity of personality to care for others. She certainly did not predict the eventual outcome of Allitt's nursing career, but wanted to make sure that the management were aware of Allitt's medical history.*

5.6.4 There is no written record of the meeting between the Superintendent Physiotherapist and the Nurse Adviser, or of any action thereafter. The Nurse Adviser felt sure that she would have passed on what she was told to the Senior Tutor at South Lincolnshire School of Nursing. We have been unable to verify what took place and certainly no further action was taken."

The Allitt inquiry concluded retrospectively that she was possibly showing serious abnormal illness behaviour as a pupil nurse:

Page 76 *"5.3.3…..In October 1990 her appendix was removed, but was found to be normal. The wound became infected twice in the weeks following operation raising, in retrospect, the possibility that she interfered with it."*

Allitt passed her exams to become an enrolled nurse in December 1990, but had to make up extra time on the wards for required experience before she could qualify. This is how she came to be placed on Ward Four. She had asked to be placed on Ward Four. The inquiry criticised the decision to allow this as it believed the decision did not reflect her training needs. Allitt was then given a six month post as an enrolled nurse on Ward Four, through a flawed recruitment process without references.

After she became a suspect in the killings and assaults, Allitt was formally diagnosed with factitious (fabricated) illness, or in those days, Munchausen Syndrome.

Page 76 *"5.3.4 In the summer of 1991, by which time Allitt was on bail following her arrest , her medical history became more florid and bizarre. In July 1991, when she was in hospital in Peterborough, the diagnosis of Munchausen Syndrome was first suggested. Confirmation of factitious interference was provided by her manipulation of thermometer readings to temperatures that were totally incompatible with her clinical state. Furthermore at the same time she was complaining of an enlarged right breast. No cause was found, but three small puncture marks in her breast were observed. These marks probably indicated that she had injected herself with water. In retrospect, the diagnosis was irrefutable. However, not criticism can be levelled because the diagnosis was not made sooner. In our judgment there were insufficient grounds for suspecting the serious disorder of behaviour that characterises Munchausen Syndrome at the time that Allitt was recruited as an enrolled nurse to Ward Four."*

The importance of specialist paediatric radiology, pathology, blood tests and toxicology

In the case of Liam Taylor, initial post mortem examination found damage to the heart but was unable to identify a cause. Re-examination by a paediatric pathologist concluded an unnatural cause, namely administration of a noxious substance.

In the case of Kayley Desmond, the inquiry queried whether or not subtle but suspicious Xray findings of air in the child's upper right arm and armpit, consistent with air introduced intravenously, would have been spotted if reviewed and formally reported by paediatric radiologists.

In the case of Paul Crampton, which links significantly with the Letby affair, lab tests confirmed the administration of exogenous insulin. The inquiry stated:

Page 47 " 4.5.5 The sample taken on 28th March, which was sent for testing in Cardiff, contained so much insulin that it was beyond the range of the equipment used to measure it. Very low levels of c-peptide were found. These results provided conclusive evidence that Paul had been given 'exogenous' insulin."

In the case of Bradley Gibson, a blood test taken an hour after he collapsed, his heart had stopped working and he lost consciousness, associated with a complaint about pain at the site of his IV drip, showed very high levels of serum potassium ("6.2mmol/L compared to a normal range of 3.7 to 5.0 mmol/L").

In Becky Phillips' case, retrospective testing of her blood after insulin poisoning was discovered in Paul Crampton's case also suggested that she had been injected with insulin.

In Katie Phillips' case the inquiry noted that possible signs of violence on xray had been missed.

In Claire Peck's case a very high level of potassium was found in her blood 45 minutes after she collapsed and her heart had stopped ("greater than 10 mmol/L"). The high level might have been due in part to the effect of the prolonged cardiac arrest. Later testing of Claire Peck's blood in 1993 also revealed a small amount of lignocaine. It might have been given during resuscitation, although the doctors did not recall using it. It was a potential means of murder. The inquiry observed: *"The amount measured was consistent with Claire having been given a massive dose before she collapsed, since her body would have continued to clear the lignocaine until she died".*

Video monitoring rejected, management's suppression of concerns and miscommunication

The inquiry noted that one of the Ward Four consultants heard a presentation about Munchausen Syndrome by Proxy at a conference that he attended in April 1991.

Page 63 "4.14.2…Dr Porter was impressed by the use of video recording equipment to detect these cases, and wondered whether it might be used to see whether someone was indeed attacking children on Ward Four".

The inquiry noted that in the period 19th to 22nd April one of the Ward Four consultants raised concerns with both the Clinical Services Manager and the duty manager, asking both for video surveillance.

The inquiry noted that management had taken a derogatory view of the consultant's concerns:

Page 65 *"4.16.5 ….This was because according to Mr Gibson, Dr Porter had a acquired a reputation for what Mr Gibson described as "fanciful ideas", by which we understood him to mean a tendency to raise alarms which were not justified in the event…..Dr Porter explained his concerns to Mr Jackson and repeated his request for video surveillance on the ward. Mr*

Jackson said this would be difficult to arrange. He said he would talk to Mr Gibson [the Unit General Manager]."

The request was not supported, partly as the other Ward Four consultant was not expressing the same degree of concern about deliberate harm.

The Assistant General Manager responded to a report about Dr Porter's ongoing concerns by describing him as "a bit unpredictable".

By 24th April the Clinical Services Manager had also accepted the concerns after accidental administration of insulin had finally been ruled out. She sought help from the Assistant General Manager, Miss Newton.

The inquiry criticised the ensuing response:

Page 71 "4.18.4 Mrs Onions' letter may have lacked sufficient detail, but it was clearly a cry for help from someone faced with a crisis situation. Miss Newton's reply, dated 13th May 1991, can only be described as a cold rebuff. The letter criticises Mrs Onions for not providing a more detailed analysis and producing solutions herself and goes on to outline the information needed to back up the case for additional staff. We acknowledge this must be seen against the background of communication between these two managers regarding the staffing situation. The staffing of Ward Four is discussed in section 5.8. Nevertheless we would have expected Miss Newton to have taken more urgent and sympathetic action in response to Mrs Onions' letter, particularly in view of the series of disasters of which she was well aware.

4.18.5 From this time until Monday 29th April, it appears that everyone was waiting for someone else to do something. Mr Gibson was still waiting to hear the outcome of the meeting between the two consultants and Mrs Onions. Miss Newton was waiting to hear whether the results from Cardiff must mean that Paul Crampton had been given insulin deliberately. Dr Porter and Dr Nanayakkara believed that they had given sufficient information to Mrs Onions and Mr Gibson and that it was for them to decide what action was appropriate to prevent a recurrence. Mrs Onions was on holiday.

4.18.16 On Monday 29th April, Dr Porter received a telephone call from Professor Sir David Hull at Queen's Medical Centre. The circumstances which prompted Sir David to make this call are discussed in section 5.13. Sir David urged Dr Porter to go direct to senior management and ask them to call the police. Dr Porter went to see Mr Gibson. They only had a brief conversation as Mr Gibson was on the way to a meeting, but Mr Gibson said he would telephone the police the next day."

Pooling of intelligence at Queen's Medical Centre

The inquiry reported that paediatricians at QMC reviewed cases of concern at a meeting on 29th April and concluded that there had to have been an extrinsic factor accounting for the unexpected clinical outcomes:

Page 115 *"5.13.21 Following these later episodes, some of the doctors in Nottingham, discussing their cases informally, realised that many of the cases which worried them were transfers from GKGH. They met together on Monday 29th April. On the previous Friday Professor Sir David Hull, the senior Consultant Paediatrician at QMC, became aware of the children who had been transferred from GKGH, none of whom had been his patient. In particular, he was alarmed to hear of the results of the tests on Paul Crampton's blood. He instigated the meeting on 29th April and asked for a report of the findings.*

5.13.22 At the meeting, the cases of Paul Crampton, Bradley Gibson, Katie Phillips, Christopher King and Patrick Elstone were discussed. Even at this stage, there was no suspicion about what had happened to Kayley Desmond or Christopher Peasgood. The meeting did not find anything common to the five cases they discussed, but they concluded that, ***"It is very clear, however, that all children have had a clinical course completely out of context to their presenting illness and we are concerned that there may be an extrinsic factor which has changed their clinical course".*** *[my emphasis]*

5.13.23 A written record of the discussion was produced the same day and passed to Professor Sir David Hull, who telephoned Dr Porter to find out what was happening. In the course of this conversation, he advised him to call the police. The next day, Sir David telephoned to check whether Dr Porter had followed his advice and was told the police had been called".

Unsafe staffing

The inquiry acknowledged that children can be abused and harmed by the determined, even when staffing levels are good.

But it criticised the persisting poor staffing levels on Ward Four, which continued despite advice from external consultants in early 1990 about this, and despite repeatedly raised staff concerns.

The reported staffing levels were as follows:

Page 89*: "5.8.3 The nursing establishment determined by GKGH for Ward Four in January 1991 was 10.66 whole time equivalents (WTE)….*

5.8.4 The actual number of staff in post on Ward Four was even lower than the funded establishment of 10.66 WTE. There were 8.86 in January 1991, rising to 9.57 in February 1991 and falling again to 9.30 in March 1991. During the months in question there were only three full-time and one part-time nurse on Ward Four who held the qualification of Registered Sick Children's Nurse (RSCN) – that is to say 3.53 WTE of the funded establishment."

The inquiry drew attention to a minimum government standard on children's care:

Page 91 "*5.8.8 The recommendation at the time in question was that there should be at least one RSCN on duty on children's wards throughout the 24 hour period. Subsequent guidance issued by the Department of Health during 1991 advised district health authorities and provider hospitals to take account of the following standards:*

"There are at least two RSCNs (or nurses who have completed the Child Health Branch of Project 2000) on duty 24 hours a day in all hospital children's departments and wards."

In particular, the inquiry commended the efforts of Mrs Jean Savill the Night Services Manager who did her best to flag the risks to patients of under-staffing, to her superiors.

Page 92 *"5.8.12 In November 1990 Mrs Jean Savill, the Night Services Manager, requested a meeting with Miss Hannah Newton and Mrs Moira Onions, the nurse managers responsible for Ward Four, to discuss the problems on night duty. Mrs Savill met with the nurse managers on two occasions in January 1991. Mrs Onions also wrote to Miss Newton expressing concerns about staffing levels at least twice. Despite all of the concerns noted by the staff nurses and night nurses, little seems to have been done other than to approve additional bank staff when required to 'special' children. The difficulty with this arrangement was that few of the bank staff were RCNs and they were often not available at busy times and during holidays.*

5.8.13 On 4th April 1991 Mrs Savill wrote again to Mrs Onions. The last paragraph of her letter read, "As the night duty nurse manager, I feel very distressed with the situation on Ward Four, and feel most strongly that being professionally accountable for these children in our care, I must voice my concerns in the sincere hope that an early solution may be implemented before a tragedy occurs. The Tribunal [of inquiry] acknowledges the notable efforts made by the late Mrs Savill to improve staffing levels on Ward Four".

The effect of poor staffing on Ward Four meant that Beverly Allitt was subject to less scrutiny than she might have been. The inquiry stated:

Page 93 *"5.8.16 The overall result of the low staffing levels and inadequate number of qualified children's nurses on Ward Four was that, as we have stated earlier, Allitt was often one of only two qualified staff on duty. This meant she was left by the nurse in charge to 'special' ill children and frequently to escort them to Queen's Medical Centre (QMC) – a task usually allocated to a much more experienced nurse. Her colleagues did note that she was invariably present when a child collapsed, but they failed to attach any significance to the fact. Indeed some of them teased her as an agent of bad luck. Nor were her colleagues particularly concerned about her undue self-confidence and apparent knowledgeability and her eagerness to accompany all children to QMC."*

In my view Allitt's escort duties to QMC of children in medical crisis raises two issues. It potentially provided opportunity for ongoing harm to already very sick children. It also potentially fed whatever psychological gain she derived from harming the children and the drama and attention that ensued.

The Allitt inquiry also noted that the medical establishment for children's services at Grantham and Kesteven General Hospital was thin, and that the pace of work for the two consultant paediatricians was arduous, making it harder to work reflectively:

Page 95 *"5.9.3 Between them, the Consultants and SHOs had to cover not only Ward Four, but also the Special Baby Care Unit and the Paediatric Out-Patient Department which was situated on Ward Four. They also had to be on hand if any problems arose with new-born babies on the maternity unit. Until the third SHO was appointed, both Consultants and SHOs were on call all day and on alternate nights during the week and alternate weekends, on a one in two rota."*

Page 96 "5.9.7 We can only speculate as to whether the two consultants would have reacted more quickly and effectively to the series of collapses had they had more time to reflect."

Monitoring equipment on Ward Four switched off but not investigated

The inquiry concluded that Allitt most likely switched off alarms monitoring children's vital signs before attacking them, but there was a failure to investigate the failure of the alarms:

Page 103 "5.11.5 There was one matter relating to equipment which was highly relevant to the circumstances of the collapses and about which we were greatly concerned. Seven of the children who collapsed were attached to monitors fitted with alarms which were set to go off if their breathing or heat beat slowed down or stopped, or if oxygen saturation of the blood fell below a safe level. On at least four occasions, these alarms did not sound when the children collapsed, although they should have been triggered. The most likely explanation now appears to be that Allitt switched them off before attacking the children. Yet there was no investigation at the time as to why the alarms did not sound."

Drug security procedures on Ward Four and possible theft of a universal key to all ward drug fridges

Page 103 *"5.12.1 It is not known how Beverly Allitt obtained the drugs she used to attack the children on Ward Four. In many cases, there is uncertainty as to which drug she used. We have heard expert evidence that it is possible to murder or seriously injure a child in a short space of time without any drug and without leaving marks on the child's body. Suffocation could produce effects similar to those seen in some of the children who collapsed. This may well have been the means used by Allitt in some cases . The implication of this is that even if she had has no access to drugs she might nevertheless have committed her crimes , albeit using different methods."*

Page 106 "5.12.9 We have noted that Allitt held the drug keys on occasion. She sometimes did so while the nurse in charge the ward was having her meal break, leaving her Allitt as the most senior nurse on the ward. It is possible that Allitt may have used the keys to remove drugs from the cupboard. It is difficult to see how such risk could have been avoided. It is essential that the nursing staff remaining on the ward during breaks have access to the drug cupboards. Nurses cannot and should not be expected to watch one another with suspicion

at all times, and a qualified nurse has to be trusted with drugs. If nurses cannot trust one another the whole system becomes unworkable.

5.12.10 If Allitt was systematically removing phials of a drug, we might expect there to have been an increase in a turnover of that drug on the ward which could have been picked up in the Pharmacy. The Pharmacy computer maintained a record of average issues of each drug to a ward. It would highlight instances of where that was a sudden issue of more than the usual amount. The system was designed to adjust the supply of each drug, rather than to track the use of that drug. It did not show up any significant increases in the use of any drug on Ward Four during the period in question. The quantity of insulin used actually decreased."

Tragically, it seems that Allitt possibly duped nursing colleagues on Ward Four by stealing a key to the drug fridge on Ward Four which also opened the drug fridges on other wards. Whilst the lock on Ward Four's fridge was changed as a result, she would still have been able to access drug fridges on other wards:

Page 107 "5.12.13 It is also possible that Allitt obtained insulin from elsewhere in GKGH. On 14th February 1991, she was handed the set of keys to fetch some eye drops from the drug refrigerator . Shortly afterwards, Allitt reported that the key was missing. The keys were kept on a sturdy key ring. It is unlikely that the refrigerator key fell off accidentally. Despite an exhaustive search, it was never found. The lock was replaced the following day. We were surprised that we were unable to find an untoward incident report in respect of this incident.

5.12.14 The senior staff on Ward Four thought that by replacing the lock they had solved the problem, even if the key had been stolen. ***What they did not know was that all the refrigerators in the hospital at that time had the same lock****. The refrigerators were not designed to prevent access by staff from other wards. This fact was not discovered until after the police had been called to Ward Four. It is therefore possible that Allitt stole the key and used it to remove drugs from refrigerators on other wards" [my highlight]*

Other cases of similar child abuse noted by the inquiry

The Allitt inquiry gave examples as follows:

Page 78 "*5.4.4 The case in Toronto arose from a dramatic increase in the mortality on a cardiology ward of a children's hospital between July 1980 and March 1981. Although most of the children who died had serious congenital heart disease, their deaths occurred at unexpected times, and their clinical history was consistent with poisoning with digoxin. In four patients, forensic scientific and routine laboratory digoxin measurements suggested digoxin had been administered shortly before death.*

5.4.5 A nurse was arrested and accused of administering these overdoses in March 1981. Charges against her were dismissed when further evidence showed that digoxin had been administered to another child while she was not on duty. An epidemiological investigation found that one was on duty for all but two of the deaths, far more than the nurse who was originally arrested. This second nurse was never arrested.

5.4.6 The second case occurred in the paediatric intensive care unit at a large medical centre in Texas, USA. Between April 1981 and June 1982 there was an unusual increase in the number of deaths and arrests in the unit. No cause for this increase could be found. It was noted that most of the incidents occurred during the evening work shift, and in the presence of one nurse. This nurse was never charged with murder in respect of these incidents, but she was charged and convicted in 1984 on one count of attempted murder. It remains whether she caused the increase in the number of deaths."

Lack of a clear system for reporting serious incidents to the Health Authority

At the of the killings by Allitt, there was no clear system for reporting serious untoward incidents to Health Authorities.

The Health Authority became involved by happenstance.

Page 117 *"5.14.5 Mr Malcolm Towson, the District General Manager of South Lincolnshire Health Authority, first heard about the events on Ward Four on Tuesday 23rd April [eleven days after the Cardiff laboratory had provided evidence of insulin poisoning]. He had attended meetings at GKGH about other matters over the preceding weeks. During the curse of a telephone conversation on 23rd April, the Unit General Manager Mr Gibson told Mr Towson about Dr Porter's telephone call on Friday 19th April and the ensuing discussions (see paras 4.16.5 to 4.16.7. Mr Gibson explained that Dr Porter feared that a child on Ward Four had been injected deliberately with insulin, but added that it was not yet clear whether his fears were justified. He said that he would keep Mr Towson informed.*

5.14.6 Mr Gibson did not ask or expect Mr Towson to take any action in response to what he told him. It might be said that Mr Towson should have made sure that Dr Porter's fears were fully investigated as quickly as possible, but we are no convinced there is ground for criticism here. Mr Towson had been informed in passing of something which at stage, Mr Gibson himself doubted would turn out to be true.'

Page 118 *"5.4.8 No report of untoward incidents on Ward Four reached Trent Regional Authority until Tuesday 30th April, after the police had been called. Dr Porter telephoned Trent RHA that afternoon in the hope of speaking to Dr (now Professor) Richard Alderslade, the Regional Director of Public Health and Regional Medical Officer. Dr Alderslade was unavailable so a lengthy explanation was given to a senior manager in the Regional General Manager's Department. She spoke to Mr Gibson immediately after their conversation to find out his view of the situation and passed on what she had been told to Dr Alderslade and to the Regional Legal Adviser.*

Of great concern, earlier in April Dr Alderslade had actually visited Ward Four and been told of the unusually high number of child deaths by the ward consultants, but they had told him they thought it was due to a virus:

"5.4.9 Earlier in April, Dr Alderslade had attended several meetings at GKGH to discuss junior doctor staffing and the development of the link between Grantham and Newark. After a

meeting on April 11th, Dr Porter and Dr Nanayakkara showed Dr Alderslade around Ward Four. As they did so, ***they mentioned there had been an unusually high number of collapses on the ward in recent weeks. Dr Alderslade asked their opinion of the cause and they told him it might be a virus.***

5.14.10 We do not believe this constituted reporting of a serious incident. The Consultant Paediatricians did not express concerns about the cause of the collapses."

Page 119 "5.14.12 One general conclusion we can draw from this experience is that Health Authorities should make clear that, once the judgment has been made that a serious untoward incident should be reported, a casual mention in passing does not constitute reporting of that incident. It should be emphasised that, although a telephone call may be sufficient initial warning of such an incident, it must always be followed by a written report. Moreover, the simple act of telling someone else of one's concerns does not absolve one of taking action oneself.

The Regional Fact Finding Inquiry into Paediatric Services at Grantham and Kesteven General Hospital

Prior to the Allitt inquiry, a separate inquiry had been set up to review the general workings of the service, which did not examine the killings.

According to the Allitt inquiry, the earlier *"…Regional Inquiry made a total of 51 recommendations to the management of both paediatric and neonatal care at GKGH"*

The Allitt inquiry was broadly supportive of the majority of the recommendations and noted that many of them had been implemented or were being implemented.

The Allitt inquiry specifically noted the recommendations on checks of criminal background, qualifications and registration status:

Page 122 "6.6 We also welcome the firm recommendations with regard to the need to extend the procedure for checking whether nurses who are liable to come into contact with children have a criminal background, and for ensuring that accurate records are maintained of the qualifications and registration status of all nursing staff. We commend the priority given to implementing these two recommendations and emphasise the importance of all employers using the UKCC's confirmation services to confirm that the claimed registration of a nurse is valid, and that they possess a current and effective registration. It should be noted that the UKCC now has the power to impose temporary suspension of a practitioner's registration. This power, however, can only be effective in protecting the public if employers avail themselves of the Council's confirmation services."

Recommendations made by the Allitt inquiry

"1) ***We recommend*** *that for all those seeking entry to the nursing profession, in addition to routine references the most recent employer or place of study should be asked to provide at least a record of time taken off on grounds of sickness (para 2.4.4)*

2) ***We recommend*** *that in every case Coroners should send copies of post mortem reports to any consultant who has been involved in the patient's care prior to death whether or not demanded under Rule 57 of the Coroner's Rules 1984 (para 4.2.9)*

3) ***We recommend*** *that the provision of paediatric pathology services be reviewed with a view to ensuring that such services be engaged in every case in which the death of a child is unexpected or clinically unaccountable, whether the post mortem examination is ordered by a Coroner or in routine hospital practice (para 4.2.16)*

4) ***We recommend*** *that no candidate for nursing in whom there is evidence of major personality disorder should be employed in this profession (para 5.4.11)*

5) ***We recommend*** *that nurses should undergo formal health screening when they obtain their first posts after qualifying (para 5.5.13).*

6) ***We recommend*** *that the possibility be reviewed of making available to Occupational Health departments any records of absence through sickness from any institution which an applicant for a nursing post has attended or been employed by (para 5.5.14).*

7) ***We recommend*** *that procedures for management referrals to occupational health should make clear the criteria which should trigger such referrals (para 5.5.14).*

8) ***We recommend*** *that further consideration be given to how the suggestion of the Chairman of the Association of NHS Occupational Physicians (see para 5.5.16) could be applied in practice (para 5.5.17).*

9) ***We recommend*** *that consideration be given to how General Practitioners, might, with the candidate's consent be asked to certify that there is nothing in the medical history of a candidate for employment in the nhs which would make them unsuitable for their chosen occupation (see para 5.5.19).*

10) ***We recommend*** *that the Department of Health should take steps to ensure that its guide, "Welfare of Children and Young People in Hospital", is more closely observed. (para 5.8.8)*

11) ***We recommend*** *that in the event of failure of an alarm on monitoring equipment, an untoward incident report should be completed and the equipment serviced before it is used again (para 5.11.6).*

*12) **We recommend** that reports of serious untoward incidents to District and Regional Health Authorities should be made in writing and through a single channel which is known to all involved (para 5.4.12)"*

Dr Minh Alexander 15 August 2023

APPENDIX

Diagram provided by the Allitt Inquiry report of the management structure within which Ward Four sat at Grantham and Kesteven General Hospital