# Appendix 10.1 Thirlwall Inquiry

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Public Trust Board Meeting – 18 November 2026

# Introduction: The Thirlwall Inquiry



- Neonatal Nurse Lucy Letby convicted for the murder and attempted murder of babies at the Countess of Chester Hospital.

- An independent public inquiry established in October 2023, led by Lady Justice Thirlwall. Final report published 15 September 2026 with 17 recommendations.
https://www.gov.uk/government/publications/thirlwall-inquiry-report

- **Aim of the inquiry**: to provide answers for the families, identify where mistakes and failures occurred, and recommend changes to improve patient safety

- All 17 recommendations listed in attached slide deck. Those highlighted are actions that the Trust will be taking between now and end March 2027.

- The inquiry examined the experiences of the affected families, the actions of hospital staff and management, and why concerns were not acted upon sooner.

- It also investigated wider failures in NHS leadership, safeguarding procedures and professional regulation to determine if earlier intervention could have prevented harm

# Recommendations



Recommendation 1: CCTV and monitoring

- All cots and incubators in all neonatal units should be fitted with baby monitors (in-cot cameras with livestreaming video), so that parents can observe their baby remotely at any time. March 2027

Recommendation 2: Insulin

- Digital devices should be used to restrict access of insulin to authorised people and record access to insulin storage units – include CCTV. March 2027.
- National *Investigation of Hypoglycaemia* guidance for the testing and reporting of insulin and C-peptide results, mandatory and of national application.

**Recommendation 3: Bereavement care**

- **The National Bereavement Care Pathway for neonatal death should be implemented nationally and in all Trusts by 31 August 2027.**

# Recommendations



**Recommendation 4: Safeguarding and contracts of employment**

- **All Trusts must provide safeguarding training to all staff (appropriate to their role and expertise) and Board members, including Non-Executive Directors.**

- **Training to include how to deal with concerns and suspicions about staff causing deliberate harm.**

- **Every existing contract of employment for work in an NHS hospital must be amended to include an obligation on the employee to follow all relevant safeguarding guidance, including the Suspicion of Deliberate Harm Protocol (at Rec 9), for dealing with concerns and suspicions about deliberate harm.**

- **Agency and bank staff contracts and all new contracts of employment must include the same obligation.**

- **By March 2027**

# Recommendations



Recommendation 5: Operating systems (interoperability)

- NHS England planning that NHS computer systems are harmonised by December 2028.
- Work on the development of a mandatory information standard with requirements for interoperability between systems.
- Data for babies and neonates entered on a single occasion, reviewed in a timely manner and facilitate continuous monitoring

**Recommendation 6: Monitoring deaths in hospitals**

- **All hospital Trusts must have effective mechanisms for Board-level monitoring of all deaths of children and babies.**
- **All hospital Trusts must have a clear and predetermined route to senior management for the escalation of concerning data trends or patterns.**
- **By March 2027**

# Recommendations



Recommendation 7: Data reporting

- All hospitals with a neonatal unit should name a 'lead reporter' with responsibility for inputting weekly data regularly, reviewing real-time data viewers on neonatal and maternity units in the relevant system and holding clinical discussions
- Where data requires immediate action, this is undertaken and reported should be made to the Medical Director and the Board immediately.
- Lead reporter should report to Trust Boards at least every six months and advise on alerts, investigations and plans

Recommendation 8: Sudden Unexpected Death in Infancy and Childhood (SUDIC)

- SUDIC process applies to the sudden and unexpected deaths of babies who have ***never*** left hospital.
- All Trusts must draw this information to the attention of all relevant staff and the Board.
- DHSC must complete its review, revise , and circulate the SUDIC guidelines. March 2027.
- SUDIC forms must be redesigned and shortened to keep bureaucracy to a minimum focusing on what it is essential to know.

# Recommendations



Recommendation 9: Suspicion of Deliberate Harm Protocol and guidance

- NHS England must produce and distribute a *one-page* Su*spicion of Deliberate Harm Protocol . E*xplicit points:
  - It is irrelevant whether the person to whom the concerns have been expressed does or does not believe they are true, as is the fact that the person raising the concern is not sure.
  - Where concerns or suspicions of deliberate harm are raised, they must be acted upon immediately.
  - Only in cases where the concerns are obviously irrational or malicious will no further action be justified.
  - Move the suspected person during the investigation – this is a neutral act
- Safeguarding steps must be followed, as a result of which the police will become involved.

Guidance

- Must set out the factors to be considered when assessing the nature of the concerns and suspicions.
- The reader directed to guard against their own biases, loyalties and prejudices.
- Explain what should be said and when to those who are or who may be involved with any investigation (pts, staff).
- Patient safety comes first, and investigation is required.
- Failure to follow the protocol will be a breach of contract by an employee, as well as a breach of the relevant code of conduct.
- Trusts must embed the Suspicion of Deliberate Harm Protocol and guidance within their hospital.
- By March 2027

# Recommendations



Recommendation 10: Panel of experts

- Serious consideration by Department of Health and Social Care (DHSC) to the setting up of a panel of independent experts from all specialties to be called upon in situations where there are emerging concerns about an individual and harm to a patient or patients.
- To conduct a swift, technical investigation into the concerns raised.
- Possibly most often necessary where there are concerns that harm is being or has been caused inadvertently.

- The precise make-up of the panel should be determined by DHSC but could include, for example:
  - two doctors and two nurses from each clinical specialty
  - four senior managers
  - four pathologists including paediatric and perinatal pathologists
  - other experts as decided by DHSC.

- A small team (including relevant clinicians) drawn from the panel to carry out an independent investigation into clinical concerns.
- Such investigations should always include safeguarding considerations (including the police).
- Experts could be called as witnesses in any proceedings and report their findings to the Trust and DHSC

# Recommendations



Recommendation 11: Medical Examiners(ME)

- National ME to prepare a document setting out steps to be taken by an ME when a neonatal death occurs.
- The revised SUDIC guidelines (see Rec 8) should be set out within the good practice guidelines for MEs.
- MEs to ask the attending practitioner directly whether there is a concern of harm or safeguarding issue.
- Where there may be a concern, the ME should ensure that there is a record made that day of the contact details of every doctor or nurse who attended to the baby during life.
- Develop a pool of neonatologists who can assist Mes with their work until such time as it is possible to appoint the appropriate number of regional neonatologist MEs.
- The ME system should be reviewed again in 2027 by DHSC.

Recommendation 12: Paediatric and perinatal pathologists

- DHSC and NHS England must ensure that, by June 2033, there are 37 doctors in training posts as paediatric and perinatal pathologists. The incentive scheme should remain in place and funded until then.

# Recommendations



**Recommendation 13: Accountability and regulation of managers**

- **DHSC and NHSE must develop and put in place a barring system for all managers (clinical and non-clinical) by Sept 2027. Review in 2030 aiming for a full statutory regulation system by Sept 2032.**

- **NHSE require any Trust seeking approval for the movement of a senior manager to another Trust to demonstrate that:**
  - **The move is not proposed because of the manager's lack of capability or misconduct.**
  - **The manager meets the fit and proper person test.**
  - **NHS England must not grant approval, and Trusts must not seek approval, unless they are able to demonstrate the matters at a. and b. above.**

- **In addition to the statutory duty for organisations, all managers must be subject to an individual duty of candour to all patients and colleagues. This should be included in the code of conduct and in the contract of employment for all managers.**

- **The NHS Leadership and Management Framework Code, a code of conduct for NHS managers published in July 2026, must be amended urgently to set out, at the beginning, the uncontroversial duty of every manager to put patients first. I suggest the following wording, with thanks to Mr Jarrold: 'I will make the care and safety of patients my first concern and act to protect them from risk.' What matters is that patients come first.**

- **In the Leadership and Management Framework Standards, the competency 'delivering across healthcare' should be first (it is currently third). The first and fundamental competency under this heading is, rightly: "*I put patients first and report safety concerns and incidents.*"**

# Recommendations



Recommendation 14: Care Quality Commission (CQC)

- CQC should conduct without-notice inspections of hospital departments.
- Inspection teams to include at least 2 practising experts in the relevant field (paediatrics/neonatology).
- Inspectors to investigate what is happening in hospital departments and not accept what they are told.
- If processes are being inspected, questions must be asked to elicit the effectiveness of those processes.
- Training should make explicit that CQC is responsible for ensuring the safety of patients in hospitals and not just for checking there are processes in place which, if implemented, should ensure patient safety.
- Inspectors and team leaders must always approach an inspection of neonatal services not as a box-ticking exercise but to determine that babies in hospital are safe.

Recommendation 15: Assessment of the performance of CQC

- There must be a rigorous and consistent review and assessment of the performance of CQC by the Health and Social Care Committee, initially once a year and, once the committee is satisfied, once every three years, or such other frequency to be determined by the select committee.

# Recommendations



Recommendation 16: Parliamentary and Health Service Ombudsman

- The functions of the National Guardian's Office should be taken over by the Parliamentary and Health Service Ombudsman in England.
- The Ombudsman's powers must be increased to include:
  - investigating complaints that whistleblowing in the NHS has not been dealt with adequately
  - assisting whistleblowers by referring their concerns to the relevant NHS bodies and overseeing the response.

Recommendation 17: Implementation of recommendations

- A new responsibility for auditing the implementation of the recommendations of statutory inquiries into NHS bodies should be given to the National Audit Office. Funding for appropriate additional staffing should be made available so that it may begin its work by September 2027.

# Actions directly for the Trust

East of England Community Health and Care NHS Trust

| Recommendation | Mitigation | Action | Lead/ Timeframe |
|---|---|---|---|
| 3 -Bereavement Care | National Bereavement Care Pathway for Neonatal Death.<br>Nine standards- parent focused, staff focused, comms, and education | Learning from Deaths discussion<br>Children and Young People's Leadership group discussion<br>Service Assurance Committee Discussion | Chief Medical Officer<br>Feb 2027 |
| 4 – Safeguarding (board training) | Board received safeguarding. training annually - this includes what the Boards responsibilities are.<br>Board received assurance that the Trust is meeting the requirements of the Safeguarding Assurance & Accountability Framework.<br>Board receive and annual safeguarding paper, plus escalations from the Quality Committee.<br>Board received ad hoc training in relation to safeguarding e.g. Domestic Abuse.<br>The safeguarding Executive Lead for the Trust is the Chief Nurse and AHP Officer – they are trained up to Safeguarding Level 4. | Provide Board with an update detailing: how to deal with concerns and suspicions about deliberate harm caused by staff. | Chief Nurse & AHP Officer<br><br>Dec 2026 |

# Action directly for the Trust



| Recommendation | Mitigation | Action | Lead/Timeframe |
|---|---|---|---|
| 4 – Safeguarding (contract) | All staff are expected to follow safeguarding guidance and policies already and undertake regular training in this area. | When suspicion of deliberate harm protocol is published, this will be sent to all existing staff/workers and included in all employment contracts/registration documents going forward. | Chief People Officer March 2027 |
| 6 – Monitoring deaths in hospitals | Learning from Deaths group reviews all inpatient deaths.<br>The group will include a Medical Examiner It focuses on learning from deaths (including children and young people) and improving processes to ensure a better death for patients and their families. | All inpatient deaths are reviewed- expected and unexpected.<br>Medical Examiners have been invited to learning from deaths meeting.<br>Discussion of Thirlwall at future learning from deaths meeting. | Chief Medical Officer Feb 2027 |

# Action directly for the Trust

East of England Community Health and Care NHS Trust

| Recommendation | Mitigation | Action | Lead/Timeframe |
|---|---|---|---|
| 13 – regulation of managers | NHS Leadership and Management Framework Code published in July 2026 is being embedded into all internal leadership development programmes. Annual process for updated fit and proper persons checks in place for senior leaders already. | Continue to share and publicise the new code and amend this as and when updated. Share updates will all managers.<br>Review contracts in relation to current duty of candour obligations and update as required.<br>Confirm senior leader meets fit and proper person test if transferring to another NHS organisation. | Chief People Officer March 2027 and ongoing |
| Overall – speaking up culture | Freedom to Speak Up Guardian and over 70 champions across the Trust. Executive and Non-Executive lead in place. | Continue to promote our speaking up culture and keep a close eye on detriment. | Chief People Officer Ongoing |