NHS
East of England
Community Health and Care
NHS Trust

Agenda item:	10
Date of meeting:	18 November 2026
Report to the:	Trust Board
Title of report:	Thirlwall Inquiry
Report author:	Kate Howard – Chief Nursing and Allied Health Professional Officer Dr Caroline Kavanagh – Chief Medical Officer Anita Pisani – Deputy Chief Executive / Chief People Officer
Executive sponsor:	Kate Howard – Chief Nursing and Allied Health Professional Officer Dr Caroline Kavanagh – Chief Medical Officer
Recommendation:	Discuss

Assurance level:	**Substantial** ☐ **Reasonable** ✓ **Partial** ☐ **Minimal** ☐
Rationale:	Highlights further action or development work underway to improve assurance.

1.0 Executive Summary

1.1 The Thirlwall Inquiry Report was published on 15 September 2026, chaired by the Rt Hon. Lady Justice Thirlwall DBE. It examines events at the neonatal unit of the Countess of Chester Hospital between 2015 and 2018, culminating in the conviction of former Neonatal Nurse Lucy Letby for the murder and attempted murder of babies in her care.

1.2 The Inquiry's central finding is that there was a complete failure, at every level of the organisation, to invoke safeguarding procedures when concerns were repeatedly raised.

The full report can be viewed here https://www.gov.uk/government/publications/thirlwall-inquiry-report.

1.3 It makes 17 recommendations, as set out in the attached slide deck at **Appendix A.** Whilst this is an acute hospital inquiry and several of recommendations are specific to hospital neonatal units, there are recommendations that do have genuine, direct read-across for our Trust. Actions detailed from **slide 13** onwards, of the attached appendix, are areas that we will work on over the next few months, we will implement the other relevant recommendations as and when additional information is published from other parties.

1.4 The Board will receive a further update from the Chief Nurse and Allied Health Professional Officer and Chief Medical Officer in the last quarter of this financial year (March 2027) into our progress.

2.0 How the report supports tackling Health Inequalities

2.1 Whilst health inequalities are not a specific focus of the Thirlwall Inquiry, its findings reinforce the importance of ensuring that all staff can raise concerns safely and that all patients receive equitable standards of care.

2.2 The inquiry highlights the need for the Trust to examine whether barriers to speaking up exist for staff groups and to use intelligence from Freedom to Speak Up, workforce and patient safety data to identify and address potential inequalities in outcomes and organisational culture.

3.0 Board Assurance Framework and Trust Risk and Issue Registers

4.0 Legal and Regulatory requirements

4.1 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, particularly:

- Regulation 12: Safe care and treatment.
- Regulation 17: Good governance.
- Regulation 20: Duty of candour.

5.0 Previous consideration by Committee or Executive

5.1 30 September 2026, Trust Board.

6.0 Report

6.1 See Appendix A.

Appendices

Appendix A: Thirlwall Inquiry