The Leeds Teaching Hospitals NHS Trust

Thirlwall Public Inquiry into events at the Countess of Chester Hospital
Progress report: update on actions

Public Board
26 November 2026

Presented for:	Information and Assurance
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Previous Committees:	Perinatal Assurance Improvement Committee (PIAC) 12 November 2026

Freedom of Information Act (FOIA) Exemption	☐**YES** (restricted from the FOIA) ☒**NO** (available to the public under the FOIA)

Link to Strategic Objective	Outcomes – being outstanding now and in the future.
Link to Provider Capability Assessment	Quality of care
Link to CQC Well-led Statement	Learning, Improvement and Innovation
Regulatory Impact	Regulation 12: Safe care and treatment Regulation 15: Premises and equipment Regulation 17: Good governance Regulation 18: Staffing

Key points:	
• The Thirlwall Public Inquiry into events at the Countess of Chester Hospital, 2015 to 2018 was published on 15 September 2026. • The report of the Thirlwall Inquiry was shared with Board in September and discussed with senior leaders on 21 October 2026, including the immediate actions set out in a letter from NHSE on 21 September 2026. • An update on progress and actions was presented to Perinatal Assurance Improvement Committee (PIAC) 12 November 2026. • A Trust-wide working group is being established to drive implementation of actions and maintain oversight of compliance.	Information and Assurance

Risk Appetite Framework			
Level 1 Risk	**Level 2 Risks**	**(Risk Appetite Scale)**	**Impact**
Clinical Risk	Patient Safety & Outcomes Risk - We will provide high quality services to patients and manage risks that could limit the ability to achieve safe and effective care for our patients.	Minimal	Operating outside
External Risk	Regulatory Risk - We will comply with or exceed all regulations, retain its CQC registration and always operate within the law.	Averse	Operating outside

1. Summary

The Thirlwall Public Inquiry into events at the Countess of Chester Hospital, 2015 to 2018 was published on 15 2026.

The Thirlwall Inquiry, a statutory Public Inquiry, chaired by Lady Justice Thirlwall, examined the events and circumstances surrounding the murders and attempted murders committed by Lucy Letby whilst employed at the Countess of Chester Hospital between 2015 and 2018. The Inquiry considered the wider organisational, professional, regulatory and cultural factors that influenced the response to the persistent concerns that were raised. The Inquiry concluded that there were significant failures of leadership, governance, safeguarding, patient safety systems, escalation processes, organisational culture and regulatory oversight.

The summary report includes a total of 17 recommendations, some of which have more than one element; these relate to hospital providers, national bodies, and regulators. The full reports are set out in three volumes. The Thirlwall Inquiry found serious failures of governance, leadership and safeguarding, with opportunities missed to act on concerns and protect babies from harm.

The report of the Thirlwall Inquiry was shared with Board in September, and discussed with senior leaders on 21 October 2026, including the immediate actions set out in a letter from NHSE on 21 September 2026.

2. Key Findings

The report concluded that repeated concerns raised by consultants were not acted upon with sufficient urgency, that organisational reputation was prioritised over patient safety, and that staff lacked confidence that concerns would be heard and acted upon.

The report distinguishes system learning investigations from regulatory, disciplinary and criminal processes, and highlights the needs for the roles, thresholds and routes between these functions to be understood, so that learning activity does not delay action required to protect patients or establish accountability. The report emphasises that clear escalation and information-sharing is needed between providers, commissioners, regulators, medical

examiners, coroners, safeguarding partners and the police, so that no single organisation sees only part of a developing risk.

The report summarised key points of failure to act on concerns and protect babies from harm, to be addressed through the recommendations:

Leadership and Governance
Clinical concerns raised by consultant paediatricians were not appropriately investigated, escalated or acted upon. Executive leaders failed to adequately respond to warning signs and did not place patient safety above organisational reputation.

Safety Signals Were Missed
A pattern of unexpected neonatal deaths and collapses were not recognised or acted upon effectively. Data, incident reports and clinical observations were not brought together in a way that enabled early identification of risk so that action could be taken.

Escalation and Speaking Up Culture
Consultants repeatedly raised concerns yet encountered resistance and delays. Staff were insufficiently supported when escalating serious patient safety matters, creating a culture in which challenge was difficult and concerns could be minimised.

Safeguarding Processes
Safeguarding systems were not sufficiently responsive to emerging concerns and serious risks to infants were not considered within the context of the safeguarding framework at an early stage.

Regulatory and System Interventions
There were significant shortcomings in the roles and interactions of NHS oversight bodies, regulators and professional organisations. Opportunities were missed by multiple organisations to identify and intervene earlier.

Whilst there are specific recommendations for neonatal services, there are also wider lessons to share with senior leaders in all CSUs. This will also inform the lines of enquiry for the Leeds Maternity and Neonatal Review, in line with the Nottingham and Amos reviews. This report will also inform the lines of enquiry in the next CQC inspection.

3. Recommendations

The report sets out 17 recommendations that apply to hospital providers, national bodies, and regulators, including the timescales for implementation where this has been agreed:

1. **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.

2. **Digital devices should be used to restrict access of insulin to authorised people and record access to insulin storage units. Until access to insulin requires the provision of biometric data, each Trust should install CCTV cameras focused on storage fridges, cupboards or units**. The cameras should store recordings for at least 28 days. The GIRFT Laboratory Handling of Insulin Requests in the Investigation

of Hypoglycaemia guidance for the testing and reporting of insulin and C-peptide results, issued in October 2025, must be made mandatory and of national application.

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

4. **All Trusts must provide safeguarding training to all staff** (appropriate to their role and expertise) and Board members, including Non-Executive Directors. **This training should include how to deal with concerns and suspicions about deliberate harm caused by staff**.

5. NHS England must provide, by 31 March 2027, a clear and timed route to ensuring that computer systems are harmonised across the NHS by December 2028. This should mean that data relating to babies and neonates in hospital may be entered on a single occasion, be reviewed in a timely manner and facilitate continuous monitoring.

6. By 31 March 2027, all hospital Trusts must have in place effective mechanisms for **Board level monitoring of all deaths of children and babies**; all hospital Trusts must have in place a clear and predetermined route to senior management for the escalation of concerning data trends or patterns.

7. **All hospitals with a neonatal unit should name a 'lead reporter' with responsibility for inputting data regularly** (at least weekly) and reviewing real-time data viewers on neonatal and maternity units in the MBRRACE system. Whilst the lead reporter does not necessarily need to be a clinician, they must be trained to understand and interpret the available data and able to explain and discuss it with clinicians.

8. **NHS England must immediately inform all Trusts with a neonatal unit that the SUDIC process applies to the sudden and unexpected deaths of babies who have never left hospital**. Direct all Trusts that they must, within seven days, draw this information to the attention of all relevant staff and the Board. DHSC must complete its review and revision of the SUDIC guidelines and ensure the revised guidelines are distributed to all Trusts by no later than 31 March 2027.

9. **By 31 March 2027, NHS England must produce and distribute a one-page protocol setting out the steps to be taken by managers when concerns or suspicions are raised that a healthcare professional may have deliberately harmed a patient**. Trusts must embed the **Suspicion of Deliberate Harm Protocol** and guidance within their hospital.

10. Serious consideration should be given by 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.

11. The National Medical Examiner should, by 31 March 2027, prepare and distribute a one-page document setting out all the steps to be taken by a medical examiner when dealing with the death of a neonate.

12. DHSC and NHS England must ensure that, by June 2033, there are 37 doctors in training posts as paediatric and perinatal pathologists, in line with the workforce requirement set out by the Royal College of Pathologists in the November 2025 Paediatric and Perinatal Pathology Workforce Report.

13. **DHSC and NHS England must develop and put in place a barring system for all managers (clinical and non-clinical) by September 2027**. It should be reviewed in 2030 with a view to moving to a full statutory regulation system by September 2032. 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.

14. CQC should conduct without-notice inspections of hospital departments. Inspection teams should include at least two current practising experts in the relevant field (in this case paediatrics/neonatology).

15. 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.

16. The functions of the National Guardian's Office should be taken over by the Parliamentary and Health Service Ombudsman in England – increase powers to investigate complaints that whistleblowing in the NHS has not been dealt with adequately.

17. A new responsibility for auditing the implementation of the recommendations of statutory inquiries into NHS bodies should be given to the National Audit Office.

The actions relating to hospital providers will be overseen by the Director of Nursing (Women's and Children's), working in conjunction with the Medical Director, Director of Operations, CSU leads and other departments where this is required, assurance on progress will be provided to PIAC.

4. Immediate Actions

A letter was received from NHSE on 21 September 2026 summarising the priority recommendations in the report and a commitment to a series of immediate actions whilst the recommendations of the Inquiry are considered in full. These were discussed at September Board and also at the Quality Improvement Group (QIG) with NHSE on 14 October 2026 and senior leaders on 21 October 2026. An update on progress and actions was presented to Perinatal Assurance Improvement Committee (PIAC) 12 November 2026. A Trust-wide working group is being established to drive implementation of actions and maintain oversight of compliance.

Immediate Action	Trust Response
Trust and ICB Board to review the Thirlwall report and to consider its findings at the next available public Board meeting: Boards should reflect on whether it would have been possible for similar events to occur at their own organisation and seek assurance that sufficient measures are in place to keep the babies and children in their care safe	Initial discussion at Board 24 September 2026; reflected on response to concerns when they are raised, assurance that they are investigated promptly, monitoring FTSU, oversight of safeguarding, mortality and morbidity, seeking assurance that learning from incidents leads to change, promoting a culture where challenge is welcomed and escalated concerns are acted upon, demonstrating visible leadership re patient safety.

Sudden and Unexpected Death in Children (SUDIC): The SUDIC protocol is applicable for every death (or collapse leading to death) of an infant or child under the age of 18 which would not have been reasonably be expected to occur 24 hours previously. This includes sudden and unexpected deaths within neonatal units. All Trusts with a neonatal unit must urgently communicate to all relevant staff and the Board that the SUDIC process applies as set out above. This must be completed by no later than **Monday 28 September 2026**.	Communication sent to staff from Director of Nursing (Women's and Children's) 28 September 2026. Discussed at Board 24 September 2026, communication shared with Board members. Board Development session 22 October 2026 - focus on mortality review process, including recommendations in the Thirlwall report and the Board's oversight of this.
National Bereavement Care Pathway for stillbirth and neonatal death: ICBs and providers should take immediate action to improve care of the bereaved as has already been set out in the NHS Medium Term Planning Framework (October 2025).	The National Bereavement Care Pathway is reviewed annually and benchmarked using the self-assessment tool. The last self-assessment was completed in October 2026 and the care pathway rated as 'compliant'. An action plan has been developed to achieve a rating of 'Championing'. The key actions have been incorporated into the Perinatal Transformation Plan for oversight and monitoring with focus on improving bereavement spaces, staff bereavement training and mentoring.
Insulin: **By 31 March 2027**, all neonatal units must meet requirements for access, control and storage of insulin as set out in the GIRFT neonatology Guide to safe insulin use. Until access to insulin requires the provision of biometric data, **each Trust should urgently install CCTV cameras in neonatal units focused on storage fridges, cupboards or units by 30 November 2026 at the latest**. The cameras should store recordings for at least 28 days.	Clinical Director, Medicines Management and Pharmacy Services and Associate Director Estates, Fire and Security co-ordinating plan to improve access, control and storage of insulin as set out by GIRFT (January 2026). Initial risk assessment and audit completed, including access to medicine storage areas in wards and location of CCTV cameras, incorporated into Neonates Fingerprint Access scheme. Installation of CCTV cameras to be completed by 30 November 2026.
Safeguarding: Trusts and ICBs should ensure that all staff and Board members are compliant with safeguarding training requirements at the appropriate level and confirm that staff know who to raise and escalate concerns to. Boards must assure themselves that the safeguarding of babies and children is given the level of prominence required.	Safeguarding training incorporated into Integrated Accountability (performance) Framework. Compliance (October 2026) 95% (level 1), 85% (level 2), 83% (level 3) – neonates 94% (total compliance).

The letter from NHSE also highlighted that the findings of this Inquiry may impact the confidence of parents and families whose babies are currently receiving neonatal care and urges trusts to consider what steps can be taken locally to provide parents with assurance of the care being given and support that is required during the care of their baby. This is being addressed by the Children's leadership team, providing information and contact details for families to discuss any concerns they may have. Support is also being provided to staff working in neonatal services, recognising the impact on them, including a review of the support services available to staff.

5. Financial Implications

There are recommendations in the report related to estate and infrastructure that will have financial implications both locally and nationally. This will be reviewed with maternity and neonatal leaders in conjunction with executive directors.

6. Risk

Perinatal Improvement Assurance Committee provides oversight of the Trust's patient safety and outcomes risk. The Trust is currently operating within the risk appetite for the level 1 risk (clinical risk), it is operating outside the risk appetite for the level 2 risk category (patient safety and outcomes) set by the Board as a consequence of the findings from the CQC inspections of maternity and neonatal services and well-led, the breaches in Regulations included in the report and the Section 29A Warning Notice that was issued under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The risk is referenced in the Corporate Risk Register CRRE1 – breache(s) of Regulations – maternity and neonatal services.

7. Communication and Involvement

The reports have been discussed with senior leaders and key messages shared with staff across the trust.

8. Impact on Equality and Health Inequalities

The themes related to health inequalities are described in specific chapters of the reports, the findings and recommendations related to this will be incorporated into the perinatal transformation plan.

9. Publication Under Freedom of Information Act

This paper has been made available under the Freedom of Information Act 2000.

10. Recommendation

Trust Board is asked to:

- Receive the report and recommendations from the Thirlwall Inquiry, published on 15 September 2026.
- Receive the update and assurance on progress against the immediate actions set out in the letter from NHSE on 21 September 2026 following publication of the Thirlwall

Inquiry report and discussion at Perinatal Assurance Improvement Committee (PIAC) 12 November 2026.

Supporting Information

Appendix 1 Thirlwall Inquiry (summary report), published 15 September 2026
Appendix 2 Letter from NHSE 21 September 2026

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November 2026