Item: 14

REPORT CLASSIFICATION	✓	CATEGORY OF PAPER	✓
Official		Proposes specific action	✓
Official: Sensitive Commercial		Provides assurance	
Official: Sensitive Personal		For information only	

BOARD 25 NOVEMBER 2026	
Report Title:	**The Thirlwall Inquiry: Findings, Recommendations, and Implications for North East and North Cumbria Integrated Care Board**

Purpose of report

This paper provides an overview of the findings, conclusions and recommendations arising from the Thirlwall Inquiry Report and identifies implications for the North East and North Cumbria (NENC) Integrated Care Board (ICB).

Key points

The Thirlwall Inquiry, chaired by Lady Justice Thirlwall was established by the Government in September 2023, following the conviction of Lucy Letby for the murder and attempted murder of babies at the Countess of Chester Hospital. The Inquiry examined the experiences of families, the hospital's response to concerns, and the effectiveness of wider NHS governance, safeguarding, leadership, and regulatory arrangements.

The Thirlwall Inquiry Report was published on 15 September 2026. The statutory public inquiry examined events at the Countess of Chester Hospital between 2015 and 2018 and their wider implications for the NHS.

The report makes 17 recommendations intended to strengthen patient safety and reduce the risk of similar failures occurring elsewhere. Its scope extends well beyond neonatal services, considering NHS leadership and culture, safeguarding, speaking up, duty of candour, medical examiners, use of data to identify safety signals, regulation and training of managers, bereavement care and the implementation of recommendations from previous inquiries.

This paper summarises the key headlines, themes and 17 recommendations and considers the implications for the NENC ICB as a strategic commissioner. It provides the Board with assurance around the recommendations and how these will be monitored within the existing NENC maternity and neonatal quality and safety arrangements.

NHS England has explicitly stated that the findings are not solely a matter for trusts providing neonatal services. Every ICB Board and trust Board is expected to consider the report, reflecting the wider system implications for leadership, culture, safeguarding and patient safety. NHS England has asked organisations to approach the learning with urgency, curiosity and openness.

For an ICB Board, the key strategic message is that Thirlwall should be viewed as a whole-system patient safety and governance issue, rather than solely a maternity and neonatal response.

A letter issued by NHS England on 22 September gives Trusts and ICBs several clear and immediate actions. The ICB is required to review the Thirlwall findings publicly, assure itself that babies and children are safeguarded across the system, strengthen safeguarding and speaking-up arrangements, improve bereavement care, and urgently escalate identified risks to NHS England.

Risks and issues

The Thirlwall Inquiry demonstrated that having governance structures, reporting arrangements and safety processes in place does not necessarily mean patients are safe. NENC ICB requires evidence that gives the Board confidence that our own arrangements would recognise, escalate and respond to the same warning signs, even when those concerns challenge senior leadership or established organisational assurances.

There are several areas requiring continued assurance:

- Strengthening the triangulation of maternity and neonatal safety intelligence
- Ensuring robust escalation arrangements for suspected deliberate harm
- Confirming interim medicines-security arrangements where permanent improvements are delayed
- Strengthening SUDIC (sudden unexpected death in infancy and childhood) and medical examiner pathways
- Addressing paediatric pathology delays
- Ensuring provider assessments demonstrate effectiveness rather than procedural compliance

Assurances and supporting documentation

The Nursing & Quality Directorate will be responsible for the NENC ICB response to the Thirlwall Report on behalf of NENC ICB. The NENC Maternity and Neonatal Team will co-ordinate this response on behalf of the Directorate and will work closely with the NEY Regional Maternity Team, NEY Specialised Commissioners and the Northern Neonatal Network.

Recommendation/action required

The Board is asked to:

1) **Note the findings and endorse the response:** note the Thirlwall Inquiry findings and recommendations and endorse the associated work required to respond as a whole-system patient safety, safeguarding, leadership and culture issue, rather than a maternity and neonatal issue alone.

2) **Require evidence of effective safeguards:** seek assurance that existing arrangements would recognise, escalate and respond to comparable warning signs, including concerns that challenge senior leadership or established organisational assurances. Note the outstanding gaps identified in the assurance summary and required actions to address them.

3) **Endorse accountability and co-ordination:** endorse co-ordination through the Nursing & Quality Directorate, supported by the Maternity and Neonatal Team. Provider trusts remain responsible for delivering actions allocated to them; national bodies remain responsible for recommendations within their respective remits. The Board's role is to oversee the response, challenge assurance and require action or escalation where risks remain unresolved.

4) **Require a reporting timetable and risk escalation:** agreed reporting through the ICB quality governance (QSC), with unresolved risks and matters requiring Board intervention clearly identified. Risks to the safety of babies and children, including barriers to speaking up and professional challenge, will be urgently discussed with the NHS England regional team. Dependencies on national guidance will be distinguished from local actions and interim mitigations needed to address risks.

5) **Assurance required in subsequent reports:** Delegate responsibility to QSC for oversight of progress, to receive reports supported by evidence, actions in progress, unresolved safety risks and dependencies on national guidance. Assurance must demonstrate whether safety signals are recognised and acted upon, concerns can be raised and escalated safely, and bereaved families receive appropriate support.

Acronyms and abbreviations explained

ICB – Integrated Care Board
CDOP – Child Death Overview Panel
CQC – Care Quality Commission
LADO - Local Authority Designated Officer (LADO) For Children
LMNS – Local Maternity and Neonatal System
MNSI - Maternity and Newborn Safety Investigation Programme
MSDS – Maternity Services Data Set

MOSS - Maternity Outcome Signal System
NENC – North East and North Cumbria
NHSE – NHS England
NEY – North East and Yorkshire
PIPOT – Person In Position Of Trust For Adults
PMRT – Perinatal Mortality Review Tool
R - Recommendation
SUDIC – Sudden Unexpected Death In Infancy And Childhood

Sponsor/Approving .Chief Officer	Hilary Lloyd, Chief Nursing Officer
Date approved by Chief Officer	18/11/2026
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Link to ICP strategy priorities	
Longer and Healthier Lives	
Fairer Outcomes for All	
Better Health and Care Services	
Giving Children and Young People the Best Start in Life	✓

Relevant legal/statutory issues

Note any relevant Acts, regulations, national guidelines etc

Any potential/actual conflicts of interest associated with the paper?	**Yes**		**No**	✓	**N/A**	
Equality analysis completed	**Yes**		**No**	✓	**N/A**	
If there is an expected impact on patient outcomes and/or experience, has a quality impact assessment been undertaken?	**Yes**		**No**	✓	**N/A**	

Essential considerations	
Financial implications and considerations	Not applicable
Contracting and Procurement	Not applicable
Commissioning Team	Not applicable
Digital implications	Not applicable
Clinical involvement	Not applicable
Health inequalities	Not applicable
Patient and public involvement	Not applicable
Partner and/or other stakeholder engagement	Not applicable
Other resources	Not applicable

The Thirlwall Inquiry: Findings, Recommendations, and Implications for the North East and North Cumbria Integrated Care Board

1. Introduction

This paper provides an overview of the findings, conclusions and recommendations arising from the Thirlwall Inquiry Report and identifies implications for the North East and North Cumbria (NENC) Integrated Care Board (ICB).

The Thirlwall Inquiry report was published on 15 September 2026. The statutory public inquiry examined events at the Countess of Chester Hospital between 2015 and 2018 and their wider implications for the NHS.

The report makes 17 recommendations intended to strengthen patient safety and reduce the risk of similar failures occurring elsewhere. Its scope extends well beyond neonatal services, considering NHS leadership and culture, safeguarding, speaking up, duty of candour, medical examiners, use of data to identify safety signals, regulation and training of managers, bereavement care and the implementation of recommendations from previous inquiries.

This paper will summarise the key headlines, themes and 17 recommendations and will consider the implications for the North East and North Cumbria (NENC) Integrated Care Board (ICB) as a strategic commissioner. It will provide the Board with assurance around the recommendations and how these will be monitored within the existing NENC maternity and neonatal quality and safety arrangements.

2. Background

The Thirlwall Inquiry, chaired by Lady Justice Thirlwall was established by the Government in September 2023, following the conviction of Lucy Letby for the murder and attempted murder of babies at the Countess of Chester Hospital. The Inquiry examined the experiences of families, the hospital's response to concerns, and the effectiveness of wider NHS governance, safeguarding, leadership, and regulatory arrangements.

3. Main Findings From The Inquiry Report

3.1 Key Headlines for NHS Bodies

Key headlines for NHS Bodies from the report include:

- Warning signs were present and were missed. Statistical signals of increased mortality were sufficient to warrant investigation far earlier than action was taken.
- Senior Managers failed to act on clinician warnings of deliberate harm and instead pursued HR and communications-led responses when safeguarding action was required.
- Reputation was placed above patient safety.
- External reviews cannot substitute for police referrals where deliberate harm is suspected
- Incident reporting systems were not fit for purpose – sudden and unexpected deteriorations in babies' conditions went unrecorded, deaths were under-graded, and the Board was left without the information it need.
- Boards must own neonatal safety data in real time, with Board-level monitoring of all child and baby deaths required by 31 March 2027.

- Most NHS inquiry recommendations over the last 30 years have not been implemented. The Report calls for independent monitoring of implementation going forward.
- NHS trusts should now act to audit governance frameworks, review escalation routes, and map the report's recommendations against current practice.

3.2 Report Recommendations

The inquiry, published in September 2026, sets out seventeen recommendations aimed at strengthening patient safety, early recognition and escalation of concerns, accountability, and oversight across the NHS.

3.3 Report Themes

The recommendations can be grouped into themes and a summary of those themes, along with the current North East and North Cumbria position are highlighted below.

3.3.1 Failure To Recognise and Act On Emerging Safety Signals

Report Findings: The report concluded increasing neonatal deaths and clinical concerns were not brought together and acted upon with sufficient urgency. The report places significant emphasis on improving mortality monitoring, data interpretation, and recognition of concerning patterns.

Associated Recommendations: Recognising and acting on Safety Signals linked recommendations: R5 interoperability; R6 monitoring deaths in hospitals; R7 data reporting; R8 SUDIC; R10 expert panel; R11 Medical Examiners.

NENC Position: The NENC maternity and neonatal team supported by North East and Yorkshire analytics team and ICB maternity and neonatal business intelligence have processes in place to monitor stillbirths and neonatal mortality via the clinical metrics dashboard which uses 16 clinical metrics and 5 neonatal clinical metrics. The dashboard was developed in response to the East Kent '*Reading the signals'* review that recommended monitoring maternity services by timely, meaningful, and risk-adjusted metrics. To distinguish genuine 'signals' from 'noise', and to have analysis that is 'robust' using statistical methods. It was developed in NENC in 2023 in the absence of any national reporting tools at that time. The dashboard purpose is to present system-wide quality and safety data in a way that helps us collectively and more effectively respond to safety signals (so called alerts and alarms). The dashboard is a core element of the NENC ICB and wider NENC Local Maternity and Neonatal System (LMNS) quality and safety approach.

Our experience shows how the Maternity Services Data Set (MSDS) can identify safety signals and the value of utilising this data set as the 'single version of the truth'. However, the key to improvement and learning is in how the LMNS set up processes for improving data quality, identifying, and investigating 'signals' and sharing learning from investigations.

The Maternity and Neonatal Clinical Dashboard is triangulated with service user feedback, maternity and newborn safety investigation (MNSI) programme, Perinatal Mortality Review Tool processes including external reviewer process and maternity outcome signal system (MOSS). Next steps will be to strengthen this work to incorporate SUDIC and Child Death Overview panels, medical examiner information, safeguarding and freedom to speak up.

3.3.2 Safeguarding and Deliberate Harm

Report Findings: Safeguarding arrangements did not respond effectively when clinicians raised the possibility of deliberate harm. The inquiry recommended clearer training and the development of a national suspicion of deliberate harm protocol including when actions when concerns are raised in good faith.

Associated Recommendations: The associated recommendations are R4 safeguarding training and employment contracts; R9 Suspicion of Deliberate Harm Protocol and R10 panel of experts. This is currently being actioned by NHS England/ Department of Health.

NENC Position: The ICB Safeguarding Designated Nurses seek assurance from each commissioned provider on safeguarding training compliance. When evidence of poor compliance nis found, risks are identified and where appropriate an action plan is put in place and monitored. Supervision is undertaken by the Safeguarding Designated Nurses with the Safeguarding Named Nurses from each Trust to advise, support and highlight any areas of concern.

Within safeguarding, professional challenge is a constant reminder. It is a regular feature in learning reviews, and ongoing focus. In the caring profession people sometimes struggle to think the unthinkable, however practitioners are and will continue to be supported by experienced safeguarding teams to consider all aspects of suspected and actual harm.

Trusts are expected to have escalation processes in place including safeguarding governance and oversight through the Trust Safeguarding committees which feed into their Board. This should include safeguarding activity, identification of risks and associated action plans, learning and assurance. This should include Freedom to Speak Up and incident reporting.

3.3.3 Leadership, Governance, and Accountability

Report Findings: The Inquiry identified serious failures in leadership and governance, including failures to place the safety of babies at the centre of decision-making. It consequently addresses stronger accountability and regulation of NHS managers.

Associated Recommendations: The associated recommendations are R13 accountability and regulation of managers; R14 CQC; R15 scrutiny of CQC performance; R17 implementation of recommendations. The recommendations are sat with NHS England/Department of Health.

NENC Position: NENC ICB should move beyond receiving evidence that processes exist to seek evidence controls are effective. Provider Thirlwall assessments should therefore have executive ownership, measurable actions, deadlines, and evidence of impact, with unresolved risk escalated through ICB quality governance.

3.3.4 Professional Hierarchy, Challenge and Speak Up

Report Findings: A major theme is whether clinical concerns are heard, challenged appropriately, and escalated. The report examines NHS culture, Freedom to Speak Up arrangements and the conditions needed for staff to raise concerns safely.

Associated Recommendations: The associated recommendations include R4 safeguarding training; R9 deliberate-harm protocol; R13 manager accountability/regulation; R16 Parliamentary and Health Service Ombudsman.

NENC Position: All Trusts have allegations against staff policies to inform them of actions to take where there is suspected or actual harm towards a person by staff. In addition, there are multi-agency policies on safeguarding children partnerships and safeguarding adult boards websites to guide staff through managing allegations against staff, this will either be through the Local Authority Designated Officer (LADO) for children or the Person in Position of Trust (PIPOT) for adults.

3.3.5 Fragmented Data Intelligence

Report Findings: Information held in different parts of the organisation did not create an effective overall safety picture. Associated Recommendations therefore address interoperability, mortality monitoring, and improved data reporting, reinforcing the importance of triangulating quantitative and qualitative intelligence.

Associated Recommendations: The associated recommendations are R5 operating-system interoperability; R6 monitoring deaths and R7 data reporting.

NENC Position: The NENC maternity and neonatal team supported by North East and Yorkshire analytics team and ICB maternity and neonatal business intelligence have processes in place to monitor stillbirths and neonatal mortality via the clinical metrics dashboard, service user feedback, maternity and newborn safety investigation (MNSI) programme and maternity outcome signal system (MOSS). Collaborative work with the Northern Neonatal Network, ICB Quality team and ICB Insights team is already established, however it is recognised the sharing of data and information could be streamlined and strengthened with a standardised dataset, agreed thresholds and escalation triggers.

3.3.6 Medicines Security And Physical Safeguards

Report Findings: The Inquiry recommends stronger controls around insulin, including restricted and recorded access, alongside CCTV arrangements, and recommends baby monitoring with livestreaming video in neonatal units.

Associated Recommendations: The associated recommendations include R1 CCTV/baby monitoring and R2 insulin access and storage. The R1 recommendation about CCTV at cot sides is currently sat with NHS England/ Department of Health as the governance and logistical implications of this recommendation have significant challenges.

NENC Position: The Northern Neonatal Network via Specialised Commissioning have been instructed not to take any further action against R1 until further instruction is received from NHS England/ Department of Health.

The R2 recommendation applies to the three of our providers neonatal units. One is currently undergoing significant refurbishment of the neonatal unit and this includes installation of biometric medicines units. This work is anticipated to be completed by January 2027 and the trust is currently looking at short term mitigations. One has CCTV already installed in treatment rooms and insulin is stored in a locked cabinet and the third is currently installing CCTV. The remaining units only give insulin on very rare occasions and therefore it is not stocked on the units. The Northern Neonatal Network pharmacist is developing system wide guidelines and governance processes which would support insulin administration in these exceptional circumstances. This would include a two-person check.

3.3.7 Death Review, Bereavement, And Family Involvement

Report Findings: The report highlights the importance of effective bereavement care and robust scrutiny following neonatal deaths, with recommendations relating to the National Bereavement Care Pathway, SUDIC, Medical Examiners and paediatric/perinatal pathology.

Associated Recommendations: The associated recommendations include R3 National Bereavement Care Pathway; R8 SUDIC; R11 Medical Examiners and R12 paediatric/perinatal pathology. The SUDIC pathway is being reviewed by NHS England and national training for both neonatal teams and the Police are being developed. NHS England will be managing R12 and there is a proposal to increase training places for pathologists.

NENC Position: All provider trusts must comply with the Stillbirth and Neonatal Death Society (SANDS) national bereavement care pathways and all units are providing updates on compliance via the Perinatal Quality Oversight meeting (PQOM). All trusts must report neonatal deaths up to 28 days via the Perinatal Mortality Review Tool (PMRT) reporting tool and term neonatal deaths are also reported on the MOSS alerts system. The PMRT tool specifically asks for evidence of family involvement. Service user feedback from bereaved parents is also obtained. The ICB also participated in the national pilot of the maternity and neonatal independent senior advocacy (MNISA) programme. Nationally this was a positive evaluation, we are awaiting the maternity and neonatal taskforce recommendations to see if this will be continued. Work will be required to strengthen medical examiners and SUDIC pathways.

Newcastle Hospitals provide all paediatric pathology services to NENC trusts. There are significant delays due to staffing and workload which is impacting on families' experiences. This is a national issue, the service is commissioned by specialised commissioning.

A review of the child death process is underway which includes the allocation of a member of staff to support bereaved parents as this provision varies across the NENC footprint.

3.3.8 External Scrutiny And Ensuring Learning Are Implemented

Report Findings: The report considers the role of the Care Quality Commission, wider NHS oversight and how recommendations from previous inquiries are implemented. A critical message is that producing recommendations is insufficient without clear accountability for delivery and evidence that changes are embedded.

Associated Recommendations: The associated recommendations are R14 CQC; R15 assessment of CQC performance; R16 PHSO and R17 implementation of recommendations.

NENC Position: The plan is to map Thirlwall recommendations into existing commissioning, quality oversight, and provider-assurance arrangements. NENC's 2027/28 commissioning intentions already propose updating maternity specifications to incorporate Thirlwall and other national recommendations including the outputs from the national maternity and neonatal taskforce who are also responding to Ockenden (2026) Nottingham investigation and Amos (2026) national maternity and neonatal investigation supported by clearer KPIs and outcomes. Alignment with the Northern Neonatal Network and specialised commissioning is also required to ensure all clear governance and oversight frameworks are in place with cross assurance reporting evident.

4. Significance For ICBs

NHS England has explicitly stated that the findings are not solely a matter for trusts providing neonatal services. Every ICB Board and trust Board is expected to consider the report, reflecting the wider system implications for leadership, culture, safeguarding and patient safety. NHS England has asked organisations to approach the learning with urgency, curiosity and openness.

For the ICB Board, the key strategic message is that Thirlwall should be viewed as a whole-system patient safety and governance issue, rather than solely a maternity and neonatal response.

A letter issued by NHS England on 22 September gives Trusts and ICBs several clear and immediate actions. The ICB is required to review the Thirlwall findings publicly, assure itself that babies and children are safeguarded across the system, strengthen safeguarding and speaking-up arrangements, improve bereavement care, and urgently escalate identified risks to NHS England.

The overall board assurance position: existing monitoring, safeguarding and bereavement arrangements provide a significant foundation for the response assurance. However, further evidence is required before the Board can be fully assured that comparable warning signs would be recognised and acted upon.

Priority concerns and gaps are the triangulation of safety intelligence; escalation of suspected deliberate harm; interim insulin-security controls where permanent improvements are delayed; SUDIC and medical examiner pathways; paediatric pathology delays; and evidence that provider controls are effective in practice.

Regional governance and cross-assurance arrangements are in place with NHSE region and the national teams leading on the response. However, the ICB remain accountable for ensuring commissioned services are safe and have a responsibility to strengthen patient safety and reduce the risk of similar failures occurring elsewhere. The ICB requires assurance and where gaps and risks are identified, actions rea tracked and escalation is in place where risks remain unresolved.

5. Recommendations

The Board is asked to:

1) **Note the findings and endorse the response:** note the Thirlwall Inquiry findings and recommendations and endorse the associated work required to respond as a whole-system patient safety, safeguarding, leadership and culture issue, rather than a maternity and neonatal issue alone.

2) **Require evidence of effective safeguards:** seek assurance that existing arrangements would recognise, escalate and respond to comparable warning signs, including concerns that challenge senior leadership or established organisational assurances. Note the outstanding gaps identified in the assurance summary and required actions to address them.

3) **Endorse accountability and co-ordination:** endorse co-ordination through the Nursing & Quality Directorate, supported by the Maternity and Neonatal Team. Provider trusts remain responsible for delivering actions allocated to them; national bodies remain responsible for recommendations within their respective remits. The Board's role is to

oversee the response, challenge assurance and require action or escalation where risks remain unresolved.

4) **Require a reporting timetable and risk escalation:** agreed reporting through the ICB quality governance (QSC), with unresolved risks and matters requiring Board intervention clearly identified. Risks to the safety of babies and children, including barriers to speaking up and professional challenge, will be urgently discussed with the NHS England regional team. Dependencies on national guidance will be distinguished from local actions and interim mitigations needed to address risks.

5) **Assurance required in subsequent reports:** Delegate responsibility to QSC for oversight of progress, to receive reports supported by evidence, actions in progress, unresolved safety risks and dependencies on national guidance. Assurance must demonstrate whether safety signals are recognised and acted upon, concerns can be raised and escalated safely, and bereaved families receive appropriate support.

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