

Meeting Title	Trust Board Trust Board Paper H					
Date of the meeting	8 October 2026					
Title	Thirlwall Inquiry: Key Recommendations and Implications for UHL					
Report presented by	Julie Hogg, Chief Nurse and Deputy Chief Executive Danni Burnett, Director of Midwifery and Deputy Chief Nurse Jonathan Cusack, Clinical Director, Womens and Childrens Clinical Management Group					
Report written by	Danni Burnett, Director of Midwifery and Deputy Chief Nurse					
Action – this paper is for	Decision/Approval	X	Assurance	X	Update	X
Trust Priorities	Transform patient care	X	Strengthen our culture	X	Deliver our financial plan	X
Where this report has been discussed previously	Executive Perinatal Oversight Meeting, 23 September 2026					

To your knowledge, does the report provide assurance or mitigate any significant risks? If yes, please detail which

The report provides reasonable, but not significant, assurance that core maternity and neonatal governance, safeguarding, mortality review, staff engagement and safety-improvement arrangements are established and that an initial response to the Thirlwall Inquiry is under way. This does not mean that all recommendations have been met. Material residual risks remain in relation to insulin security and surveillance, the scope and operation of CCTV, safeguarding and escalation training, workforce resilience, bereavement support, data and system interoperability, estate and digital capacity, and consistency of experience for women, babies, families and staff. Further work is required to confirm compliance, actions, costs and evidence of sustained improvement. These risks will remain under active oversight through the Executive Perinatal Oversight Meeting, Perinatal Assurance Committee, relevant Trust committees and the Board, with immediate escalation where required.

Impact Assessment

The Trust's response is intended to strengthen safety, quality, experience, workforce culture and equality by improving how concerns are heard and escalated, how unusual patterns are identified, and how learning leads to sustained change. The Trust recognises that the Inquiry's findings may cause distress and anxiety for bereaved families, other families and staff, and will engage compassionately, provide accessible information and ensure appropriate support is available. A full assessment of equality, financial, workforce, digital and estate implications has not yet been completed. These impacts will be considered through the Trust-wide gap analysis, options appraisal and the appropriate governance routes.

Supporting Papers

Appendix 1 NHS England letter of 21 September 2026 setting out immediate actions for providers and integrated care boards.

BOARD OF DIRECTORS 8 OCTOBER 2026

Thirlwall Inquiry: Key Recommendations and Implications for UHL

Purpose of the Report

To provide the Board with a public update on the findings of the Thirlwall Inquiry, the immediate actions required by NHS England, and the implications for University Hospitals of Leicester NHS Trust (UHL). The report sets out the Trust's initial assurance position, areas requiring further review or investment, and the proposed governance and reporting arrangements.

Recommendation

- Receive the update on the Thirlwall Inquiry and NHS England's letter of 21 September 2026
- Note the immediate actions and deadlines, including communication of the SUDIC process, installation of CCTV focused on neonatal insulin storage by 30 November 2026, and compliance with GIRFT insulin access-control and storage requirements by 31 March 2027.
- Be assured that an initial Trust-wide response is underway, supported by executive oversight, staff and family engagement, and existing safety and safeguarding arrangements.
- Note that the current assurance position is reasonable rather than significant because full compliance, cost and resource implications have not yet been confirmed.
- Support completion of a Trust-wide gap analysis, named executive and operational ownership, and regular reporting of progress, risks, exceptions and evidence of impact through the relevant committees and Board.

Summary

The [Thirlwall Inquiry](#) makes recommendations across 17 areas following the deaths and collapses of babies at the Countess of Chester Hospital. Its central message extends beyond neonatal care: organisations must listen to concerns, encourage professional challenge, identify unusual patterns and act promptly when risks emerge.

UHL recognises that the Inquiry's findings are deeply distressing and may cause renewed anxiety for bereaved families, parents whose babies have received neonatal care, and staff. We extend our sincere sympathies to everyone affected and are committed to listening with compassion, responding openly to concerns and ensuring that appropriate support is available.

The Board can take reasonable assurance that core maternity and neonatal governance, safeguarding, mortality review, staff engagement and safety-improvement arrangements are established and that immediate work is underway. Material residual risks remain in relation to insulin security and surveillance, the scope and operation of CCTV, safeguarding and escalation training, workforce resilience, bereavement support, data and system interoperability, estate and digital capacity, and consistency of experience for women, babies, families and staff.

On 25 September 2026 we communicated the applicable SUDIC process and work is in progress to address the CCTV requirement by 30 November 2026 and the GIRFT insulin standard by 31 March 2027. A full gap analysis and options appraisal will establish the remaining actions, evidence, costs and delivery timescales.

Main Report Detail

1. Inquiry findings and key recommendations

The Inquiry found serious and sustained failures to recognise and act on warning signs, listen to concerns, bring together information about unusual patterns, and protect babies when deliberate harm was suspected. It also identified weaknesses in leadership accountability, safeguarding, medicines security, mortality review, bereavement support, professional challenge, external scrutiny and the coordination of information between organisations. The recommendations are therefore intended not only to introduce specific controls, but to strengthen the culture, systems and accountability needed to identify risk early and act decisively.

The 17 recommendation areas can be grouped into five themes:

- **Immediate safety and security:** proportionate CCTV and monitoring arrangements, together with secure storage and controlled access to insulin.
- **Support for families:** consistent, compassionate bereavement care and clear arrangements for Sudden Unexpected Death in Infancy and Childhood (SUDIC).
- **Safeguarding and decisive action:** stronger safeguarding, employment and precautionary-action processes, supported by a national protocol where deliberate harm is suspected.
- **Information, review and expert scrutiny:** interoperable systems, improved monitoring and reporting of deaths, and timely access to independent clinical, medical examiner and specialist pathology expertise.
- **Leadership, regulation and assurance:** stronger regulation and accountability of managers, improved effectiveness of the Care Quality Commission and Parliamentary and Health Service Ombudsman, and independent audit of implementation.

Taken together, the recommendations require providers to show that concerns are heard and escalated, unusual patterns are actively identified, urgent protective action can be taken, learning results in sustained change, and Boards receive clear evidence that the recommendations have been implemented and are working in practice.

2. UHL's initial response

Many themes align with work already underway through UHL's perinatal safety and cultural improvement programme, Guardian Service, safeguarding governance, Patient Safety Incident Response Framework, Martha's Rule, and family & staff engagement. Communication has been issued to maternity, neonatal and children's services; a staff briefing took place on 17 September; support and leadership visibility have been increased; and engagement with families and the Maternity and Neonatal Voices Partnership will help shape accessible information and escalation routes.

Pharmacy, Estates and clinical teams are assessing secure storage, controlled access and CCTV options. The work must also establish whether requirements extend to other areas where babies and children are cared for. Existing wiring, recording, monitoring, Wi-Fi resilience, privacy, information governance and operational ownership will form part of the assessment.

UHL has specialist neonatal input into scrutiny of every neonatal death working alongside the medical examiner team. This provides a basis for assurance but will be formally tested against national guidance, including independence, escalation, evidence of learning and access to specialist pathology or external expertise. Employment contracts, job plans, safeguarding responsibilities, training and processes for immediate precautionary action will also be reviewed.

3. Next steps

- i. To complete a Trust-wide gap analysis across all 17 recommendation areas relevant to the acute sector, identifying current controls, evidence, gaps, interdependencies and immediate risks;
- ii. To confirm the organisational scope, including safeguarding, paediatrics, medicines governance, digital systems, workforce, mortality review, bereavement care and corporate leadership;
- iii. To appoint a designated executive lead and named owner for each action, with milestones, deadlines, evidence requirements and escalation routes;
- iv. To develop costed options through the appropriate Finance, Digital, Estates, Workforce, HR, Safeguarding, Medicines Governance and clinical governance routes; and
- v. To establish a reporting cycle so progress, exceptions, risks and evidence of impact are visible to executives, relevant committees and the Board.

Supporting Documentation

- [Thirlwall Inquiry](#) final report and recommendations.
- NHS England letter of 21 September 2026 setting out immediate provider and integrated care board actions.
- Relevant national guidance on SUDIC, neonatal insulin security, bereavement care and mortality review.

Acronym	Meaning	Acronym	Meaning
CCTV	Closed-circuit television	GIRFT	Getting It Right First Time
ICB	Integrated Care Board	MNVP	Maternity and Neonatal Voices Partnership
PAC	Perinatal Assurance Committee	PSIP	Perinatal Safety Improvement Programme
PSIRF	Patient Safety Incident Response Framework	SUDIC	Sudden Unexpected Death in Infancy and Childhood