Oxford University Hospitals NHS
NHS Foundation Trust

Cover Sheet

Trust Board Meeting in Public: Wednesday 25 November 2026

TB2026.100

Title:	**Thirlwall Inquiry Trust Response**

Status:	**For Discussion**
History:	**Trust Management Executive 12 November 2026; Maternity Clinical Governance 16 November 2026; Trust Clinical Governance 18 November 2026; Perinatal Assurance Group 23 November 2026**

Board Lead:	**Chief Nursing Officer; Chief Medical Officer**
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Confidential:	**No**
Strategic Pillar:	**Patient Care**

Executive Summary

1. The Thirlwall Inquiry reported on 15 September 2026. The NHS England letter of 21 September 2026 asks every Board to consider the findings at its next public meeting, reflect on whether similar events could occur in its own organisation, and seek assurance that babies and children are safe in every setting. This paper sets out the Trust's position against the letter as at 16 November 2026.
2. Work is in progress to deliver interim CCTV on neonatal insulin storage by 30 November 2026 and to approve and implement the interim route for a suspicion of deliberate harm. The Chief Medical Officer will confirm before 25 November 2026 that existing mortality reporting gives the Board the visibility it needs of child and neonatal deaths, unexpected collapses and patterns across cases.
3. The letter sets three dated requirements. These are communication that the Sudden and Unexpected Death in Children (SUDIC) protocol applies in neonatal units by 28 September 2026, CCTV covering neonatal insulin storage by 30 November 2026, and insulin access control and storage to the GIRFT standard by 31 March 2027.

What is in place

4. The SUDIC requirement was met on 28 September 2026. The Chief Medical Officer and Chief Nursing Officer wrote to all staff, including Board members, setting out when the SUDIC process applies and directing staff to the Trust's child death, safeguarding and Freedom to Speak Up routes. The Trust's child death processes are well established. All 23 unexpected child deaths at OUH in 2025/26 were referred to HM Coroner and received an urgent Joint Agency Response.
5. Neonatal insulin is already protected. It is held in a swipe access drug room and a digitally locked fridge, and a laboratory insulin and C-peptide safeguard went live on 4 November 2026. The integrated perinatal death reporting procedure, approved on 16 November 2026, strengthens weekly checking, escalation and reporting to the Board.

Progress on the outstanding areas

6. **Interim CCTV.** The room has been identified and a quotation is in place. Security, Estates and IM&T are completing the cabling, asbestos survey and small works, and the installation date is being confirmed. Insulin stays secured by swipe access and a locked fridge in the meantime. If the 30 November 2026 date cannot be met, the Chief Nursing Officer and Chief Medical Officer will escalate to the regional team.
7. **Insulin access to the GIRFT standard.** The gap analysis and work on biometric access are under way with Security and Estates, against an OUH target of 30 November 2026 and the national deadline of 31 March 2027.
8. **Suspicion of deliberate harm.** A written Trust protocol has been drafted and circulated for comment, with the Chief Nursing Officer as executive owner and the

Head of Safeguarding as operational owner. It is due for approval by the Strategic Safeguarding Committee and implementation by 30 November 2026.

9. **Board visibility of deaths.** Existing mortality reporting includes quarterly Learning from Deaths and perinatal mortality reporting to the public Board and the annual child mortality report. The Chief Medical Officer will confirm before 25 November 2026 that it gives the Board the visibility it needs of child and neonatal deaths, unexpected collapses and patterns across cases, with set escalation triggers.
10. **Speaking up and safeguarding training.** The Trust has an established Freedom to Speak Up policy and confidential reporting platform, and no risks have been reported through staff feedback. The Board will receive service-level speaking up evidence for neonatal, maternity and children's services. All executive directors are in date with safeguarding training, and an update session has been arranged for non-executive directors in addition to their usual training. Staff compliance is reported quarterly through the safeguarding reports.
11. **Scope and national developments.** The response is being extended to every service caring for babies and children across all Trust sites, including the Children's Hospital and paediatric inpatient, critical care, emergency and surgical services. Further national guidance is expected on in-cot cameras, revised SUDIC forms and the regulation of NHS managers, and the Trust will respond as it is issued.

Recommendations

12. The Trust Board is asked to:
    - Consider the findings of the Thirlwall Inquiry and reflect on whether similar events could occur at OUH.
    - Consider the assurance in this paper that measures are in place to keep babies and children in the Trust's care safe in every setting.
    - Note that the SUDIC communication reached all staff and Board members on 28 September 2026.

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1. Background

1.1. The Thirlwall Inquiry examined events at the Countess of Chester Hospital between 2015 and 2018 and their implications for the NHS. Its report of 15 September 2026 found a complete failure to protect babies. It found dysfunctional management and governance, a gulf between leadership and clinicians, and a failure at every level to invoke safeguarding procedures when a member of staff was suspected of causing deliberate harm. It made 17 recommendations to Trusts, NHS England, the Department of Health and Social Care and regulators.

1.2. The NHS England letter of 21 September 2026 states that the learning applies to every Trust and every setting in which babies and children are cared for. It asks Boards to consider the report in public, to reflect on whether similar events could occur locally, and to seek assurance that babies and children are protected. It sets immediate actions on the SUDIC protocol, bereavement care, insulin storage and CCTV, and safeguarding training, and asks Boards to discuss any risk to a culture of professional curiosity and speaking up with the regional team, to use the Insightful Provider Board guide, and to consider support for parents and staff. Regional teams are the route for any risk the Board identifies.

1.3. This paper is presented to the Trust Board in public on 25 November 2026.

1.4. The Chief Nursing Officer and Chief Medical Officer are the joint executive Senior Responsible Officers. The Chief Medical Officer leads on the mortality review elements, and the Chief Medical Officer and Chief Nursing Officer jointly lead on suspected deliberate harm. The response is being extended to every service caring for babies and children across all Trust sites. Delivery is reviewed weekly by the Chief Nursing Officer and reported monthly to the Perinatal Assurance Group, with exception reporting to the Quality and Performance Committee and escalation to the NHS England regional team where required.

2. Position against the letter

2.1. Table 1 summarises the position against each requirement of the letter as at 16 November 2026, drawing on the action plan and the supporting evidence identified for each requirement. The supporting narrative is set out below the table and in the action plan.

Requirement in the letter	In place at 16 November 2026	Outstanding	Owner	Date
Board considers the report in public and reflects on whether similar events could occur at OUH	Paper prepared for the Trust Board in public on 25 November 2026, the first public Board since the letter, with a self-assessment against the Inquiry's findings.	Board consideration and reflection at the meeting.	Chief Nursing Officer and Chief Medical Officer	25 November 2026
Culture of professional curiosity and speaking up, with any risk discussed with the regional team	The all-staff SUDIC communication included reporting responsibilities and a Freedom to Speak Up Guardian link. Established Freedom to Speak Up policy and confidential reporting platform.	Service-level evidence, and confirmation whether any risk needs regional discussion.	Chief People Officer	Before 25 November 2026
SUDIC protocol applies in neonatal units, with staff and Board told by 28 September 2026	Communication to all staff, including Board members, issued 28 September 2026 by the Chief Medical Officer and Chief Nursing Officer, within the national deadline. Established child-death and Newborn Care pathways with Trust-wide Joint Agency Response activity.	Neonatal readiness and the checking mechanism.	Chief Medical Officer and Chief Nursing Officer	28 September 2026 (national). Remaining assurance before 25 November 2026.
National Bereavement Care Pathway for stillbirth and neonatal death, with immediate action to improve care of the bereaved	Bereavement support in place. Bereavement care audit in progress.	National Bereavement Care Pathway position and completion date.	Director of Midwifery	Before 25 November 2026
CCTV on neonatal insulin storage by 30 November 2026, with recordings kept at least 28 days	Insulin held in a swipe-access drug room and a digitally locked fridge. Installation work in progress with the neonatal leadership team, Security, Estates and the digital team. Room identified and quotation available.	Data routing, asbestos survey, small works approval, installation and commissioning, with a date confirmed by Estates.	Divisional Director of Nursing, NOTSSCaN	30 November 2026 (national)

Requirement in the letter	In place at 16 November 2026	Outstanding	Owner	Date
Insulin access control and storage to the GIRFT standard by 31 March 2027	Swipe-access drug room and digitally locked fridge. Laboratory C-peptide safeguard implemented 4 November 2026.	GIRFT gap analysis and digital access controls.	Divisional Director of Nursing, NOTSSCaN	30 November 2026 (OUH target), 31 March 2027 (national)
Safeguarding training for all staff and Board members, with staff knowing who to escalate to	Safeguarding Training Strategy in place. Compliance reported through divisional quality reports, quarterly safeguarding reports and the annual Board safeguarding report. All executive directors in date with safeguarding training. Update session arranged for non-executive directors in addition to their usual training.	Staff compliance by level and evidence that staff know the escalation route.	Head of Safeguarding	Before 25 November 2026, OUH delivery target 30 November 2026
Safeguarding of babies and children prominent at Board	Mortality Review Policy with quarterly public Board reporting. Quarterly Learning from Deaths and perinatal mortality reporting, annual child mortality report and Quality Account. Integrated perinatal death reporting procedure approved 16 November 2026.	Chief Medical Officer confirmation that existing mortality reporting gives the Board the visibility it needs of deaths, unexpected collapses and cross-case patterns, with escalation triggers.	Chief Medical Officer	Before 25 November 2026
Insightful Provider Board guide used by the Board	Board safeguarding seminar planned for January 2027.	Assessment of Board information against the guide.	Head of Corporate Governance	January 2027
Reassurance for parents of babies in neonatal care	Bereavement support, feedback arrangements and a completed cot-camera survey. Preparatory enquiries on in-cot cameras pending national guidance.	Reassurance communication to parents.	Divisional Director of Nursing, NOTSSCaN	Before 25 November 2026
Support for staff working in neonatal services	Not yet evidenced.	Review of staff support.	Divisional Director of Nursing, NOTSSCaN	Before 25 November 2026

Table 1: Position against each requirement of the NHS England letter of 21 September 2026

2.2. **Requirement that fell due before this meeting.** The letter states that the SUDIC protocol applies to every death, or collapse leading to death, of an infant or child under the age of 18 which would not have been reasonably expected to occur 24 hours previously and in whom no pre-existing medical cause of death is apparent, irrespective of the place of death, including sudden and unexpected deaths within neonatal units. SUDIC reporting runs alongside the Trust's own internal reporting.

2.3. **Established child-death and Newborn Care pathways.** The OUH Child Death Process Flow Charts and Explanatory Notes provide the operational framework for recognition, notification, escalation and Joint Agency Response (JAR), with links to the Newborn Care death checklist, neonatal medical guidance and NICU unexpected-death pathway. Within Newborn Care, the neonatal death checklist (green sheet) is the established process. Where a death, or the collapse leading to death, is sudden and unexpected, JAR is initiated alongside safeguarding, Coroner and Medical Examiner processes and incident reporting, followed by neonatal mortality review and the Perinatal Mortality Review Tool (PMRT). The Newborn Care green sheet (2025) explicitly prompts recognition of unexpected or unexplained death, Coroner referral, contact with the Child Mortality Team and consideration of a multi-agency response.

2.4. **Evidence of operation in practice.** The Child Mortality Annual Report 2025/26, covering April 2025 to March 2026, records 23 unexpected child deaths at OUH. All were referred to HM Coroner and underwent an urgent JAR. There were no unexpected deaths in Newborn Care or Delivery Suite during that period. The Trust-wide process operates in practice, though no neonatal case arose in the period, so neonatal staff awareness and readiness still require assurance.

2.5. **Mortality governance evidence.** The supporting evidence, including the Mortality Review Policy, quarterly Learning from Deaths and perinatal mortality reports, the Child Mortality Annual Report 2025/26 and the Quality Account, is referenced in the action plan.

Insulin governance

2.6. Neonatal insulin is held in a swipe access drug room and a digitally locked fridge. The gap analysis against the GIRFT neonatology guide and work on biometric access remain in progress with Security and Estates. The laboratory insulin and C-peptide workflow was implemented on 4 November 2026, as recorded in the laboratory implementation evidence. Completion of the laboratory change does not establish completion of the separate insulin access and storage requirements. Interim CCTV is reported in Table 1.

3. Self-assessment against the Inquiry's findings

3.1. The letter asks every Board to reflect on whether the same could happen in its own organisation. The assessment below considers OUH's arrangements against the failings identified in the Inquiry's published summary of 15 September 2026.

3.2. **Recognising a pattern of harm.** At the Countess of Chester a rise in deaths and collapses was not treated as a signal requiring urgent investigation. OUH has an established Trust-wide mortality governance and reporting framework, with quarterly Learning from Deaths and perinatal mortality reporting, annual reporting through the Quality Account, and specialist review of every child death through the Child Mortality Team, Neonatal M&M, PMRT and Joint Agency Response where applicable. The Chief Medical Officer will confirm before 25 November 2026 that these arrangements give explicit and timely visibility of child and neonatal deaths, relevant unexpected collapses and cross-case patterns, with predetermined escalation to the executive and Board.

3.3. **Acting on concerns about a colleague.** The Inquiry found that no one understood that safeguarding action is required when a member of staff is suspected of causing deliberate harm. OUH has prepared a written Trust Suspicion of Deliberate Harm Protocol, circulated for comment on 5 November 2026, with the Chief Nursing Officer as executive owner, the Head of Safeguarding as operational owner and the Strategic Safeguarding Committee as approval body. Formal approval, implementation, police-referral responsibilities and timescales, and the protection of the safety response from delay by employment processes, are not yet confirmed. Approval and implementation of the interim protocol is proposed by 30 November 2026.

3.4. **Speaking up without fear.** The consultants who raised concerns at the Countess of Chester were themselves investigated through the grievance process. OUH has a well-established Freedom to Speak Up policy and a confidential reporting platform, and no risks have been reported in the staff feedback reviewed. Service-level evidence for neonatal, maternity and children's services will be provided by the Chief People Officer before the Board meeting, as recorded in Table 2. Any risk identified will be discussed with the NHS England regional team.

3.5. **Safeguarding as the lens.** The Inquiry's central conclusion is that there was a complete failure, at every level, to invoke safeguarding procedures. The Board needs assurance that staff and Board members are trained at the required level and that an unexplained deterioration or death is recognised as a potential safeguarding concern. Whether the safeguarding policy addresses deliberate harm by a member of staff, how the

safeguarding team is notified of unexpected deaths and collapses, and the arrangements with the Local Authority Designated Officer and the police, are not yet confirmed and form part of the interim protocol work.

3.6. **What the Board sees and how it challenges.** The Inquiry described a gulf between hospital leadership and clinicians and recommends Board-level monitoring of all child and baby deaths with a predetermined escalation route. At OUH the Perinatal Assurance Group is chaired by a Non-Executive Director and exceptions go to the Quality and Performance Committee. A consolidated statement of current Board and committee reporting of safeguarding and Freedom to Speak Up is not yet provided, and the January 2027 Board seminar is proposed to test Board information against the Insightful Provider Board guide.

3.7. **Scope beyond the neonatal unit.** The letter is explicit that the learning applies in every setting in which babies and children are cared for. The response was organised through the perinatal service and is being widened to the Children's Hospital and all paediatric inpatient, critical care, emergency and surgical services through directorate and divisional governance and the Clinical Governance Committee. Confirmation that the children's services actions are in the action plan, with owners, dates and the governance route, is an action in Table 2.

3.8. **Support for parents and staff.** The letter asks Trusts to consider the reassurance given to parents of babies currently in neonatal care and to review the support available to staff in these services. Bereavement support, feedback arrangements and a completed cot-camera survey are recorded. A specific reassurance communication to parents and a review of staff support mechanisms are not yet evidenced and are actions in Table 2.

3.9. Three assurance gaps remain. These are confirmation by the Chief Medical Officer that existing mortality reporting gives the Board the visibility it needs, approval and implementation of the written interim route for a suspicion of deliberate harm, and service-level evidence on speaking up. Each has an action, owner and date in Table 2.

4. The Inquiry's 17 recommendations

4.1. The Inquiry made 17 recommendations to Trusts, NHS England, the Department of Health and Social Care and regulators. They are tracked in the action plan. For recommendations addressed to national bodies, local implementation depends on new national guidance, and preparatory work within the Trust's remit is recorded separately. Preparatory work is not presented as completion of the national action. The Maternity and Neonatal Ten-Point Plan and the local Amos report are reported to the Board separately.

5. Actions in this paper

5.1. Table 2 sets out the actions in this paper, each with an owner and a date.

Action	Owner	Date
Complete the remaining SUDIC assurance, neonatal readiness and the arrangements for checking consistent application.	Chief Medical Officer and Chief Nursing Officer	Before 25 November 2026
Confirm that existing mortality reporting gives the Board the visibility it needs of child and neonatal deaths, unexpected collapses and cross-case patterns, with escalation triggers.	Chief Medical Officer	Before 25 November 2026
Interim CCTV on all neonatal insulin storage, with 28 day retention.	Divisional Director of Nursing, NOTSSCaN	30 November 2026
Approve and implement the written interim route for a suspicion of deliberate harm.	Chief Medical Officer and Chief Nursing Officer	30 November 2026
Provide service-level speaking up evidence for neonatal, maternity and children's services.	Chief People Officer	Before 25 November 2026
Evidence staff safeguarding training compliance by level, with gaps and the escalation route.	Head of Safeguarding	Before 25 November 2026
Confirm the National Bereavement Care Pathway position and completion date.	Director of Midwifery	Before 25 November 2026
Confirm the children's services actions are in the action plan, with owners, dates and the governance route.	Divisional Director of Nursing, NOTSSCaN	Before 25 November 2026
Issue a reassurance communication to parents of babies in neonatal care.	Divisional Director of Nursing, NOTSSCaN	Before 25 November 2026
Review the support available to staff working in neonatal services.	Divisional Director of Nursing, NOTSSCaN	Before 25 November 2026
Insulin access control and storage to the GIRFT standard.	Divisional Director of Nursing, NOTSSCaN	OUH target 30 November 2026, national deadline 31 March 2027
Board safeguarding seminar, assessing Board information against the Insightful Provider Board guide.	Chief Nursing Officer with the Head of Corporate Governance	January 2027

Table 2: Actions in this paper

6. Conclusion and recommendations

6.1. The Trust has responded to each requirement of the NHS England letter of 21 September 2026. The SUDIC requirement was met on 28 September 2026, neonatal insulin is protected by swipe access, a digitally locked fridge and a laboratory insulin and C-peptide safeguard, and the integrated perinatal death reporting procedure was approved on 16 November 2026. All executive directors are in date with safeguarding training, and an update session has been arranged for non-executive directors.

6.2. Work is in progress to deliver interim CCTV on neonatal insulin storage by 30 November 2026 and insulin access control and storage to the GIRFT standard by 31 March 2027, and to approve and implement the interim route for a suspicion of deliberate harm by 30 November 2026. The Chief Medical Officer will confirm before 25 November 2026 that existing mortality reporting gives the Board the visibility it needs. The response is being extended to every service caring for babies and children across all Trust sites. Delivery is reviewed weekly by the Chief Nursing Officer and reported monthly to the Perinatal Assurance Group, with exceptions reported to the Quality and Performance Committee.

6.3. The Trust Board is asked to:

- Consider the findings of the Thirlwall Inquiry and reflect on whether similar events could occur at OUH.
- Consider the assurance in this paper that measures are in place to keep babies and children in the Trust's care safe in every setting.
- Note that the SUDIC communication reached all staff and Board members on 28 September 2026.