# Thirlwall Inquiry

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At last, we know what happened at the Countess of Chester hospital where Lucy Letby worked as a nurse and was convicted of murdering 7 babies and attempting to murder others in a busy, cramped and out of date neonatal unit.

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Each baby death or injury is set out in some considerable detail which will be poured over by those seeking to have Letby's conviction reviewed.

Thirlwall did not seek to review the criminal case at all and focused on establishing what happened within the hospital when worries first arose about an unexpected and unexplained increase in deaths on the neonatal unit .

A number of consultants were suspicious that Letby's presence at many of the unexpected deaths might be connected but the Medical Director and Director of Nursing were unconvinced and this reflected their reports to the main Board.

This was, Thirlwall reported, the "*beginning of an exercise is spin, steering the Board away from concerns about criminal acts and the need to report the matters to the police*". When the Trust took legal advice it too downplayed the need to make a reference to the police. The reputational damage would be enormous and if the neonatal unit became a crime scene it would have to be further downgraded or close.

Inquiry after inquiry followed, all inconclusive.

The coroner got involved. Letby lodged a grievance alleging victimisation and discrimination. The doctors involved had to apologise.

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*At this stage the Executive team was contemplating reporting them to the GMC but never did.*

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The Trust eventually reported the issue to the Cheshire Police as unconfirmed suspicions. The Police started their inquiries which led eventually to Letby's conviction.

Tony Chambers the Chief Executive, a nurse by background, faced a vote of no confidence by the medical staff committee and decided to move on.

A letter describing his departure talked about his integrity as a leader. Thirlwall concluded that "*this was just another spin*" to avoid the vote of no confidence. There was, she concluded, a complete failure to protect babies from harm.

It is a sorry story of a Trust under enormous strain as senior management and professional leaders grappled with the unthinkable…that a nurse would deliberately harm her young patients.

Perhaps the most important conclusion is that hospitals must act when there is a creditable SUSPICION that a member of staff is deliberately harming patients. They do not need proof;

suspicion is enough to ensure the protection of other patients.

There are 17 recommendations the first of which was accepted within hours of the inquiry report by ministers. They include;

1. All neonatal units should have CCTV and baby monitoring systems installed and this should include cameras that cover insulin storage. They should allow parents to observe their babies at all times.
2. Staffing on neonatal units should be reviewed [increased]
3. There should be much stronger systems for staff, and particularly doctors, to raise concerns. There was major gulf between clinicians and managers.
4. NHS Boards need a much clearer accountability for patient safety.
5. Record keeping and sharing must be improved. Interoperable computer systems should be harmonised. All inpatient deaths should be reviewed and outcomes reported to Boards.
6. A national protocol for reporting suspicious events to the police should be issued.
7. Better safeguarding arrangements and more training including Board directors.
8. A national expert committee to review emerging concerns about patient safety.
9. A review of CQC… **another!** The functions of the National Guardian's office [Whistle blowing] should be transferred to the Parliamentary Ombudsman.
10. A stronger code of conduct for NHS managers and an individual duty of candour. Managers guilty of misconduct should be barred from future involvement with the NHS.

So, there you go, the managers are largely to blame whenever something goes wrong.

One of the strongest themes is that management cannot rely on clinicians to resolve serious concerns themselves.

Managers must get involved even if this leads to resistance by medical staff committees.

When safety issues are involved of course Boards and their Executive teams should get involved. If managers know that the services they are managing are potentially unsafe they should say so even if this puts them in personal danger.

Most hospital wards in the NHS are operating, and have been for some time, with occupancy levels well above a safety level of 85%.
Is anybody at the top of the NHS listening?

**Do** they know?
**Does** the Duty of Candour apply to NHS England?
**Will it** apply to the DHSC when they take over the NHS?

Almost as an after thought the Inquiry looked at what happened to other Public Inquiry reports, Most were accepted but implementation had been patchy.

Perhaps, the recommendations were not fit for purpose! Perhaps, the Inquiry pondered, should the National Audit Office review implementation and report to the House of Commons.

Not a bad idea if the brief includes a review of the performance and cost of each inquiry.

As always the Thirlwall Inquiry has done what Inquiries do best…establish the facts but at a substantial cost.

The recommendations are not strong and will do little to help prevent a reoccurrence.

**That requires a fundamental s shift in NHS and particularly professional culture.**

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