Recommendations

My recommendations are set out below. The reasons for each are explained in the relevant chapters of this report.

The long-standing underfunding of hospital services for babies and children is well recognised and requires action. The drive to increase the provision of health services in the community should not obscure or undermine the urgent need for adequate and enduring funding for hospital services for babies and children. I trust that the government will give this issue the urgent attention it requires.

CCTV and monitoring

Recommendation 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. The funding for this should be centrally managed and ring-fenced, to ensure consistency and implementation across all neonatal units at speed. By 31 March 2027, NHS England should set out a roadmap for how this will be implemented.

Chapter 33

Insulin

Recommendation 2

i. Digital devices should be used to restrict access of insulin to authorised people and record access to insulin storage units. I acknowledge that steps are being taken to achieve this. By 31 March 2027, all neonatal units must meet the expected requirements for access control and storage of insulin set out in the NHS England Getting It Right First Time guide, *GIRFT Neonatology: Guide to safe insulin use*.

ii. 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.

iii. 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.

Chapter 34

Bereavement care

Recommendation 3

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

Chapter 29

Safeguarding and contracts of employment

Recommendation 4

i. 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.

ii. By March 2027, every existing contract of employment for work in an NHS hospital must be amended to include an obligation on the employee to follow all relevant safeguarding guidance, including the Suspicion of Deliberate Harm Protocol (at Recommendation 9), for dealing with concerns and suspicions about deliberate harm. Agency and bank staff contracts and all new contracts of employment must include the same obligation.

Chapter 41

Operating systems (interoperability)

Recommendation 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. Work on the development of a mandatory information standard with requirements for interoperability between systems should be taken forward and implemented as soon as possible. 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.[1]

Chapter 35

Monitoring deaths in hospitals

Recommendation 6

i. By 31 March 2027, all hospital Trusts must have in place effective mechanisms for Board-level monitoring of all deaths of children and babies.

ii. By 31 March 2027, all hospital Trusts must have in place a clear and predetermined route to senior management for the escalation of concerning data trends or patterns.

Chapter 35

Data reporting

Recommendation 7

i. 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.

ii. Save where data requires immediate action, in which case a report should be made to the Medical Director and the Board immediately, the lead reporter should report to Trust Boards at least every six months and advise:

    a. whether any alerts or a need for investigation have arisen

    b. the investigation or action plan in place.

Chapter 35

Sudden Unexpected Death in Infancy and Childhood (SUDIC)

Recommendation 8

i. NHS England must:

    a. 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.

    b. Direct all Trusts that they must, within seven days, draw this information to the attention of all relevant staff and the Board.

ii. 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. The guidelines must include a clear statement that SUDIC applies to sudden and unexpected deaths of babies who have never left hospital.

iii. SUDIC forms must be redesigned and shortened to keep bureaucracy to a minimum. The focus should be on what it is essential to know.

Chapters 12 and 28

Suspicion of Deliberate Harm Protocol and guidance

Recommendation 9

Protocol

i. 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. The Suspicion of Deliberate Harm Protocol must make explicit that:

   a. It is irrelevant whether the person to whom the concerns have been expressed does or does not believe they are true, as is the fact that the person raising the concern is not sure.

   b. Where concerns or suspicions of deliberate harm are being raised in good faith, they must be acted upon immediately.

   c. Only in cases where the concerns are obviously irrational or malicious (which assessment must be recorded) will no further action be justified.

   d. Pending investigation of a member of staff, action to protect patients by moving the person suspected of causing harm is likely to be the first step.

   e. The moving of a person suspected of causing harm and the investigation into suspicions and concerns about a member of staff is a neutral act.

   f. Safeguarding steps must be followed, as a result of which the police will become involved.

Guidance

ii. Guidance of no more than two pages should accompany the protocol. It must set out the factors to be considered when assessing the nature of the concerns and suspicions. The reader should be directed to guard against their own biases, loyalties and prejudices. The guidance should explain what should be said and when to those who are or who may be involved with any investigation (such as patients, parents and staff). This must include that patient safety comes first, and investigation is required. The guidance should also explain that failure to follow the protocol will be a breach of contract by an employee, as well as a breach of the relevant code of conduct.

Implementation

iii. Trusts must embed the Suspicion of Deliberate Harm Protocol and guidance within their hospital.

Chapter 41

Panel of experts

Recommendation 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. A team from any specialty or combination of specialties would be drawn from the panel to conduct a swift, technical investigation into the concerns raised. This may most often be necessary where there are concerns that harm is being or has been caused inadvertently.

The precise make-up of the panel should be determined by DHSC but could include, for example:

a. two doctors and two nurses from each clinical specialty

b. four senior managers

c. four pathologists including paediatric and perinatal pathologists

d. other experts as decided by DHSC.

Where necessary, a small team (always including clinicians from the relevant specialty/specialties) would be drawn from the panel to carry out an independent investigation into clinical concerns. Such investigations should always include safeguarding considerations (including contacting the police). In addition to reporting their findings to the Trust and DHSC, the experts would be available to be called as witnesses in any proceedings that may follow.[2]

Chapter 41

Medical examiners

Recommendation 11

i. 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.

ii. The revised SUDIC guidelines (see Recommendation 8 above) should be set out within the good practice guidelines for medical examiners, not merely signposted.

iii. Medical examiners should ask direct questions of the attending practitioner as to whether there is a concern that a child has been harmed or some other safeguarding concern. Where there may be such a concern, the medical examiner should ensure that there is a record made that day of the contact details of every doctor or nurse who attended to the baby during life.

iv. There should be a pool of neonatologists who can assist medical examiners with their work until such time as it is possible to appoint the appropriate number of regional neonatologist medical examiners. Ring-fenced funding should be provided for this purpose.

v. The medical examiner system should be reviewed again in 2027 by DHSC. The review should include the adequacy of funding for medical examiners and their support staff and offices. In particular, the question of whether the funding should be ring-fenced must be addressed. Thereafter, reviews should be as directed by DHSC and NHS England.

Chapter 32

Paediatric and perinatal pathologists

Recommendation 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*. The incentive scheme should remain in place and funded until at least 37 doctors are in training posts as paediatric and perinatal pathologists.

Chapter 28

Accountability and regulation of managers

Recommendation 13

i. 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.

ii. NHS England must require any Trust seeking approval for the movement of a senior manager to another Trust to demonstrate that:

    a. The move is not proposed because of the manager's lack of capability or misconduct.

    b. The manager meets the fit and proper person test.

    NHS England must not grant approval, and Trusts must not seek approval, unless they are able to demonstrate the matters at a. and b. above.

iii. In addition to the statutory duty for organisations, all managers must be subject to an individual duty of candour to all patients and colleagues. This should be included in the code of conduct and in the contract of employment for all managers.

iv. 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. I suggest the following wording, with thanks to Mr Jarrold: 'I will make the care and safety of patients my first concern and act to protect them from risk.' What matters is that patients come first.

v. In the Leadership and Management Framework Standards, the competency 'delivering across healthcare' should be first (it is currently third). The first and fundamental competency under this heading is, rightly: "*I put patients first and report safety concerns and incidents.*"

Chapter 37

Care Quality Commission (CQC)

Recommendation 14

i. 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).

ii. Inspectors should investigate what is happening in hospital departments and not accept what they are told at face value. Where processes are being inspected, questions must be asked to elicit the effectiveness of those processes.[3]

iii. Training should make explicit that CQC is responsible for ensuring the safety of patients in hospitals and not just for checking there are processes in place which, if implemented, should ensure patient safety. Inspectors and team leaders must always approach an inspection of neonatal services not as a box-ticking exercise but as a way to determine that babies in hospital are safe.

Chapter 42

Assessment of the performance of CQC

Recommendation 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.

Chapter 42

Parliamentary and Health Service Ombudsman

Recommendation 16

The functions of the National Guardian's Office should be taken over by the Parliamentary and Health Service Ombudsman in England. The Ombudsman's powers must be increased to include:

a. investigating complaints that whistleblowing in the NHS has not been dealt with adequately

b. assisting whistleblowers by referring their concerns to the relevant NHS bodies and overseeing the response.

Chapter 31

Implementation of recommendations

Recommendation 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. Funding for appropriate additional staffing should be made available so that it may begin its work by September 2027.

Chapter 31

Endnotes

1 Baroness Amos's final report from the National Maternity and Neonatal Investigation recommends DHSC/NHSE must deliver estates and digital systems that are fit for modern maternity and neonatal care with 12-month, 5-year and 10-year investment commitments and implementation deadlines. The importance of interoperable digital systems is a common theme in both our reports and should be treated as a priority. The Rt Hon. the Baroness Valerie Amos LG CH, *Independent Investigation into Maternity and Neonatal Services in England: Final report and recommendations*, June 2026 (**https://www.matneoinv.org.uk/wp-content/uploads/2026/08/NMNI-Final-Report-and-Recommendations.pdf**)

2 Baroness Amos's final report recommends that NHS England, DHSC and CQC "*put in place a specialist regulatory unit, with a sufficiently sensitive methodology, to provide regulatory assessment for maternity and neonatal services*" within nine months. This must include clinicians so that "*the most recent clinical perspectives are fully integrated into the regulatory function*". This recommendation aligns with my recommendation and should be taken forward with urgency. The Rt Hon. the Baroness Valerie Amos LG CH, *Independent Investigation into Maternity and Neonatal Services in England: Final report and recommendations*, June 2026, page 20 (**https://www.matneoinv.org.uk/wp-content/uploads/2026/08/NMNI-Final-Report-and-Recommendations.pdf #page=20**)

3 Baroness Amos's final report recommends that DHSC, NHS England and CQC must drive improvement within 12 months in the quality, transparency, oversight and accountability of their investigations, and ensure that learning is captured and acted upon when things go wrong. Our recommendations regarding CQC should be taken forward with urgency. The Rt Hon. the Baroness Valerie Amos LG CH, *Independent Investigation into Maternity and Neonatal Services in England: Final report and recommendations*, June 2026, page 16 (**https://www.matneoinv.org.uk/wp-content/uploads/2026/08/NMNI-Final-Report-and-Recommendations.pdf#page=16**)