Witness Name: Emma Kate Taylor
Statement No: 1
Exhibits: 12
Dated: 15.04.2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF EMMA KATE TAYLOR

I, **Emma Kate Taylor**, will say as follows: -

1. Where the content of this witness statement is within my personal knowledge it is true. Where it outside my personal knowledge, and derived from other sources, it is true to the best of my information and belief.

2. This statement was taken from me by TEAMS interview.

3. I make this statement in response to the Inquiries Rule 9 request dated 18 December 2023

Introduction

4. I started work with Cheshire West and Chester Council ("the Council"), on 1 December 2014. I left the Council's employment on 11 April 2021. Initially, I was employed as the Director of Children's Social Care. Thereafter I became the Director of Children's Services ('DCS'). This is a statutory role. Before 2014, I worked in the Wirral and Halton.

5. I am a Social Worker. I qualified in July 1995 and have retained my social work registration with Social Work England.

6. I am now the Chief Executive Officer (CEO) of the Sandwell Children's Trust. I took up this role in April 2021. Through a contractual arrangement with Sandwell Council, it provides social care services, early help services and other children's services for Sandwell as an independent company. Nothing in my new role is connected to matters the Inquiry is looking at.

7. As the Council's DCS, I represented them as a statutory partner within the Safeguarding Children's Partnership ("SCP"), and also in the Local Safeguarding Children's Board ("LSCB") before that. I attended meetings alongside other statutory partners, namely the police and health (Clinical Commissioning Group, then more recently the Integrated Care Board). Between 2015 and 2021 I was a regular attendee at partnership meetings (LSCB and latterly SCP).

Background

8. What I say here refers to the structure when I was at the Council. It will have changed since. The Director of Children's Services (DCS) is statutorily responsible for the whole of Children Services. When I joined the council there were three directors under the DCS :

   - Director of Children's Social Care.
   - Director of Education.
   - Director of Early Help.

   I was the Director of Children's Social Care and all three reported to the DCS.

9. When I became the DCS, I retained some responsibilities of my previous role. The other two Directors did not formally report to me; however I was statutorily responsible for Children's Services and we met individually and worked closely together. Underneath me, there was a range of senior managers and operational managers. Social care work was organised on a locality model. The teams aimed to work closely with early help to prevent children entering the system. In particular, education had a significant role there. There were both child in care and locality senior leaders. This was all designed to meet the needs of children in the borough.

10. The Council also had a safeguarding manager who was a contact point for the Local Safeguarding Children Board (LSCB). That itself had a quality and assurance function.

11. In addition, the Children Services Department dealt with the front door service – where child protection referrals are made; and the LADO service – which receives referrals about professionals who work with children. Hospitals, including the Countess of Chester Hospital ("the Hospital"), do make referrals to Children's Social Care, because they deal with children. Mostly, these are safeguarding referrals relating to children who appear at hospital with, say, injuries. However, hospitals also make LADO referrals as an employer, if they suspect there is a safeguarding issue posed by professionals who have access to children.

12. In 2016, the then DCS, Gerald Meehan, became the Council's Chief Executive. I then took the DCS role. At that point, the LADO did not report directly to the DCS. That changed later. However, when I took on the role, I took on statutory responsibility for children. There was nothing on my radar about the Hospital until Alison Kelly briefed the LSCB – see below.

13. Since 2010, central government has been issuing guidance to local authorities and those who safeguard children, about joined up working. This guidance is known as "Working

Together". The first issue of Working Together was 2010. It was then revised in 2013, 2015, 2018 and 2023.

14. It is the Council's responsibility in the legislation to safeguard and promote children's welfare. As a result, it needs to follow the Working Together statutory guidance and to ensure that it is put into practice. The advice itself identifies statutory responsibility and requires for a Council to act if there is a risk of harm to children. The Council's responsibilities are as the key statutory partner for children. Indeed, only the Council could take children into care if necessary. However, the guidance makes it clear, that agencies must work together. The Council is required to work in partnership with the other statutory agencies.

15. If the Hospital had reported suspicions about LL earlier, the LADO would have become involved and looked to set up a strategy meeting. However, by the time the LADO report was made in this case, there was already a complex police investigation in progress. That had to take precedence.

Safeguarding Arrangements

16. The Council's lead officer for suspicions relating to adults is the LADO. They are responsible for sharing suspicions with other agencies – through the strategy meeting in the LADO process. The LADO does report to the LSCB (now SCP) annually. That is an overview report and information about individual cases is not shared at board level. Instead, the themes to emerge are examined. However, if the annual report threw up a particular issue or problem, it is likely that this would be examined in more detail. For example, if there were a number of teachers engaged in abuse at the same school, there would be a need for further investigation. In my time at the Council, I do not recall a situation in which concerns were flagged up about a particular agency. I do not recall any evidence of systemic failures being presented to us. Early on in my time at the Council I do recall some discussions about the Jimmy Saville inquiry, but that was limited.

17. The LADO needs to receive referrals in order to start their work. Accordingly, it would be the Hospital's responsibility to refer concerns about LL. If that had happened, there would probably have been a strategy meeting involving the Hospital, police and social care (if any of the children could be identified). Of course, by the time the LADO referral was made, the police investigation was up and running. At that point, information shared with the Council or LSCB was limited.

18. Turning to professional regulators, it is the duty of the home employer to report a member of staff to a regulator – such as to the Nursing & Midwifery Council. The Council would only make referrals to regulators (Social Work England) as employer. Clearly, if there is a report of concerns about a particular individual, and the LADO is investigating, they will tell the employer agency about the need to report. It might be a recommendation from a strategy meeting.

19. Specifically with regard to LL, we would expect the Hospital to refer her to professional bodies and to make a DBS report.

20. The Council does make DBS reports in respect of its own staff where there has been a reportable incident. Again, as with professional bodies, we would expect DBS referrals to be made by the employer agency.

21. Turning to Hospital settings, I have heard of the NHS Safeguarding and Accountability Framework ("SAAF"), but I am not aware of its detail. The LSCB used to sign off lots of safeguarding policies and procedures and it may well be that it was examined by them. However, personally, I cannot assist further.

22. As far as I am aware, there is no real difference in process between how the LADO works with Hospitals and other agencies. It is a process running on the same protocol, irrespective of where the child protection concern comes from. A referral is made to the LADO, it is assessed, and if it meets the threshold, there will be a strategy meeting.

23. The LSCB (now SCP) has done lots of work with hospitals. Hospital visits have been undertaken and I can recall visiting A&E at the Hospital itself. The Hospital and every school are aware of the LADO process and what they must do. I cannot see that it would be necessary to have a special LADO system for Hospitals.

24. I am not aware that the Hospital had any special procedures in place to specifically safeguard babies in neonatal units. How safeguarding policies are applied at local level is a matter for individual organisations – here the Hospital.

25. The Council did not have any role in developing policies or procedures relating to safeguarding babies in hospital. The LSCB partnership approach applied across the borough. What it was doing was to ensure that the training was in place, so that staff members knew what to do if they saw a baby being harmed. The board's responsibility was for training and developing policy for children's welfare. The theme here was that organisations should have safeguarding policies and apply them. This would be universal across all agencies. However, it is important to bear in mind that the board's remit was

children's safeguarding and child protection. This meant abuse and neglect in whatever setting; and it is a sad fact that most children suffer abuse or neglect within the family. Abuse by third party professionals in an institutional setting, is much rarer.

26. I am not aware that there is or was any guidance on the Council website regarding safeguarding and protection of babies in hospital. The only material which would be available on the Council's website and that of the LSCB (now SCP), would be details of the LADO service. That sets out what a doctor or other colleague should do if they have concerns about a member of their healthcare team towards babies. All organisations that work with children will have a Designated Safeguarding Lead ("DSL"). The starting point for most professional referrals in an institution will be a member of staff contacting the safeguarding lead. Based on what is known of LL's case, I do not know why a LADO referral wasn't made when consultants became suspicious of her.

27. As a Member of the SCP (formerly LSCB) the Council is fully involved in multi-agency training. The Safeguarding Unit employed by the Council is often involved in this. Training tends to be based on themes. I could not provide a list of what training was done and how often, but there was a regular programme of learning in the calendar which was advertised to agencies. Where there was a particular issue or need, the partnerships can offer stand-alone training or workshops on it. For exceptional matters it is necessary to get together. The SCP (formerly LSCB), organised an annual conference to the safeguarding partnership with training. There was good provision of training. And this was well attended.

The LADO

28. I cannot provide any detail on how the LADO works or liaises with professionals in healthcare settings, other than to identify that Paul Jenkins had a close relationship with colleagues from other agencies. He sat on the LSCB (later SCP) for the Council. The old CCG (now ICB) was part of the partnerships and so there would have been regular contact.

29. Personally, I am only aware of one LADO referral by the Hospital to the Council about a healthcare professional – the LL referral. This arrived in 2018 and the police investigation was already running. I was given information by the Hospital that there was an investigation into an individual professional. I met with Alison Kelly (the Director of Nursing) and was given LL's name and date of birth. I gave Paul Jenkins that information. However, we had to defer to the police in what was a complex criminal investigation. In March 2018, the Hospital made a retrospective formal LADO referral which was logged.

30. I cannot assist the Inquiry with whether the LADO provided advice and information to healthcare employers about prevention of harm. There is details of the LADO on the SCP

website, but I am not aware of specific training. That said, the LADO did issue information and guidance to partners.

31. When information is reported to the LADO, they must assess that referral. Assuming that the referral raises something which requires investigation, there will be a strategy meeting. The aim of this will be to bring together the agencies that will need to investigate what has happened, and the adult(s) in question. If the Hospital had made a LADO referral at an early stage, there would probably have been a meeting involving social care, the CCG and police. There are clear criteria for calling a meeting and where this is the case, it should happen in line with statutory guidance. The LADO coordinates that initial meeting. If an agency was not going to recognise the level of concern and attend, I would expect the LADO to contact that organisation and if necessary, escalate the matter within the organisation. Again, if there is a need for regulators to be informed (like the Nursing & Midwifery Council), that would be a matter for the agency which employed the suspect professional.

32. The role of the LADO is to ensure that partners are dealing appropriately with the situation and also to make sure that any children involved are safe. If there was any failure to follow the LADO's recommendations, there would be a need to escalate within the organisation. Similarly, if we hit a procedural wall, or there was a failure to take matters seriously, the LADO would again escalate the process.

Reporting the LL Allegations

33. In early summer 2017, I recall a healthcare colleague sharing brief details about an unusually high neonatal death rate between 2015 and 2016. This was in a statutory partners meeting. I do not recall if it was an LSCB related meeting. I was told there had been an independent review to understand why this had happened. The review was inconclusive and so the Hospital had invited Cheshire Police to look further into this matter. I was not made aware of any concerns relating to a specific individual at this stage. In June 2017, Alison Kelly briefed the LSCB. From then on, the Hospital shared periodic updates about this with LSCB members, minutes of which were shared with the partners. (EXHIBIT HKT1 [INQ0013195, INQ0013196, INQ0013197]).

34. In March 2018, I met with Alison Kelly. Whilst I cannot recall the detail of how the request came about, I do know it related to the neonatal investigation and a possible link with the LADO. I met with her and she gave me an envelope. She explained there was confidential information in the envelope relating to an individual involved in the investigation. When I opened the envelope I saw LL's name and date of birth handwritten on a piece of paper.

That piece of paper cannot now be found. We had a brief conversation and I recall Alison Kelly asking me if this referral should have been sent earlier. I confirmed that it should have been.

35. I explained I would pass the information onto the LADO and that an official referral was required. When I returned to my office I informed the Council's LADO, Paul Jenkins, about this. The information was logged onto the LADO system that day. I cannot say with certainty, but my practice was to always pass on sensitive information like this to the proper officer, and put any original paper into the confidential destruction bin.

36. On 29 March 2018, I was copied into an email sent at 16.50 hours to the LADO email account, from Alison Kelly. The message stated, *"Following recent discussion with Emma Taylor, please see retrospective LADO referral – police investigation ongoing".* (EXHIBIT HKT2 [INQ0013065]).

37. On 9 May 2018, I received an email from Alison Kelly regarding unsubstantiated allegations against staff. Mt exchange with her is attached (EXHIBIT HKT3 [INQ0013076]).

38. On 3 July 2018, I received a message from another healthcare colleague (Paula Wedd – West Cheshire CCG), about a teleconference being arranged in response to the investigation now being in the public domain. Due to media interest, an incident coordination call would be arranged the following morning at 9am. (EXHIBIT HKT4 [INQ0013127]).

39. The next day (4 July 2018), the telephone conference took place, led by Margaret Kitching, Chief Nurse North (NHSE & NHS Improvement). (EXHIBIT HKT5 [INQ0013040]). This was in response to the investigation becoming public and subsequent media interest. I do not recall the conversations that took place. However, I am aware that the Initial Incident Coordination Panel was set up for 10 July 2018, after that telephone conference. (EXHIBIT HKT6 [INQ0013038]).

40. Later that day, Alison Kelly forwarded me an email from the LADO email account. It stated that due to the police involvement, a strategy meeting needed to take place. It requested that she provided further information on a consultation form. I advised this was the usual procedure and that it is for the LADO to reconvene the meeting if there has been a significant change in circumstances. At this point, the Incident Coordination Panel had been arranged within the week. Therefore, I proposed that the next LADO meeting would progress after the meeting on 10 July 2018 – unless information came to light that suggested LL was back in the community.

41. The Incident Coordination Panel Meeting took place on 10 July 2018. The groups represented were the Council, Countess of Chester Hospital, Liverpool Women's NHS Foundation Trust, West Cheshire CCG, The Care Quality Commission, Cheshire & Wirral Partnership Foundation Trust and the Police. I attended these meetings on behalf of the Council (EXHIBIT HKT7 [INQ0013040]). I received minutes from these meetings which were held on 10 July 2018; 22 October 2018 (EXHIBIT HKT8 [INQ0013038, INQ0013039]); 28 January 2019 (EXHIBIT HKT9 [INQ0013041]) and 5 April 2019 (EXHIBIT HKT10 [INQ0013042]). They were face to face meetings. The purpose of the meetings was to provide strategic oversight of the situation in light of the fact that the NHS had received a call on 4 July 2018 confirming LL's arrest and consequential media interest.

42. At the initial meeting, a memorandum of understanding was shared with the group and it was explained by the chair that the meetings would be conducted within this framework. (EXHIBIT HKT11 [INQ0013046]). At the start of the initial meeting, the importance of confidentiality was highlighted by the chair and emphasised by the police. Everyone signed a confidentiality agreement. At the start of each meeting, the importance of confidentiality was emphasised and recorded in the minutes.

43. The main agenda items covered in the meetings were an overview of the investigation by Cheshire Police, updates from the NHS Trust and communication/media. The police did not provide particularly detailed overviews of what was going on. My role in the meeting was to highlight any safeguarding implications. At the initial meeting, I recall the police advised bail conditions had included the suspect not being able to work with children under the age of 16. I advised the police that under the Children Act 1989 a child is a person under the age of 18 and the conditions were subsequently changed to refer to working with any child – i.e., up to the age of 18. There is a reference to this in the minutes.

44. The LADO process ran parallel to the Incident Coordination Group. I recall getting updates from the LADO, confirming that this process could not progress due to the police investigation and the very limited information coming from the police. This was preventing decision-making. During the Incident Coordination Meeting on 5 April 2019, I confirmed that the LADO process remained open and this is recorded in the minutes. However, the LADO could not operate in the normal way because of the lack of information from the police. (EXHIBIT HKT12 [INQ0013042]).

45. Throughout the police investigation, I acted as the single point of contact for any enquiries that arose that needed input from the Council. I received a very small number of emails from Cheshire Police that related to any Council services that might be connected with the investigation. Information shared about the investigation was very limited.

46. As a representative of the partner agency, I was required to sign a confidentiality agreement by Cheshire Police. I recall it referred to me not discussing any information relating to the investigation. I signed two copies of this in front of the Senior Investigating Officer at the time (Paul Hughes). He kept one and I was given the other. I do not have access to either copy anymore.

47. Criminal investigations do take place around matters that have been referred to the LADO. Whilst the social care professionals accept the need for investigations to be conducted impartially and for no steps to be taken that might threaten the prosecution, or the defendant's right to a fair trial, I recall being told that there is a lack of information sharing when the police become involved. How much information should be shared, and in what circumstances is something that it would be useful to have better statutory guidance upon and it would be helpful for the Inquiry to consider that.

Child Safeguarding Practice Review Panels

48. The Council's role in Child Safeguarding Practice Review Panels ("CSPRP"), is to be an equal partner in the processes. They are run locally by the SCP and a Council representative can chair the review panels. If a child dies, there is a set process from the point of death. This depends on the cause of death and the Council must be involved. The first question on a child death is whether it meets the criteria for a SCP rapid review. From that there might then be a need for a Child Safeguarding Practice Review. How that would operate here, I cannot say, because I have never encountered a professional murder in babies before.

49. A rapid review would require some initial learning and the Council would look to communicate that where appropriate.

50. When a child dies where abuse or neglect is suspected, it is the Council's responsibility to notify the SCP. In addition, CDOP become involved. It is sometimes very clearcut how a child might have died. It is clearly abuse or neglect (e.g., those sad cases where a child is killed by a parent or carer). The role of the Council is to discuss matters with the other statutory parties and agree if the matter is notifiable to the national panel. We try to reach a consensus on this but, in the final analysis, the DCS can notify. Overall, I consider that these various panels are rigorous. The partners are generally good at sharing information.

Child Death Review Meetings and Overview Panels

51. When a child dies, it is the responsibility of the Child Review Partners (including the Council) to refer the matter to the Child Death Overview Panel ("CDOP"). They will then

report. Depending on the circumstances, they might undertake a rapid response approach, this is not dissimilar to the CSP's rapid review.

52. CDOP liaises with the SCP (formerly LSCB) in the form of a detailed annual report. Included in that, is detail of deaths that have been caused by modifiable factors. That is things that could be changed. The report will identify the modifiable factors and what could be different – with a view to obtaining a joint agency response. The CDOP report is analysed, shared with partners and the SCP (formerly LSCB), decides what can be done. If there is an emerging theme, this can go on to a practice review. Ordinarily, there is no role for the LADO in an infant death unless a professional person is suspected.

53. Accordingly, the LADO is not routinely considered to be one of the Child Death Review Partners. The LADO is engaged in only one aspect of child safeguarding – harm caused by professionals. Sadly, children come to harm in all sorts of different ways, often at the hands of parents or carers.

54. The Council's role in CDOP is as a member of it. The CDOP itself used to be a sub-committee of the old LSCB. With the move to the new SCP arrangements, CDOP has been made independent and is no longer a part of the board/partnership. In my time at the Council, I have not sat on a CDOP panel. Accordingly, I cannot assist on operation. However, I did receive reports. There was nothing to suggest that CDOP was doing anything other than working within the statutory framework. I did not have concerns about it.

55. CDOP reports and analyses are an effective to aid learning, because there is a lot of analysis in the review process. The reports look at factors leading to death and make recommendations. The test of any safeguarding system is of course how recommendations are taken and implemented. That is a matter for the SCP.

56. I am aware there was a possible issue sitting within the CDOP data, in that the spike did not show up immediately because some babies were for families in North Wales and CDOP arrangements did change to create a Pan Cheshire Panel.

57. The events relating to LL clearly require a safeguarding review, but I moved on from the Council in 2021. Accordingly, that is not a matter for me.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: PD

Dated: 15.04.2024