Witness Name: Helen Elizabeth Brackenbury
Statement No:1
Exhibits:
Dated: 15 April '24

THIRLWALL INQUIRY

WITNESS STATEMENT OF HELEN ELIZABETH BRACKENBURY

I, **Helen Elizabeth Brackenbury**, will say as follows: -

1. Where the content of this statement is within my personal knowledge, it is true. Where it is 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 Inquiry's Rule 9 request dated 18 December 2023.

Introduction

4. I am employed by Cheshire West and Chester Council ("the Council") as the Executive Director of Children and Families. For ease of reference I will call this "Director of Children's Services" or DCS. I have held this post since April 2021. Before that, I was the Director of Early Help and Prevention. I came into that post in 2014.
5. Professionally, I started as a nursery nurse and worked up through the local authority, taking on management and multiagency work. I became involved in the prevention agenda in the Early Help work.
6. I succeeded Emma Taylor, who was the Director for Children and Families (DCS)before me.
7. I make this statement in response to the Inquiries Rule 9 request of 18 December 2023.

Child Protection and Safeguarding

8. Local authorities have the overarching responsibility for safeguarding and promoting the welfare of all children within their area. This includes specific duties in relation to children in need and children suffering, or likely to suffer, significant harm. The Director of Children's Services (which is my role) and the lead member for Children's Services, are

key points of contact within local authorities and have both professional and political accountability for the effective delivery of these functions.

9. I should explain that responsibility for children's social care lies with the top tier of local government. This means it is the responsibility of County Councils, large Metropolitan Councils, and Unitary Authorities. Whilst second tier councils are expected to promote child welfare, they do not operate children's social services.

10. The most important of the statutory duties are to be found in the Children Acts, and, for ease of reference, I recite the relevant sections below:

(1) Section 17 Children Act 1989:

"*(1) It shall be the general duty of every local authority (in addition to other duties imposed upon them by this Part) –*

(a) To safeguard and promote the welfare of children within their area who are in need; and

(b) So far is consistent with that duty, to promote the upbringing of such children by their families.

(c) By providing a range and level of services appropriate to those children's needs.

(2) Children Act 1989, Section 47:

"(1) Where a local authority:

(a) are informed that a child who lives, or is found, in their area –

(i) Is the subject of an emergency protection order; or

(ii) Is in police protection.

(b) have reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm, that the authority shall make, or cause to be made, such inquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare".

(3) Children Act 2004, Section 11

"(2) Each person and body to whom this section applies must make arrangements for ensuring that –

(a) their functions are discharged having regard to the need to safeguard and promote the welfare of children; and

(b) any services provided by another person pursuant to arrangements made by the person or body in the discharge of their functions are provided having regard to that need.

Section 11 applies to Local Authorities in England, NHS England, and Integrated Care Boards and NHS Trusts. Throughout the relevant period (2012-2023) this section applied to both the Council and the Countess of Chester Hospital ("the Hospital").

11. Drawing upon good practice, the organisations mentioned in Section 11 (including the Council and the Hospital) should have had, throughout the date range, arrangements in place that reflected the importance of safeguarding and promoting the welfare of children. These include, inter alia:
    (1) a clear line of accountability for the commissioning and/or provision of services designed to safeguard and promote the welfare of children.
    (2) a senior board level lead, to take leadership responsibility for the organisation of safeguarding arrangements.
    (3) a culture of listening to children and taking account of their wishes and feelings, both in individual decisions and the development of services.
    (4) clear whistleblowing procedures, which reflect the principle of Sir Robert Francis's Freedom to Speak Up Review and are suitably referenced in staff training and codes of conduct, and a culture that enables issues about safeguarding and promoting the welfare of children to be addressed.
    (5) arrangements which set out clearly the processes for sharing information with other professionals and the Safeguarding Children Partnership ("SCP"), formerly the Local Safeguarding Children Board ("LSCB").
    (6) a designated professional lead (or, for health provider organisations, named professionals) for safeguarding. Their role is to support other professionals in their agencies to recognise the needs of children including rescue from possible abuse or neglect. Designated professional roles should always be explicitly defined in job descriptions. Professionals should be given sufficient time, funding, supervision and support to fulfil their child welfare and safeguarding responsibilities effectively.
    (7) safe recruitment practices for individuals whom the organisation will permit to work regularly with children, including policies on when to obtain a criminal records check.
    (8) appropriate supervision and support for staff including undertaking safeguarding training.
    (9) employers are responsible for ensuring that their staff are competent to carry out their responsibilities for safeguarding and promoting the welfare of children and creating an environment where staff feel free to raise concerns and feel supported in their safeguarding role.

(10) staff should be given a mandatory induction, which includes familiarisation with child protection responsibilities and procedures followed if anyone has any concerns about a child's safety or welfare.

(11) all professionals should have regular reviews of their own practice to ensure they improve over time.

(12) clear policies in line with those from the SCP (formerly LSCB) for dealing with allegations against people who work with children. Such policies should make a clear distinction between an allegation, a concern about the quality of care, or a practice or complaint. An allegation may relate to a person who works with children who has:

- behaved in a way that has harmed a child or may have harmed a child.
- possibly committed a criminal offence against or related to a child.
- behaved towards children in a way which indicates they may pose a risk of harm to children.

(13) all local authorities should ensure that allegations against people who work with children are not dealt with in isolation. I will cover this in more detail when I discuss the council's LADO service.

(14) employers and organisations should ensure that they have clear policies in place setting out the processes, (including timescales) for investigation of allegations against employees – with detail of what support and advice will be made available to them. Any allegation against people who work with children, should be reported immediately to a senior manager within the organisation. The designated officer, or team of officers, at the local authority should then be informed by that senior manager. The council has a referral form for this process. Organisations working with children, such as hospitals or schools, will be familiar with the process.

The Council – Structure, Role and Function

12. As a first-tier authority, the Council has diverse responsibilities ranging from highways to provision of adult social care. Given the nature of this Inquiry, I propose to focus my comments on structure and management on children's services and safeguarding.

13. As a preliminary matter, however, the Council is divided into three directorates:

- Community, environmental and economic services.
- Corporate services.
- Health and Wellbeing.

14. The Health and Wellbeing Directorate is where social services sit, and includes the Director of Children's Services (me), the Director of Adult Services (DAS)and the Director

of Public Health DPH). However, there are some unique arrangements in relation to Directors of Public Health.

15. The Council has a responsibility, as set out above, to provide children's and family services. This includes social care, education, inclusion and early help services. The primary roles are:
    - Children's Social Care.
    - Early Health and Prevention.
    - Education and Inclusion.
16. The Director of Children Services itself is a statutory role. There is also a lead elected member for children services, because it is a statutory requirement for each local authority to have a portfolio holder for it. In my time, I can recall four lead members – 2014 Mark stocks 2015 Nicole Meardon; January/February 2020 Robert Cernik; May 2023 Adam Langan. It's important to note that the lead member can change as a result of the democratic process. These are political roles so they do change more frequently than the administrative roles.
17. The day-to-day job for a Director of Children's Services is to have oversight of what is going on in children's social care; early help and prevention; education and inclusion. It is my job to ensure that we operate in accordance with the "Working Together" guidelines when dealing with the safety of children in the borough who are receiving services. In that regard, it is important to bear in mind that the "Working Together" guidance has been through several iterations. It was first published in 2010, then changed and updated in 2013, 2015, 2018 and 2023. I am told that Lucy Letby ("LL") was believed to be offending in 2015 and the first half of 2016. This means that the versions of Working Together in force at the time of the offending, were the guidance published in 2013 and 2015.
18. Returning to my role, responsibility for the safeguarding of children and young people is the primary function additionally the DCS has responsibility for sufficiency across the spectrum of service this includes foster carers, residential care placements and supported living arrangements for those who are care experienced . Additionally this includes sufficiency of school places and special educational needs provision and sufficient early years cover.
19. Relevant to this inquiry, however, is the question of safeguarding and the Director is responsible for overseeing that practice is responsive and proportionate. This means leadership, setting strategy, and examining the effectiveness of the each area of children services.
20. This inquiry is focused on one aspect of child safeguarding – the dangers from professionals who work with children. However, for completeness, the council's children

services also operate a "front door service" which receives referrals about harm to children. It is known as the Integrated Access Referral Team ("IART"). This is where concerns are referred by all sorts of agencies (including the police), and the general public. However, where we receive referrals about a professional who works with children, there is a statutory postholder responsible for directing investigations – the Local Authority Designated Officer ("LADO"). That person is responsible for directing investigations relating to professionals who work with children. Accordingly, if it was felt that a nurse represented a safeguarding hazard, the hospital would be expected to make a LADO referral. There is a specific form for this, and details of how to contact the LADO service are on the Safeguarding Children Partnership website (that would have been on the Local Safeguarding Children Board website before that). There is no restriction on who can make a report to the LADO service. It does not have to be the designated safeguarding lead, a senior police officer or a head teacher. Any professional who has concerns about safety to children can make a LADO referral. From experience, most LADO referrals come from schools.

21. At the time of LL's offending, the named LADO was Paul Jenkins. He remains in post and is still the council's named LADO. Prior to me taking up the Director of Children Services role, he used to report to the Deputy Chief Executive, Del Curtis. However, line management responsibility changed t when I came into post, and he now reports directly into me. This enables me to have closer oversight of the LADO activity.
22. Turning to the council's safeguarding responsibilities, I have alluded to the statutory duties above. Where it is suspected that a child has been harmed, it is our duty to progress a Section 47 enquiries (Children Act 1989) This would include a strategy discussion where a multi-agency group agree on the course of action. This inquiry is, however, about the safeguarding of children from a professional rather than safeguarding an individual child. Within a family setting, social care investigations would be directed at what was happening to an individual child. In a LADO investigation, about a professional, the question is what risks does that professional pose to children? For example, a middle-aged teacher who was sexually attracted to teenage girls, could represent a danger to children with whom they worked. In the event of a referral, the council's legal responsibility is to undertake an assessment of the scenario and to coordinate the investigations by other agencies – in particular, the police.
23. The state agency with responsibility for children is the Department for Education, which is responsible for guidance, and publications like "Working Together". However, the Department for Education is not mandated to take children into care. The state agency that can act, in order to protect children, is the local authority. The police clearly have powers to arrest where criminal offences are concerned and can take out police

protection orders. However, ultimately, the only agency which can take a child into care, is the local authority supported by the judiciary. However, the local authority undertakes an assessment and acquires information from other agencies involved with the family. Depending on whether we are dealing with an individual referral relating to a child, or a referral relating to a professional, it will go via the child safeguarding or LADO routes. LADO investigations can also uncover the need for individual child safeguarding. The DfE work closely with OFSTED who are the regulatory body for LA Childrens services.

24. The important point when it comes to safeguarding is that all the agencies work together, share information and share risk to safeguard the child. However, it is the local authority's responsibility to go through and lead the necessary legal process.
25. Turning to the various versions of "Working Together", these provide the legal framework for multi-agency work. They provide a platform for challenge across the partnership by myself or my team. It is an important document and something that the children's workforce is familiar with. It is a framework for all agencies to work.
26. If I became aware of a statistical 'spike', it would create some professional curiosity .In the context of the inquiry it is important to mention that it would not be unusual to see deaths in a neonatal units because they are often dealing with very vulnerable or poorly babies. However, if I became aware through the sharing of data at the SCP of increased death rates, depending on the circumstances, I may well ask them to seek information about this. I would have to consider if it was a LADO matter. The position is that I would be inquisitive and curious. If there was no easy explanation, we would have to consider whether it was a LADO matter – i.e., whether there was an individual professional involved in the issue. The point is that a statistical spike could be technological failure (a defective incubator), a public health issue such as an outbreak of disease, or it could be a change in systems that has an unintended consequence. The final possibility is, of course, that the spike is connected to a person, if so, it would be my view that it becomes a LADO matter. However, the starting point is to look at the spike and to think about which of the potential causes it might be.
27. The council is a statutory member of the local SCP. This is a collaborative arrangement where the key partners are:
    - The Council.
    - The Integrated Care Board ("ICB"); and
    - The Police.
28. This makeup is as a result of the changes in Working Together 2018 .
29. Prior to 2018, the SCP was known as the Local Safeguarding Children Board ("LSCB"). The membership at that time also included elective member representation and membership from voluntary third sectors.

30. The other significant change came in 2021 following the Wood review with the introduction of the scrutineer function in respect of multi-agency safeguarding arrangements.
31. The most recent iteration of Working together which was released in December 2023 requires one of the statutory partners to become the chairs. Here in Cheshire West and Chester we have agreed that I will take over the Chair of the SCP from April 2024 We will continue to require the scrutineer function, to enable the partnership to have independent assurance on practice in line with legislation across all agencies.
32. The SCP (and the LSCB before it), undertakes regular audit activity, to gain assurances of safeguarding practice across the partnership The SCP (and LSCB before) has a quality assurance group that looks at a range of qualitative and quantative data. This allows us to have an overview of data and trends. The quality and assurance group also checks the practices and procedures of agencies to ensure compliance with the regulations. They ensure training takes place and specifically that:
    - Training is pertinent and up to date.
    - It monitors the take-up of training across the agencies.
33. A significant amount of the SCP's work is about ensuring compliance across the agencies in line with Working together s.
34. The council does internal quality assurance of its own practices. There is regular analysis of data and trends. Recently we analysed the data behind growing numbers of children coming into care. We noticed an increase in in the use of Police Protection Orders (PPOs). We analysed 6 examples of this with colleagues from the police and then reflected on what alternative action could have been taken and what would be required in order to avoid a PPO being issued in the future.
35. This brings me back to the LADO. The council has a statutory responsibility to ensure that a LADO is recruited and is available to the partnership. He manages on behalf of the partnership all allegations against adults in respect of children across the council boundary.
36. The LADO service receives referrals. They then triage each referral. If they meet the criteria to investigate, the LADO will organise a multi-agency strategy meeting
37. If there is a need for an investigation, this is progressed. The LADO coordinate the investigation and make recommendations to the home organisation (the one that made the referral), about what to do next.
38. It is the council's responsibility to ensure that there is an independent LADO in place. The important part to have in mind with the LADO role, however, is that it is a referral point. The LADO does not investigate.

Safeguarding Arrangements

39. Turning specifically to healthcare professionals, the council's role is much the same as with teachers or any other professional group that works with children. The council provides a LADO service, of which the safeguarding teams in local hospital trusts are aware. It is anticipated that staff from healthcare settings y know how to make referrals.
40. The council does not have a specific duty to notify professional or service regulators.
41. However, it will do so if it is the relevant employer with a duty to report. If we had a LADO referral relating to a social worker which was then upheld, we would inform the national social work body. With regard to healthcare referrals, if the allegation was made out, the LADO would ensure that a recommendation went into the final investigation requiring the employer to notify. That said, where a child of any age has died, and there are safeguarding concerns, it is the council's duty to report the matter to OFSTED as a statutory notification. That is a report about the child, not the individual.
42. The LADO does not have a duty to report to regulatory agencies, that is the responsibility of the home organisation, the employer. If we are the home organisation (and it were a council employee who had been investigated), the notification would be made by Human Resources.
43. We undertake full data Disclosure and Barring Service ("DBS") searches on all new employees. DBS hits are matters for the manager who is proposing to employ someone. Council policy is that all eligible childrens workforce staff will have their DBS check redone every three years. If safeguarding concerns arise relating to the council's employees, we follow our HR policy for managing these concerns.
44. Turning to the role of partner agencies safeguarding, I have a limited knowledge of the NHS Safeguarding and Accountability Framework ("SAAF"). This is a matter for the ICB. I am aware it exists, but I could not give the Inquiry any detail about it. It will be a framework for safeguarding. It probably directs the interface with the SCP, but I cannot assist further.
45. The LADO work with hospitals is no different than for any other organisation across the children's workforce The referral process for the LADO is in place and can be found from the SCP website (previously LSCB). There is a referral point for anyone involved with children. This is the same for all hospitals. Indeed, the LADO does receive any referrals in respect of hospital staff. However, when a child is in hospital, it is often with its parents constantly. The opportunity to harm a child (as a professional or volunteer) is limited by comparison with say a school, in which teachers and classroom assistants do get unsupervised access to children. Access to the LADO is available to any healthcare

professional who feels that they have concerns worthy of reporting. Within a healthcare setting, I would expect all professional staff to know this.

46. There are no specific local authority policies relating to safeguarding babies in neonatal units. The hospital trusts themselves will have safeguarding policies and the council would expect them to follow those.
47. It is not the council's responsibility to develop procedures or policies related to safeguarding babies in any third-party setting, including hospital. The council's responsibility is to convene and work as part of the SCP and to provide a LADO service. Each hospital trust is required to develop its own safeguarding policy, indeed, the hospital (specifically a neonatal unit), is the organisation which has the knowledge of the safeguarding challenges and responsibilities within its control. The council does not provide neonatal hospital services and as such, could never bring the same degree of expertise that a hospital trust could. The council is required as a statutory partner, to participate and support the SCP in its policy development. If a hospital trust contacted the council for advice on neonatal safeguarding policies, we would direct them to the SCP business manager. It is not the council's role acting as a council. The council is involved in safeguarding for organisations through its membership of the SCP.
48. The council website does not contain any specific guidance relating to the protection of babies in hospital. However, there is a link to the SCP and information on safeguarding policies, safeguarding training and how to make a LADO referral. The council website is a broader resource which provides information on what to do if you think that a child has been abused. The website signposts the LADO process. Since the conviction of LL, I am not aware of any changes to safeguarding policy or procedures by the council.
49. The council is involved in multi-agency processes to learn from safeguarding issues through the SCP. They do all the multi-agency training and work. This is extremely important because there is yet to be an SCP investigation into the events surrounding LL. This issue needs to be considered, in light of the council's ability to interact with the inquiry. It is quite possible that the inquiry will deal with the need for learning out of the LL events. However, without a detailed understanding of precisely what the inquiry's approach is, and sight of the evidence it obtains (particularly from the hospital), the SCP will not be in a position to judge whether further investigation is required. This creates a difficult situation for the SCP because of its statutory responsibilities.
50. The SCP produces induction booklets and e-learning for agencies to use for safeguarding training. They are reviewed and updated by the SCP's quality assurance group. The multi-agency approach is extremely important, and the SCP's work is crucial. They do practice learning reviews, in bitesize lunch sessions and learning exercise. They

aim to push this out to individuals. All of this training and learning is done on a cycle. Training is driven through to schools, social workers, youth service, voluntary sector etc.

51. There is a need for some practice learning arising out of the LL case. At SCP level, this is currently 'on hold' because of the inquiry. The question is how can that be addressed.

The LADO

52. Council has a statutory responsibility to provide the LADO service. Our current LADO is Paul Jenkins.
53. The LADO receives referrals about adults who work with children and who may represent a safeguarding danger to them. Upon receipt of a referral, the LADO service will triage it – i.e., work out if there is anything in there that requires investigation. If there is, the LADO will convene a strategy discussion. They are required to take account of the learning which comes from a particular case, as part of the practice review. Paul Jenkins is very proactive in doing this work. He is working with a very well-established SCP and so there are good links.
54. I expect that the named LADO has had concerns relating to healthcare professionals reported to him directly. However, Paul Jenkins is best placed to provide this information – about what was recorded and how it was managed.
55. The LADO service does provide guidance and information to healthcare employers, and all organisations that work with children, to ensure awareness of prevention of harm. The LADO service conducts training sessions for those working or volunteering with children in healthcare settings. This is provided by the service rather than by Paul himself and also through the SCP.
56. As indicated, when a report is made to the LADO about potential harm to a child or baby, (irrespective of setting), there will be an initial triage and then a strategy meeting. It is important to bear in mind, however, that the LADO service is all about investigating the fitness of a particular individual to work with children. Safeguarding the child is undertaken by social services. This distinction is important. Accordingly, if a vulnerable 14-year-old was being groomed into sex by a geography teacher at school, we would expect the school to make a LADO referral. That relates to the teacher, the danger he might represent and his fitness to work with children. At the same time, upon learning that a 14-year-old girl had become sexually active, it is likely that there would be some social services involvement running concurrently. Allegations against adults are what the LADO is about. Protecting the child themselves is a different form of safeguarding.
57. The threshold for a LADO investigation is whether there is a risk of significant harm to children, or a child has suffered significant harm. If that is the case, there will be a full

investigation. Dependent upon the circumstances, there may be a need to urgently safeguard a child (such as the 14-year-old girl in my example), in which case the LADO will refer matters to police and social services. It is likely that both would be involved in the first strategy meeting in any event. However, separate referrals would be made by the LADO where necessary.

58. Most LADO referrals come from schools.

Child Safeguarding Practice Review Panels

59. It is the duty of the SCP to notify the Child Safeguarding Practice Review Panel ("CSPRP"), if a child in its area has died or been seriously harmed and abuse or neglect of the child is known or suspected. The council is involved as a partner on the SCP.
60. Where the SCP considers that abuse or neglect of a child has led to serious harm, it must consider whether to undertake a Local Child Safeguarding Practice Review ("LCSPR"). Previously, and at the time of LL's offending, the SCPs were known as LSCBs. Where there had been serious harm, where abuse or neglect was suspected, the old LSCB could commission a Serious Case Review ("SCR").
61. The role of the local authority is to have representation on the SCP and to participate in the review and in the review of the learning produced. My responsibility as a representative on the executive board of the SCP is to sign-off these reports before they are published, given to the coroner's court or submitted to the national CSPRP. Before that, the council's response is to have a relevant representative in any practice review process. It must submit paperwork and evidence of its involvements with a family. A relevant representative is somebody who has the experience of the type of problem which arose. It is important that Reviews involve safeguarding professionals. Generally, the panel needs to be made up of senior representatives.
62. The council will report matters to the national CSPRP where the underlying events fit the criteria for a safeguarding review. For example, if there was to be a repeat of LL's offending, that would meet the criteria for a LCSPR and would therefore be reported to the national panel. Where there has been a serious event, the SCP may hold a Rapid Review to get an early evaluation of events. This can reveal if it is necessary to hold an LCSPR. It is also necessary to notify OFSTED where there has been a death.
63. Where there has been a serious incident or death, the SCP (formerly the LSCB) has a discretion whether to undertake local investigations. There is a threshold document to guide practitioners on this. I am mindful that there has not been a Serious Case Review (as per the old arrangements) or a LCSPR in this case. That is a concern.

64. The Child Safeguarding Practice Review Panels are effective. The rapid reviews are very good and mobilised quickly. There is an openness to learning across the SCP. This reflects how matters used to be under the LSCB. We have managed to get to a point where the national panel is happy that we do all we can. It is good practice for learning to be disseminated within the SCP, especially amongst the key partners, however, there is some evidence that learning from these reviews is less evident in organisations at the periphery of the child service areas such housing trusts.
65. Schools and social workers do pick up the learning from our reviews. If this was to be improved, we would like better guidance around the delays that should be imposed around a criminal process. Whilst it is important that criminal processes proceed fairly, there is often a need for urgent safeguarding investigations and conclusions. This is a difficult balance to strike and in LL's case, the police were cautious about the sharing of information in the wider partnership and restricted access to information.

Child Death Review Meetings and Overview Panels

66. If a child dies in the council's area, we implement the SUDIC response. It is the same as the Rapid Response, for which the child death partners are responsible. It involves multiple professional individuals coming together to identify any gaps in what happened, or areas of good and bad practice. For example, when dealing with the death of a baby, a recent SUDIC investigation suggested that further publicity and guidance should be issued, warning against the dangers of co-sleeping with babies. The SUDIC process is about investigations relating to the child post-death. It is not normally a LADO issue, unless an identifiable adult (working in a professional capacity) has been identified.
67. The Cheshire LADO service does become involved in the SUDIC process because it has a quality assurance role as part of the safeguarding unit of the SCP. As such, it has some limited involvement.
68. The council's primary role in a Child Death Overview Panel ("CDOP"), is through its Director of Public Health. This used to be on a sub-region basis but there is now a pan Cheshire CDOP covering the whole county. I am unable to assist how they operated specifically, I am aware of their existence, that they meet, and I have seen CDOP reports. I have seen those reports in my role as the Director of Children's Services. I find that they contain a level of information which is broadly helpful.
69. The Cheshire CDOP panel is delivered in accordance with the National Statutory Guidelines "Child Death Review" and is a shared arrangement between organisations

within the geographical area covered by the Council, Cheshire East Council, Halton Borough Council and Warrington Borough Council. Funding for the panel is shared between the statutory partners in each area. Funding for the panel is used to fund an independent panel chair, an administrator, and more latterly access to the national CDOP IT system.

70. As part of these shared arrangements, the role of public health adviser to Cheshire CDOP panel is rotated between the participating local authorities and I provided this role between November 2016 and September 2021 (prior to this period, the public health adviser was provided by Cheshire East Council). Following this period, it is provided by Warrington Council.
71. During the period November 2016 to September 2021, the council's public health input to CDOP included:
    - Attendance at all panel meetings where cases were reviewed.
    - Providing advice and guidance on matters relating to public health.
    - Participating in child death review meetings where there was a specific need for public health advice.
    - Supporting the development of any actions coming from the CDOP panel – e.g., delivery of learning events, communications, campaigns etc.
    - Providing a point of contact between the panel and other departments within the council (for example where the panel requested further information from services other than public health).
    - Acting as a point of liaison and feedback to the directors of public health from the other local authority areas covered by the cheshire CDOP.
    - Supporting the governance and reporting process as part of CDOP.
    - Supporting developments and emerging CDOP process, e.g., renewed governance and funding arrangements.
72. Finally, I should like to emphasise that I was not the Director of Children Services during the period of LL's offending. At that time, I was the Director of Early Health and Prevention.
73. What is clear to me from events, is that the local authority's ability to act on referrals about dangerous adults depends very much on the home agency making a referral. Until the council is aware of events, there is limited action it can take, other than to ensure that relevant agencies know about the LADO reporting regime. Once something is reported, the LADO coordinates investigations and the SCP must decide whether a LSCPR is required. That decision has not yet been made in respect of the LL events. That will depend upon whether the SCP can be assured that the inquiry will ask the questions and see the documents that the SCP would regard as important for the investigative process.

In that regard, we must bear in mind that the SCP is staffed by child protection professionals. As such, they will have considerably greater experience of LCSPR style investigations than maybe available to the inquiry through lawyers.

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 April 2024