Witness Name: Paul Crispin Jenkins
Statement No.: 1
Exhibits: 2
Dated: 15.04.2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF PAUL CRISPIN JENKINS

I, **Paul Crispin Jenkins** will say as follows: -

1. Where the content of this witness 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.

Background

4. I am employed by Cheshire West and Cheshire Council ("the Council") as a Senior Manager for Safeguarding and Quality Assurance. I am the named Local Authority Designated Officer (LADO). I came into this post on 1 April 2014. Previously, I was the Head of Safeguarding and Quality Assurance in St. Helens and child protection co-ordinator in Wrexham. In both post I was responsible for the management of allegations against those in a position of trust.

5. By profession, I am a qualified and registered social worker. I qualified in 1989. I have a Bachelor of Science Degree, CQSW and a Post Graduate Diploma in Applied Social Science. Since qualifying I have worked for five local authorities in several safeguarding and child protection roles. I am an experienced child protection officer. The LADO is a statutory role which was first laid out in government guidance in 2006 and is referred to and included in the subsequent versions of the Working Together guidance – 2010, 2013, 2015, 2018 and 2023. The LADO role is governed by the local authority's duties under Section 11 of the Children Act 2004. The LADO is responsible for managing allegations against adults who work with children. This involves working with the police, children's

social care, employers and other professionals. It is important to understand that the LADO does not conduct investigations themselves. Rather the LADO oversees and directs investigations by other agencies – to ensure thoroughness, timeliness and fairness. To ensure impartiality, the LADO will not have direct contact with the adults against whom the allegation has been made, or the family of the child or children involved. However, it is the LADO's duty to ensure that both the adult and the families are kept informed regarding outcomes.

6. The council operates its LADO service in a slightly unusual way. Whilst I am the named designated officer, I rarely undertake the LADO function. There is a team of five child protection conference chairs who undertake the LADO function and report to me. They operate on a rota basis, dealing with the referrals. However, as there needs to be a named designated officer, that is me. The function is undertaken by my team. Child protection conference chairs are experienced social care professionals and undertake the LADO work well.

Background – The Council

7. As indicated, I am employed by the Council. The LADO service sits outside Children's Social Care because it is acknowledged that it requires a degree of independence from front line social work functions. When I started in the council, it was managed across Cheshire West and Halton within the remit of the Director of Children's Services, but not by the Head of Children's Social Care. It is now managed by the Director of Children's Social Care. Before, it was the Deputy Chief Executive – Del Curtis. That was a good position for the LADO service because of the degree of independence.

8. It is important that there is a degree of independence in the role, so that the LADO service can provide an effective challenge to the Council and the Safeguarding Children Partnership ("SCP"). We need to be able to ask the awkward questions and I am expected to. This is a privileged position within the council. There is variation between authorities as to how the LADO service is seen. Some LADOs regard themselves as local authority facing, others as SCP facing. This can cause some tension. However, the perception within the council is that I am the safeguarding interface between the SCP Partners and the local authority. This, of course, notes that the three SCP Partners are in fact the Council, the Integrated Care Board ("ICB") and the Police.

9. The LADO service also provides an annual report to the SCP.

10. I consider that the structure and governance of the council's LADO service is broadly right. We have a responsibility under the Children Act and Working Together to record allegations of harm to all children within the council's footprint. We undertake our statutory duties effectively. We have a statutory duty to have an effective and well-trained workforce that is overseen and trained by us. The council practices safe recruitment itself and works with partners to ensure that they have a safely recruited and managed workforce.

11. In a perfect world, I would like to be able to do more with the wider group of employers who work with children – more safe recruiting work. It would be useful to engage with some of these wider sector employers on a more promotional basis. We can support them in developing internal processes.

12. We do safe recruitment training, and our seminars are well attended. We must keep ourselves updated as new Working Together guidance is issued. We are now working through the changes from Working Together 2023. The original Working Together (2010) was very detailed and has become more streamlined over time. There have been some changes such as removing the 'suitability' criterion for adults working with children and then adding it back in. The LADO also needs to consider how behaviours in private life can affect professional life.

13. I am also an Officer of the SCP and was an Officer of the Local Safeguarding Children Board ("LSCB") previously. I attend all their groups and sub-groups. I report to them. Our way of working as a partnership operates well and that has translated into practice. Over the years we have seen a significant improvement in the multi-agency strategy meetings. We have a deep understanding of each other's core responsibilities and limitations. The strength and weaknesses are understood. The SCP (and the LSCB before), allows for effective and constructive challenge. Importantly, the safeguarding picture is joined up with no silos. At times police feel unable to release information and there can be delay in completing investigations.

14. The council's LADO role is to ensure compliance with statutory guidance – although delivery of the actual service is as I have described. Employers have easy access to LADOs to support them in safe decision-making following allegations and concern. We are

also there to give the SCP (LSCB before) the comfort that allegations are managed properly and in a timely fashion.

15. We work on the basis of a LADO Referral Form. This can be obtained from the council or SCP website. We use the form for first contact. We do not engage in pre-referral discussions. Our referrals are invariably from organisations, and mostly schools. We seldom receive a direct referral from a member of the public unless they have no recourse through the employer. In that regard, an individual clinician who was concerned, could make a LADO referral if their organisation was not doing so, and the clinician felt it was necessary.

16. Most LADO referrals come from schools. Although we see some from social care and we also have them from hospitals. When the referral arrives, it is passed to one of the duty LADOs to assess. They will decide if it meets the threshold for taking further, or whether it is a matter to close at that point. If it is to be taken further, the duty LADO will organise a strategy meeting which will involve the employer, the police and all other relevant agencies.

17. Turning to Lucy Letby's ("LL") offending, Alison Kelly completed a LADO form on 27th March 2018. That is one of our forms. (Exhibit PCJ1 [INQ0013064]).

18. Once we have the form we will respond in 24 hours, irrespective of the level of detail given in it. As indicated, any professional can make a LADO referral, although it is normally made by the Designated Safeguarding Lead, ("DSL") of the organisation. We do an internal triage at receipt. Most forms are completed by DSLs and the current hospital DSL at the Countess of Chester is Jill Cooper. Most of the LADO conversations with the Countess of Chester Hospital involved their safeguarding team.

19. When the forms come in, they got to whoever is the duty LADO that day. I speak with the LADOs every day. The team covers for each other. If we receive more than three referrals day subsequent referrals are allocated to another available officer. We know the hospital safeguarding team and I believe we have a positive working relationship with them, and recent feedback would evidence they feel supported by the team. To be clear, the LL offending involved the murder of children and is therefore a safeguarding issue which should be reported to a LADO.

20. We use a form-based approach to ensure that we keep a full audit trail of what came, when, what advice was given and how we responded.

Safeguarding Arrangements

21. When a LADO referral is made, including suspicions about an individual professional who works with children, this is dealt with at a strategy meeting – if the allegation requires that. The strategy meeting involves partner agencies, and an action plan is agreed. That might include jobs for the police (e.g. investigate offending behaviour) and jobs for social services such as safeguarding with the child or children concerned. The LADO service is required to monitor that plan and ensure that it is undertaken. I check that the results are appropriate. We would not normally feedback to the SCP (formerly LSCB) on an individual offender, unless something emerged from the individual's offending, which was part of a theme for the employing organisation. An example might be a school in which offending was able to take place because the head teacher did not drive proper safeguarding policies through the organisation.

22. The LADO service feeds back to the SCP (formerly LSCB) through an annual report. The report is data driven, but we try to extract themes and the impacts of LADO interventions in the report.

23. If LADO investigations revealed concerns about a particular hospital on an issue like safe recruitment, I would raise that through the SCP Quality and Assurance sub-group. I would also raise it with the Safeguarding Team at that hospital trust. I would not wait for the annual report, in order to do so. If there is an issue it needs to be raised. From experience, every professional who works in safeguarding, assumes that their judgement on a particular issue was correct. The SCP (formerly LSCB) has an ability to reflect that across a variety of partners.

24. When an employer makes a referral, it is not the role of the LADO to make a report to regulatory bodies – such as the General Teaching Council or the Nursing and Midwifery Council. It is the duty of the employer to make a referral to regulatory bodies. We routinely include that in the action plan which emerges from the strategy meetings. There will be a recommendation around referral. It is not the role of the LADO to submit the referral instead it is the LADO's role to ensure that referral is made by the employer if it is a recommendation in the strategy meeting. It is important to bear in mind that a strategy meeting is about working together to safeguard the children. That means actions relating

to safeguarding a child/children, together with actions for the employers and the statutory agency. A DBS referral is a matter for the employer.

25. As I understand the LL case, the police made a referral to DBS..

26. The LADO service regularly comes into contact with the police, and police investigations do flow from referrals made to us. We never struggle with getting the police to investigate or to take matters seriously, but it is a challenge to arrange meetings within statutory timescales. What we do struggle with, is the police keeping us updated with information about the investigation and ensuring that all enquires are completed within reasonable timescales. That, in turn, can cause drift in the strategy, with implications for both employer and employee. For example, if the police investigation drags, an employee may be suspended from their role for a long time. This particular problem was identified in a local government ombudsman report of the council's LADO service, which criticised us for delays caused by police activity.

27. Child protection processes can fail when professionals are faced with the 'unthinkable'. This is where multi-agency scrutiny, and a fresh opinion is important. However, this is speculation. What is concerning in this case, is that when professionals have reached the point of thinking the unthinkable, the matter was not referred to the LADO service.

28. When the issue was raised, I am aware that regular meetings took place involving the Council's Director of Children Services (Emma Taylor), the hospital and other agencies. I did not attend those meetings. Upon reflection, if the same events happened now, I would insist on being at all of those meetings. That would fit in with the LADO process. However, in my view there is an issue about the status of the LADO and where they should fit into complex high-level meetings. The problem from a LADO point of view was that the police effectively 'shut up shop' on the investigation and dictated all the steps. As a result, it fell out of the process. Whilst this is not ideal, it was acceptable (from a LADO point of view) because the person of interest had been removed from clinical duties and access to children. That meant there was no immediate safeguarding issue.

29. Turning to hospital safeguarding, I am aware of the NHS Safeguarding and Accountability Framework ("SAAF"). I have not read it and it is not part of the Working Together guidance specifically. Responsibility for children under the safeguarding legislation is the same, irrespective of whether they are babies, children, or teenagers. The duty is the same irrespective of setting. The prospective dangers and questions around safeguarding will be different, but the principal responsibilities are the same. In that regard, safeguarding

processes at a school would be different from safeguarding procedures within a hospital, because teachers and clinical staff interact with children in different ways and in different circumstances.

30. Turning to the Countess of Chester Hospital, the Safeguarding and Quality Assurance Unit works with them by attending the quarterly Think Family Safeguarding Steering Group.. Previously this group was chaired by Alison Kelly but at that time had a different name. I attend those meetings and feedback to the SCP (formerly LSCB) as necessary.

31. At the point the hospital thought it was appropriate to bring police in to investigate the increased rate of infant mortality, the hospital should have thought about a LADO referral. Broadly, when they were thinking about involving the police, it was time to make contact with my service. There were also opportunities to refer to the LADO service when the consultants expressed concern about LL and when the hospital decided that she would not do unaccompanied night shifts. These two points are less clearcut because at that time, it was not unreasonable for the hospital to wonder whether the increased mortality related to a clinical or systems problem. However, once they were thinking about the police, the position is pretty clearcut – there should have been a LADO referral. That said, it would have been after the event and would have made no difference to LL's offending.

32. I am not aware that the council had any process in place for safeguarding babies in neonatal units at the time of LL's offending. The reporting line with infant death would be through CDOP. We would have been involved in all rapid response meetings and the SCP would have undertaken rapid reviews if a serious incident notification had been submitted. When it comes to the safeguarding of babies in hospital, that is a matter which sits with the Countess of Chester Hospital itself. What the LADO service and the SCP provide is specialist advice on that. I am unaware of whether the council or SCP have adapted their policies in light of LL's conviction.

33. I do not believe there is anything on the council's website which relates to the specific protection of babies in hospitals. If there is a problem, clinicians have access to a designated doctor who is linked to the SCP and able to refer into it. The hospital should have made staff groups fully aware of what resources were available and who they could work with. The hospital would also have had a DSL.

34. I understand that consultants raised concerns about LL. The challenge for them is what should they have done next. As LADO, I would have expected them to escalate their concerns internally if they were not satisfied with the response any safeguarding concerns

could then be escalated out via the SCP Everyone involved in providing services to children should know that they can share information with the LADO service and escalate it. They can escalate it above me if they wished to do so. Good safeguarding relies on there being a culture in which practice around children can be challenged. I would expect to see a culture of challenge within the hospital.

35. The multi-agency learning which will emerge from LL's case is a matter for the SCP. In due course, it will be examined by the training and development sub-group. This may be as a result of a child safeguarding practice review by the SCP, or as a result of studying the Inquiry's output. Certainly, from a LADO point of view, we would want to look at compliance with training amongst doctors (hospital records included). We would want to look at exception reports to the SCP, of people not attending training. The LADO briefings are about raising awareness amongst professionals. We would want to know that the hospital staff knew how to make referrals, what the outcome would be. The SCP is running three sessions a year on referrals. It is free to members. The ICB can attend the training.

The LADO Referral Process (LL Case)

36. Under Working Together, the LADO must be contacted within one working day in respect of all cases in which it is alleged that a person who works with children has:
    - Behaved in a way that has harmed or may have harmed a child.
    - Possibly committed a criminal offence against or related to a child.
    - Behaved towards a child in a way that indicates that they may pose a risk of harm to children.
    - Behaved in a way that would suggest that they are unsuitable to work with children.

37. In considering the allegation, there are three strands which need to be considered:
    - A police investigation of a possible criminal offence.
    - Enquiries and assessment by Children's Social Care about whether a child needs protection or is in need of services.
    - Consideration by an employer of disciplinary action against the individual

38. As indicated above, the LADO does not conduct investigations themselves. Instead, the LADO is responsible for:
    - Providing advice, information and guidance to employers and voluntary organisations around allegations and concerns relating to paid and unpaid workers.

- Managing and overseeing individual cases from all partner agencies.
- Ensuring the child's voice is heard and that they are safeguarded.
- Ensuring there is a consistent, fair and thorough process for all adults working with children and young people, against whom an allegation has been made.
- Monitoring the progress of cases to ensure that they are dealt with as quickly as possible.
- Recommending a referral and chairing the strategy meeting, in cases where the allegation requires investigation by the police and/or social care.

39. The LADO is normally involved from the initial referral of the allegation through to conclusion of the case. The LADO is available to discuss any concerns and to assist employers in deciding whether they need to take any immediate management action to protect a child. All agencies must complete the council's agreed LADO referral form, apart from the police, who will refer using a VPA (Vulnerable Person Assessment), this is the standard document used by Cheshire Police and that has been agreed with the SCP.

40. On 5 June 2017, the hospital's Director of Nursing (Alison Kelly), provided a briefing to the LSCB about the hospital's review of neonatal deaths. It at this meeting that I first became aware Cheshire Police had been asked to assist the hospital in completing their internal enquiries. At this point, there was no information to suggest that concerns related to a specific individual.

41. I became aware that there was a person of interest in the investigation subsequently, but at that time no LADO referral had been made. I discussed the situation with the Director of Children's Social Care (then Emma Taylor) and she agreed to discuss it with the Director of Nursing at the hospital. The Director of Nursing passed the name to Emma Taylor and this information was shared with me.

42. On 27 March 2018 I spoke directly with Alison Kelly and confirmed the detail of the suspect. I indicated that a LADO referral was required. We discussed the detail of the current concern and what action had been taken by the hospital. I was assured that LL was no longer working directly with children and families. She was not employed in any other regulated setting and nor did she have children of her own. Accordingly, she was isolated from children.

43. It was agreed that no formal meeting would be held at that time, and we would monitor the ongoing police enquiries. I confirmed this position with Cheshire Police and Emma Taylor.

As I say above, it can certainly be argued that a referral should have been made when clinicians expressed concerns about LL or when she was removed from night duties. From a LADO perspective, I would prefer a report, which we could triage and make a decision on rather than no report at all.

44. On 11 July 2018 I had another telephone conversation with Alison Kelly and it was confirmed that LL had been arrested and interviewed under caution, but released on police bail. It was agreed we would proceed to a formal LADO strategy meeting. That took place on 27 July 2018 and was chaired by the allocated LADO Allison Roberts. An action plan was agreed. In essence, whilst the police investigation was ongoing, we would not convene routine review meetings, as we were assured that the bail conditions meant there would be no contact between LL and children. She was continuing to receive support through the hospital trust. It was agreed that at strategic level, agencies would be met to update on progress – Director of Children's Services, NHS England, the Trust and Cheshire Police. With hindsight, as LADO, I should have formally requested to be a party in these strategic meetings. I was dependent on feedback from those in attendance because I did not have access to the minutes or action plans.

45. On 11 October 2019 the LADO [Simone Taylor ST] spoke with Cheshire Police to see if there had been any developments in the progression of the investigation. There were no significant changes noted in the police position and the bail had been extended. The Senior Investigating Officer indicated they would update me if there was any change to the police view. At this point, the LADO had not been provided with a single point of contact in NHS England, despite requests in the summer of 2019. This was being tracked by Emma Taylor, the DCS. As LADO I liaised with her for updates.

46. On 11 November 2019 ST spoke with the Senior Investigating Officer at the police. There was no progress to report. The Crown Prosecution Service was still considering evidence and requesting further expert reports to be submitted to inform the decision making. The Senior Investigating Officer promised that they would advise us of any changes in the case.

47. On 24 January 2020, ST received information from the police that LL was to be bailed for a further period of time into the late Spring. This would be very much dependent on the CPS prosecution decision. The bail conditions remained as set. I contacted the police again on 30 March 2020. I was told there was no outcome yet because the CPS decision was pending. I shared this information with Emma Taylor. On 4 September 2020, I

requested an update via telephone but received no response. On 23 October 2020, no information was available from the police and Emma Taylor informed me that the LADO could not track this case in the usual way, due to the nature of the investigation and the pending consideration of the Crown Prosecution Service. We agreed there were no new risks and risk was managed via bail conditions.

48. On 12 November 2020 LADO [ST] saw news reports that indicated LL had been arrested and charged with eight murders and 10 attempted murders of babies. There was no bail and she had been remanded in custody – location unknown. I verified these news reports with Emma Taylor, because we had not been updated by the police or the hospital trust. On 20 November 2020, LL appeared in court and offered no plea. There was no change in circumstance. It was agreed that the LADO strategy should be to call for updates from the police to inform the LADO process. NHS England was to be invited. This raised the question of whether the process could be ended as LL was now in custody.

49. On 10 December 2020, a LADO review meeting took place, the police only attended. There was no representation from the hospital or NHS England. There was a discussion between the LADO and the police. Given that LL had been charged, there was discussion about ending the LADO process at that point. I felt the matter needed to be kept open until the criminal prosecutions were completed and any subsequent actions – i.e., internal enquires, or reference to regulatory bodies and the DBS. The police provided an update that the trial would hopefully be in 2021, but that other lines of enquiry were being followed. LL had been suspended by the Nursing and Midwifery Panel pending the outcome of the court case. The DBS had been notified by the police. It was agreed that we would review matters once the outcome of the trial was known.

50. On 17 December 2020, LADO agreed that the referral should remain open until the criminal proceedings were concluded. It was not appropriate for the LADO to pre-empt the court outcome. Contact was made with Alison Kelly, Emma Taylor, and NHS England to update on this decision. We agreed the LADO process would remain open until the criminal proceedings were concluded. On 4 January 2021 there was a further discussion as to whether the LADO process should continue. It was decided that it should, but it was not appropriate to request updates from agencies as the matter was before the court and would be dictated by a court timetable. LL remained in custody (whereabouts unknown) and NHS England had ceased to be directly involved. However, LL remained a hospital employee. Contact was made with the North Wales Safeguarding Children Partnership as some of the babies were believed to be from Wales. Cheshire Police had not notified the

relevant local authority (Flintshire). The LADO shared information regarding the current position and progress. Management would be through a joint SCP meeting process.

51. On 2 March 2021, the LADO was advised of the outcome of a meeting of the Welsh SCP. Agreements were reached for information sharing. I asked them to share information relating to their LADO process. I spoke to the senior manager by telephone and shared what information we held. I explained we were waiting for enquiries to be completed and provided contact details for the Senior Investigating Officer so that they could request information to ensure that Flintshire families were being appropriately supported. This information should have been shared with Flintshire at the initial stage of involvement. It was known that children from Flintshire had also died but we assumed that the hospital trust or Cheshire Police would have shared this. However, that was not the case. Upon reflection, it would have been wise to have had a LADO-to-LADO discussion at the time. That is normal practice where an employer works across local authority boundaries.

52. The referral would remain open until the trial was concluded.

53. On 18 August 2023, LL was convicted. In September 2023, the SCP and the LADO reviewed the information from the trial. I had a discussion with the current DCS (now Helen Brackenbury) and the Deputy Chief Executive as to what assurance if any should be sought and received from the hospital trust. The referral was formally closed in January 2023 in consultation with the police and the trust. Based on the outcome of trial and fitness to practice hearings, there was no further need for LADO involvement. This was agreed despite knowledge of the appeal and ongoing criminal enquiries. Should the appeal throw up concerns about the prosecution and conviction, the Senior Investigating Officer has agreed to refer to the LADO.

54. Whilst looking at this sequence of events, I have also reviewed the LADO referrals received from the hospital trust since 2015. (Exhibit PCJ2 [INQ0013028, INQ0013032, INQ0013033, INQ0013034, INQ0013035, INQ0013036]). There is a small number, and they refer to concerns about the behaviour of or incidents in the private life of hospital employees. An example of this is a hospital employee who was the victim of domestic violence. These referrals were appropriate, given the possibility of unobserved or unsupervised contact with children at work. I have also sought assurance from the hospital that the LADO process is understood by staff and followed. The interim head of safeguarding has provided that assurance. Overall, my experience of working with the

hospital trust has been positive. I have been allowed to attend strategic safeguarding meetings at the trust and the LADO service has worked well with them historically.

The LADO

55. I work with designated safeguarding professionals in a wide range of organisations, but through the SCP (the LSCB before). With healthcare professionals, that is work with the ICB, local hospital trusts and commissioned services who are members of the same groups within the Safeguarding Children Partnership as I am. With regard to the COCH Trust my main contact is Jill Cooper. With the ICB it is Sue Pilkington. We are all members of the same SCP groups. I attend all of these sub-groups and we work on auditing together. We work on the audits together in the Quality Assurance and Scrutiny Group. This is the merged Data and Quality Assurance Sub-Groups of the LSCB. It was felt that by combining Quality Assurance with data analysis, the partnership gets a better view of practice.

56. The LADO service does provide guidance and information to healthcare employers around awareness of our services, prevention of harm and safeguarding children. The majority of concerns that are referred to us, however, relate to the private lives of healthcare professionals. I have mentioned above that we have seen instances of this where healthcare professionals have been either the victim or perpetrator of domestic violence. The question is whether the personal life impacts on the professional life. Referrals lead to strategy meetings or possibly a consultation with the organisation. Looking at the referrals for the Countess of Chester, I have found five. This is a small number given the size of the workforce. It shows, however, that that hospital was well aware of how to make LADO referrals.

57. The LADO service does provide guidance and information to healthcare employers. We also conduct training sessions. The LADO service is certainly well known. The issue here is about being visible. One matter about the LL issue that I am curious about, is why the consultants went to the Director of Nursing (Alison Kelly), rather than the safeguarding team and the designated lead in the hospital? I would normally expect them to take that route. I feel that there is probably learning for the hospital there.

58. If a concern is reported about someone harming a child or baby in a healthcare setting, the first question we have to ask, is whether the threshold has been met. For that, we need evidence that a child has been harmed or that the professional acted in a way that put the child at risk. There is likely to be a criminal offence involved in that. There is also a

threshold met if someone is behaving in a way which suggests that they are unsuitable to work with children. An example of this would be a 40-year-old male teacher who engaged in graphic sexual conversations with teenage female students. Once the threshold is met, we convene the strategy meeting with the employer, the police, and any other relevant agencies, together with the local authority.

59. Specific referrals about behaviour are relatively clearcut, the question of unsuitability to work with children is less precise. When we look at suitability, behaviour and often social media are in the mix and when social media posts are of concern this can be complex. We seldom never rebuke employers for making inappropriate referrals. We deal with all of the referrals. We consider them and apply our threshold.

60. When a concern is reported, child safety is achieved by involving the relevant agencies – the employer, police or local authority. The only outside agency with which we routinely engage is OFSTED. We do at times engage with the Care Quality Commission (CQC). We do that where concerns are raised around a CQC registered organisation in the community. An example of this might be a private sector provider dealing with specialised children accommodation for ages 16 to 25. They are regulated by the CQC. Finally, we also on occasions liaise with police professional standards. The strategy meeting should involve every agency that is involved with the employee and those linked to the child alleged to have been harmed.

61. It is possible to interrogate the LADO annual reports to identify the number of healthcare related referrals. However, the data only goes as far as the fact that it came from a healthcare source rather than any other. It is not broken down to setting level.

Child Safeguarding Practice Review Panels

62. The LADO service can become involved in Child Safeguarding Practice Reviews. I am involved in those reviews, but not in my LADO role. I notify the National Child Safeguarding Practice if the threshold for notification is met – a serious incident to a child that has caused injury or death. I will seek out information from the partners on this. I also attend the SCP's rapid review meetings as a Safeguarding Manager. Every rapid review meeting is triggered by a referred to the national panel. Often the rapid reviews (which take place in the two weeks after the notification) provide enough information for the Child Safeguarding Practice Review Panel.

63. I find that the rapid reviews are conducted openly with a willingness on the part of all partners to learn what has happened and apply that learning as appropriate.

Child Death Review Meetings and Overview Panels

64. In Cheshire West, there is no formal role for the LADO in the CDOP. If there has been an unexpected child death, the Child Death Review Partners (who are part of CDOP), can convene a rapid response meeting. That is convened by the designated professionals with support of the police. If there is a rapid response meeting, I will become involved as the local authority representative. We discuss the circumstances of death. We decide whether these circumstances are such that it needs to be referred to the SCP for review. We will also enquire whether any of the key partners intend to refer to the national panel. The rapid response meeting needs to move very quickly and takes place within five days.

65. The council's LADO is not routinely considered to be one of the child death review partners. However, I am involved because of my other roles.

66. The council has a representative on the CDOP. I am only involved in the rapid review process. CDOP is a Pan-Cheshire meeting.

67. The Child Death Review Partners and the CDOP operate as they should in Cheshire. Where unexpected child deaths happen, there will be a rapid response. Generally, if a child death happens in a hospital setting, it is less likely to be 'unexpected' because the child was in hospital for a reason. However, if the death was not expected, (and we would learn that from the hospital), there will be a rapid response meeting.

68. A possible outcome of reviews into the LL offending may throw up some questions around neonatal deaths and whether they are 'expected'. If not expected, we would examine it on a rapid response. However, given the nature of neonatal medicine, it is possible that hospitals do not immediately recognise that a neonatal death is unexpected. Sometimes there are sudden and unexpected collapses of babies. As such, there may be something to tighten up in a greater willingness to classify neonatal deaths as unexpected.

69. The panels do work effectively. If a child dies within the Cheshire footprint, agencies will be notified by CDOP. If the death is expected, there will not be investigation. Accordingly, we are reliant upon the hospital to make a judgement on whether the death was expected/unexpected in a neonatal setting. The LADO does not have a role in this until

there is evidence to link events to a person. My personal involvement in this comes as a safeguarding quality assurance manager at the local authority.

70. There is an effective and joined up SCP (formerly LSCB) in Cheshire. The agencies work together well, and I believe the LADO service is efficient and operating appropriately. All of these agencies were involved after LL's offending.

71. That said, it is my view that once hospital employees started to suspect an individual, a LADO referral should have been made.

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

_____

15 April 2024

Dated: _____