Witness Name: SIAN LOUISE JONES
Statement No. 1
Exhibits: 12
Dated: 16.04.2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF SIAN LOUISE JONES

I, **Sian Louise Jones** 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.

Introduction

4. At the time of making this statement I was employed by Cheshire West and Chester Council ("the Council") as the Safeguarding Children Partnership ("SCP") Manger.
5. I started work for the Council on 1 April 2014. At that time, I was the Business Manager of the Local Safeguarding Children Board ("LSCB"). The LSCB was the predecessor to the SCP. In October 2017 I left the Council's service and worked in Wolverhampton for a period of 12 months. I returned to Cheshire West Council in September 2018 as the LSCB Business Manager. I held this role until the transition under "Working Together" 2018 when the LSCB became the SCP. Since July 2019 my role has been entitled Safeguarding Children Partnership Manager, but the role and responsibilities remain largely unchanged from when I was the LSCB Business Manager. I left Cheshire West and Chester Council on 28th February 2024 to undertake work in another Authority.
6. I have referred to both the LSCB and the SCP. The change from Local Safeguarding Children Board to Safeguarding Children Partnership occurred following the issue of "Working Together" 2018. That document is statutory guidance issued by government which covered multi agency working for safeguarding children. There have been a number of versions – "Working Together" 2010 (Exhibit SLJ1 [INQ0013232]), 2013 (Exhibit SLJ2

[INQ0013234]), 2015 (Exhibit SJL3 [INQ0013235]), 2018 (Exhibit SLJ4 [INQ0013233]) and 2023 (Exhibit SLJ5 [INQ0013219]).

7. The main change from LSCB to SCP has been a move from the Local Authority leading the arrangements to equal accountability from three statutory partners – the Integrated Care Board ("ICB"), the Police and the Local Authority. Locally, this was not a big change because the LSCB was considered to be working well (as is evidenced in the Ofsted Inspection of Children's Services and Local Safeguarding Children Board 2015 and the Joint Targeted Area Inspection 2017). There was a slight change to the governance arrangements with the implementation of Working Together 2018, and a change to the titles and acronyms but this was minimal.

8. By profession I am a trained and qualified Probation Officer. I had progressed to a Senior Probation Officer. I chose to leave the Probation Service at the point that privatisation was planned as I was uncomfortable with that arrangement. I had been a Safeguarding Lead in the Probation Service, so when I saw an advert for the LSCB Business Manager it felt like a natural progression.

Background

9. My role was very much partnership facing. I was rarely involved with Council only activity. Some of the Council's representatives (e.g. LADO and Children's Services) required input from SCP partners. Where the Council's role interfaced with me was the requirement for engagement with the Safeguarding Children Partnership. The first such Partnership arrangements would have been developed around 2006. They were embedded by about 2009. The old Cheshire County Council was disbanded, and two new authorities (Cheshire West and Chester Council and Cheshire East Council) were set up that year.

10. Under the old LSCB arrangements there was a Lead Elected Member for Safeguarding Children who would attend meetings of the LSCB as a Participating Observer. There is no Elected Member representation required within the current Safeguarding Children Partnership arrangements. I believe the arrangements have been designed that way because it is too prescriptive and now requires equal accountability across the Integrated Care Boards and the Police (although links between the SCP and Elected Members continue through themed scrutiny sessions as relevant and quarterly meetings between the SCP Independent Scrutineer, Chief Executive of the Council, Lead Member and the Director of Children's Services).

11. My direct management sat within the Safeguarding and Quality Assurance Unit of the Local Authority. Paul Jenkins was my Line Manager. He was also the Council's named LADO (Local Authority Designated Officer). The Safeguarding and Quality Assurance Unit was independent of Children's Social Care and at the time was managed by the Assistant Chief Executive.

12. Paul had been my manager since 2014. I perceive that I have a good level of independence from the local authority. This is afforded by the Council and local partnership structures and governance. I was also managed outside of Children's Social Care and regularly meet with statutory partners. I was able to check and challenge the Council and others as a critical friend. I was able to challenge all of the SCP partners equally. The fact the Local Authority gave me permission to reflect all voices equally is important. This is not universally true of SCP's and I have observed different practices in other areas.

13. The SCP itself is made up of three statutory partners plus other "relevant" agencies. The statutory partners are:

    - The Local Authority (here the Council)
    - The Integrated Commissioning Board – ("ICB"), representing health
    - The Police

14. Underlying the work of the LSCB and subsequently the SCP is central government guidance – "Working Together". There have been five versions of this guidance; 2010, 2013, 2015, 2018 and 2023. I understand that Lucy Letby ("LL") is likely to have been offending in 2015 and the first half of 2016 – a period of roughly 18 months. I appreciate there can be no clarity around this. However, it is worth identifying the time period because it means that the versions of "Working Together" applicable during the offending period were 2013 and 2015. There have been changes to "Working Together" but the fundamental principles remain the same – derived from the Children Act 1989.

15. Under the Children Act 1989, Local Authorities have duties to promote the safeguarding and welfare of children. This is also seen in the Children Act 2004. Section 11 places duties on Local Authorities, the Police, NHS and various other agencies to ensure that their duties are discharged having regard to the need for safeguarding and promoting the welfare of children. This, together with other legislation means the Council has to provide Social Care Services. The Section 11 duty is extremely important, and SCP's will undertake Section 11 audits of local agencies. The SCP is looking to seek assurance via these audits that services are complying with safeguarding expectations. We need to

ensure that arrangements exist for sharing information with the SCP (formerly LSCB), and between the SCP, other boards/partnerships and other agencies as appropriate.

16. "Working Together" in any iteration requires statutory agencies to work together to safeguard children. No one agency can safeguard a child. For obvious reasons the 2010 guidance was the most impactful because it was the first. The LSCB was Independently Chaired by Gill Frame form 2014 until 2018. She remained in post until 2019 having supported the transition from LSCB to SCP.

17. Under "Working Together" 2023 the SCPs are no longer required to have an Independent Chair but are required to have Independent Scrutiny. Paula St Alban is currently the Independent Chair and Scrutineer but will move to be the Independent Scrutineer when Helen Brackenbury (current DCS) takes up chairing responsibility for the SCP later in 2024 as per the requirements of Working Together 2023. The new rules require the SCP chairs to be drawn from the statutory partners. It does feel like there has been an extended period of change around the safeguarding legislation since 2018.

18. The thresholds for intervention in respect of any child is based on a "continuum of need" across services which is ratified by the SCP. In theory, as the child's needs increase so should the support. This framework is predominantly focused on the response that a child requires due to the needs or risks within the family or as a result of harms outside the home in the form of exploitation, serious violence, etc. The framework requires agencies to work together and that is what the regulations aim to achieve. In Cheshire there is also a Child Death Overview Panel ("CDOP") as well as the LADO and the Local Safeguarding Children's Board were required to conduct Serious Case Reviews. All of those arrangements were in place. Since the change to SCP, Serious Case Reviews have been replaced with Local Child Safeguarding Practice Reviews ("LCSPR") although the criteria for reviews remains largely unchanged, it is more the process of conducting the reviews that was updated by Working Together 2018.

19. Where a child's death is concerned, the SCP can undertake a rapid review if criteria is met. The Child Death Overview Panel ("CDOP") can undertake a rapid response meeting. Whilst these reviews sound similar they have different purposes. This is specified in "Working Together". I have no experience of the CDOP operational role. I have never sat in the CDOP meetings. I have only received a rapid response set of minutes where they have been relevant to a Rapid Review meeting being conducted by the SCP.

20. Before the 2018 version of "Working Together" CDOP was the responsibility of the LSCB. After 2018, responsibility was moved to the new Child Death Review Partners – the Local Authority and the ICB. Locally arrangements are led by Public Health for the Local

Authority and the ICB; I understand the rationale is that CDOP has a focus on preventable deaths (or what is also referred to as "modifiable events"). In other words: what factors could be modified to prevent another child death? Those are normally public health issues for example, car seat usage, smoking in pregnancy, health and lifestyle issues. This change towards Public Health marks a greater shift to a health agenda for CDOP.

21. This raises the question of whether CDOP as it is currently constituted, might have spotted events from death statistics and detected LL earlier. The difficulty is that until such time as a pattern specific to a setting or increased mortality could be identified it may be difficult for a multi-agency arena such as CDOP to see this due to the way in which information was processed at the time. I am aware of reporting which suggests that a group of clinicians had suspicions about LL in 2016. Those suspicions related to an individual and so should have been reported to the LADO. They could also have escalated their concerns to the LSCB or via Whistleblowing procedures.

22. There are subgroups within the SCP: a Training and Development Subgroup which looks at the multi-agency training needed by agencies which make up the partnership and seeks assurance about who attends and who does not. That group conducts a Training Needs Analysis with single agencies to develop a view about strengths and gaps in single agencies safeguarding training and the multi-agency safeguarding training needs.

23. The Quality Assurance Sub-Group meets quarterly. It receives a range of information e.g. multi-agency data, and single agency assurance reports. For example, the Safeguarding Children in Education team (responsible for 163 schools) routinely sends in a report offering an overview of safeguarding issues in education. Under the 2018 Regulations, the Quality Assurance Group was merged with the Audit and Case Review Group (which receives reports on audit activity of operational practice) so that the members could triangulate data with practice issues. This group is now called the Quality Assurance and Scrutiny Group and has met monthly since August 2023.

24. There is also a Pan Cheshire Policy and Procedure Group. That group ensures policy and practice guidance is in place at a sub-regional level. There are also some local policies that each LSCB and now SCP is responsible for keeping up to date. It is for each local SCP to seek assurance that all agencies have safeguarding policies in place and that they are adhering where relevant to the local and sub-regional multi-agency policies.

25. There is a small degree of overlap between children's safeguarding and the safeguarding of adults. The SCP meets every other month with the Adult Safeguarding Board and the Community Safeguarding Partnership. However, the SCP's responsibility is children pre birth to age 18. Whilst the SCP has policies that are baby related, they mostly relate to

factors that would give rise for concern about the welfare of babies in the care of their parents or wider family; one such example is the Pre-Birth Assessment Policy another is Non-Accidental Injury in Babies and the ICON programme. ICON is targeted information to reduce the incidence of abusive head trauma. What the SCP does not have is a specific set of guidelines or single agency scrutiny that is specifically applicable to a maternity ward. It is the single agency's (the Hospital Trust) responsibility to have maternity ward safeguarding policies and to offer that assurance to the SCP via the processes I have described above i.e. the Section 11 audit. The SCP involvement would be triggered by a serious incident notification following a death of or significant harm to a child as a result of abuse or neglect; at which time the Rapid Review process I described earlier would commence. Whilst the Rapid Review (SCP) and Rapid Response (CDOP) processes may happen in tandem and some members of the meetings are the same, they do have distinct and separate roles and functions.

26. Since the inception of LSCBs, guidance on safeguarding has tended to focus on harm and abuse caused by carers and acquaintances of a child; more recently there has been a shift in requirements to consider the harm peers and others can cause to children outside of their homes. There is nevertheless policy and guidance in respect of Allegations of Abuse against Professionals (LADO) and Whistle Blowing Policies in place to raise concerns about those who are in positions of trust working with children and they would be relevant to this set of circumstances. At the point that any professional had suspicions that it may have been another professional causing harm to the babies, these processes should have been triggered.

27. Our interface with the LADO has not changed with the shift from LSCB to SCP. The named LADO is Paul Jenkins. The Council has an arrangement where the LADO service is covered on a rota basis and there will always be a LADO available. The individuals who cover are Child Protection Conference Chairs. The rota is based on days and ensures consistency. The system was already in place when I joined in 2014 and sits within the responsibility of the Safeguarding and Quality Assurance Unit. My main interface point with the LADO is via the LADO Annual Report presented to the SCP. We have also had bi-annual reports (for emerging themes) in the past. We thought this might have assisted with matters such as allegations against professionals arising from a lack of education in specific workforces e.g. unsafe holds. That type of allegation would normally come through a LADO and seeing reports every six months had the potential to assist in us addressing practice more efficiently, but this level of reporting has been inconsistent, particularly during Covid.

28. The SCP provides LADO training (amongst other safeguarding topics) to frontline professionals, delivered by the LADOs. The training covers processes around referral to LADO, responsibilities on employers and the outcomes from the LADO. It is multi-agency training targeted at the Designated Safeguarding Lead (DSL) within organisations that work with children, including the third sector/voluntary sector and statutory partners. In that regard, a DSL is only going to be effective if the staff on the ground know what to look for and how to communicate their concerns and this should be covered as part of the safeguarding training within their own organisations.

29. We did not have responsibility for single agency safeguarding training; that can be directly commissioned (for a charge) from the SCP or other providers, and most statutory partners already have this in place. Both the LSCB and SCP made training available including LADO training. If necessary, I could audit the attendance of this.

30. It is important that DSLs cascade safeguarding information down through organisations, including the whistleblowing policy.

31. Sometimes professionals do disagree with each other about whether a safeguarding matter should be brought to the partnership or referred to a LADO.

32. It is the responsibility of all professionals to act in accordance with safeguarding statutes. Policies should be in place so that new starters, when inducted into organisations, are trained on them. It is important that there is a culture of support within organisations to raise concerns and make referrals when necessary.

33. The SCP (formally LSCB) has a wide range of training available across a range of topics e.g. neglect, child exploitation, working together. There are also e-learning courses available.

34. Staff from the Countess of Chester Hospital would have attended various of these safeguarding sessions over the years. It will be possible to undertake an attendance check on that. Health colleagues have also been heavily involved in both the delivery and attendance at pre-birth training courses, but as noted above this would not have been relevant given the nature of the harm presented by LL.

Safeguarding arrangements

35. Reports or suspicions about professional people who work with children go to the Council's LADO. They are not initially a matter for the SCP, information remains confidential to the

LADO and the SCP receives information in the form of data, themes and learning arising. It is the employer's responsibility to make a LADO referral.

36. If a particular issue arose (say a cluster of reports in the same setting), it is possible for the SCP to have an extraordinary meeting to discuss. It is not uncommon for organisations and professionals to also share information with the SCP where extraordinary concerns have arisen. In other instances, concerns shared are more routine concerns that need to be redirected to the appropriate place e.g., referrals in respect of a specific child would be a children's social services matter and directed at the Council unless it was part of an escalation. Concerns relating to an adult who works with children are a LADO matter.

37. Personally, I first became aware of the concerns at the hospital in June 2017 when the neonatal review was reported to the LSCB. Alison Kelly did a presentation on it and that was the first information shared with the partnership which suggested cause for concern. At that point, it did not appear to relate to an individual. I do not recall there being an extraordinary meeting at any point that an individual was being considered to potentially present the risk. Individual member agencies may have participated in meetings but this was not raised at the SCP until after LL's arrest at which time I am aware there was a group formed involving the hospital, the Police and the Council and the SCP was provided with regular briefings, although these contained minimal detail given the nature of the investigation.

38. In my roles at the LSCB and subsequently SCP, I was aware that the NHS has a range of safeguarding assurance and governance systems in place e.g. NHS England, Clinical Commissioning Group (now Integrated Care Boards) and the Care Quality Commission (CQC). I cannot comment other than in general terms how the LADO service works within hospitals. It is very much referral dependent but should be in line with the local process.

39. As to neonatal safeguarding at the hospital, the SCP undertakes Section 11 audits of organisations that work with children. It looks to all its relevant agencies / partners to complete these. The Section 11 audit requires partners to submit documents to support their answers including relevant policies and procedures. Within health, there is a Designated Safeguarding Nurse in the ICB (formerly Clinical Commissioning Group – CCG) as it has commissioning responsibilities. When an NHS Trust does a Section 11 audit that information filters through the Designated Safeguarding Nurse role for their assurance and then comes to the partnership, this prevents duplication. The SCP will also have considered the policies that emanate from the ICB (previously CCG) as part of their Section 11 response. A Section 11 Audit should take place every two years. In between the audits the SCP expects to be updated on actions arising from the previous one. This

is work undertaken through the quality assurance officer and into the Quality Assurance and Scrutiny Group of the SCP. I can confirm that Countess of Chester Hospital complied with Section 11 submissions.

40. The SCP did not have a direct role in developing policies or procedures within individual hospital trusts.

41. The SCP (previously LSCB) seeks assurance from single agencies that work with children through a range of audit activity. Section 11 is one example but we also run multi-agency audits and the hospital would contribute to those depending on the nature of the audit theme e.g. pre-birth assessments, self-harm, etc. The safeguarding duty clearly includes babies, and also takes account of risk of harm from parents/carers as the hospital will support the family in the maternity unit as well. Beyond questions of safer recruitment, proper induction and whistleblowing policies, the SCP does not have specific materials on the vulnerability of babies in hospital - that I am aware of. There is no specific SCP guidance about the protection of babies in hospital from staff. The Council's website and the SCP (and former LSCB) signpost that allegations against professionals should be referred to the LADO. The important part is that the hospital staff understand their single agency procedures and specifically, when to report concerns. The safeguarding leads should then know where to pass these on to – Children Social Care if it relates to a child, the LADO if it relates to suspicions about adult professionals. However, responsibility for developing safeguarding policies for children in hospital lies with the hospital. The SCP may review these policies as part of the Section 11 audit.

42. The SCP has not changed any of its policies in light of LL's conviction as far as I am aware. I do not know if that is the case in relation to CDOP policy and procedure as that is reviewed and endorsed via the CDOP Partners. I believe there have been some discussions in that babies from Welsh families where not considered by the Pan Cheshire CDOP and my understanding is that now when any baby dies in our area, the CDOP will review the death.

43. The SCB (formerly LSCB) has been providing multi-agency training to organisations that work with children since at least 2014 (when I started). Training is always refreshed in line with Working Together and other legislative updates. We also deliver refresher courses on Working Together which is a requirement every 2 years. Statutory Partners and some "relevant agencies" are not charged for this training; that includes the hospital as they financially contribute to the partnership arrangements. Non-paying partners will pay to attend training. We offer training face to face, and online to facilitate ease of access for partners. We will also do training sessions when there have been national reviews or

reports. The SCP (and formerly LSCB) offer free to attend bite-sized briefings for multi-agency partners on a regular basis. Most recently, we offered these briefings following the reviews elsewhere into the death of Arthur Labinjo-Hughes and Star Hobson. We do look to adapt local training to reflect national learning also. This is an ongoing process.

44. The SCP will directly intervene in operational practice when appropriate to do so. For example, if an issue is highlighted during audits, or via the Escalation Policy, we would ensure the appropriate agency is actioned to address the area of concern.

Child Safeguarding Practice Review Panels

45. A key part of my role at the SCP (and formerly the LSCB) was to oversee adherence to statutory case review procedures, known as Child Safeguarding Practice Reviews. Child Safeguarding Practice Reviews (previously known as Serious Case Reviews) are conducted by the SCP if a child has suffered significant harm (serious or permanent impairment of health or development) or has died; and abuse or neglect is known or suspected. When a partner believes this criteria to have been met they will complete a referral and our statutory safeguarding partners (Local Authority, ICB and Police) consider this with myself. If it is agreed it meets criteria then the Council is required to notify a serious incident to Ofsted and the National Child Safeguarding Practice Review Panel, which in turns triggers the Rapid Review Process I mentioned earlier. The individual responsible for the completion of the Serious Incident Notification Form is Paul Jenkins once the decision has been made.

46. Whilst I was at the Council, the SCP undertook an average of 3 such reviews each year. We examined them locally and then submitted a report on each child to the National Child Safeguarding Practice Review Panel. We also had to include all learning and summary of activity in our SCP annual report which is a public document. We looked at the themes and the learning which emerged from the individual reviews. The National Panel takes a view on quality and adherence to Working Together requirements, including timeliness of completion.

47. We frequently found that the Rapid Review meeting provides sufficient learning from the safeguarding incident to satisfy our obligations and identify improvements in practice where required. It is a multi-agency process to which all involved services will contribute. If we undertook a rapid review, the timeline is: the SCP must be notified within five days of the incident, and it needs to have investigated under the rapid review procedure and reported to the national panel within 15 working days. The whole rapid review process

should be completed in 20 days and locally we had a good record of meeting those requirements. Having undertaken the rapid review, the partnership needs to decide whether we think it meets the threshold for a CSPR (formerly SCR). If the threshold is met then the Rapid Review report must be published or the partnership can choose to conduct a more detailed independent review by appointing an independent author. In the latter circumstance the review must be concluded within 6 months. Nationally, and locally these timescales are harder to achieve, particularly when there are parallel processes running alongside the review, such as a criminal case, which impacts on the partnerships ability to speak with families and / or professionals depending on the circumstances.

48. The purpose of the rapid review and the child safeguarding practice review is to learn lessons that improve the way in which services work, both individually and collectively, to safeguard and promote the welfare of children. It will include learning as to how services are engaged with children and families.

49. There has been no referral to the LSCB or the SCP to consider a Child Safeguarding Practice Review in respect of LL's actions and the children's deaths. The applicable guidance at the time of LL's arrest was Working Together 2015. It could have been considered a notifiable incident (serious incident) because a child/ren died where abuse and neglect were suspected. When it became clear it was a professional suspected of perpetrating the harm, the matter should have been referred to the LADO and could still have been referred as a Serious Incident. However, at this point there was a significant Police investigation which needed to take precedence and I am confident will have impacted the timely progression of a Child Safeguarding Practice Review. Since the conviction, we have debated whether there should be a CSPR conducted in relation to the children's deaths but by this time the Public Inquiry had been established which in itself will identify learning.

50. The Inquiry also impacts on the partnership and what information can be shared. It impacts what other partners may share with us too.

51. This is a difficult situation for the SCP because as an SCP they need to ensure that the LADO process ran and continue to run effectively and that the CDOP was effective in knowing what information it was possible to know. I understand why other processes will have taken precedence and this may have influenced why a referral was not made to the SCP. It is important that the learning from all processes are brought together by the SCP and other bodies, so that assurance is sought that any learning is acted on swifty and embedded in practice going forward.

Child death review meetings and overview panels

52. Where a child dies due to external causes or there is an unexpected death and there are suspicions around a professional, that would require the LADO to be notified as well as CDOP. I was not personally close to LADO or CDOP operational practice. I do not believe that there were any SUDIC meetings in relation to the babies that died in the hospital, however they are done as standard for unexpected deaths at home. Some learning did arise for the partnership when exploring this further as it became apparent to me that accessing the most current SUDIC protocol (which is Pan Cheshire Policy) was not straight forward. Two different versions could be found in different locations. I alerted the child death review partners to this. As this is a Pan Cheshire CDOP document it was being hosted on the Cheshire East Website as they administrate for the CDOP, but a different version was available on Cheshire West, Halton and Warrington websites. This has been identified as a breakdown in communication which has now been rectified and all procedures will be sent via the Pan Cheshire Policy and Procedure Group in future to ensure effective dissemination.

53. I was not involved in CDOP operational meetings. I got the birds eye view at the SCP by way of annual reports. The Cheshire West CDOP dates back to 2009 when the old Cheshire County Council was split. This led to an East Cheshire CDOP and Cheshire West CDOP. Very quickly people started to discuss the idea of having a Pan Cheshire CDOP including Halton and Warrington. These changes mean there were numerous different formats of CDOP annual reports and disjointed information until 2014 when the Pan Cheshire CDOP was created. Therefore, if reviewing child death numbers in 2015 or 2016, there would have been very little historical data being brought together in one place for comparison for the Pan Cheshire CDOP to consider trends easily. Reports are now of a consistent format, and it is easy to compare year to year.

54. The CDOP reports also now contain more detail and looking back now it is possible to identify the increased child deaths in 2015/16. However, the SCP receives a high-level summary of the CDOP information which makes it difficult to interrogate the underlying data, for instance the report will identify the death is on a neonatal ward but will not specify at which hospital.

55. I am not able to say if LL's offending had not coincided with this period of change in the CDOP arrangements, whether a pattern of concern would have been picked up through CDOP discussions. Regardless, we must ensure there is consistency of data and sufficient intelligence analysed and shared on which to form judgements.

The LL Events

56. On 05.06.2017 the LSCB received a report presented by the Director of Nursing at the hospital (Alison Kelly) advising that they had undertaken a review to explore the higher than usual number of neonatal deaths. The report advised that the Trust had formally requested support from Cheshire Police to enable the Trust to rule out unnatural causes of death (Exhibit SLJ6 [INQ0013028]), (Exhibit SLJ7 [INQ0013195]).

57. I can confirm from records that about seven months later, on 22.01.2018 Alison Kelly provided a verbal update on the hospital's neonatal review to the LSCB Board Meeting. I was not present at this meeting as I was working in another authority at the time. Minutes indicate that Alison Kelly said that the formal action plan had been completed and would be reviewed at a Trust meeting in February 2018. The Police investigation was ongoing with no date for completion. Discussions were taking place about the neonatal unit returning to pre-incident working. Daily monitoring was being undertaken with no safety concerns raised. It was noted that the North Wales Regional Board had asked for an update and whilst a verbal update had been given at a recent joint meeting, it was agreed that the board notes would also be shared with them (Exhibit SLJ8 [INQ0013196]).

58. Emma Taylor (the Council's Director of Children's Services at the time) briefly attended an LSCB Executive meeting on 04.07.2018 to provide an update on the neonatal review. This was the first time that the LSCB was made aware of the arrest of a hospital worker (LL) on suspicion of murder. The Executive was told that a telephone conversation had been held that morning between key agencies and that a single co-ordination panel would be set up and there would be a memorandum of understanding to govern activities. The leads were identified as Paula Wedd for the Clinical Commissioning Group and Emma Taylor for the Local Authority (Exhibit SLJ9 [INQAWAITED]).

59. On 27.07.2018, Alison Kelly provided an update to the LSCB Board Meeting on the investigation being conducted by Cheshire Police. The investigation was ongoing with restrictions in place regarding information sharing. The neonatal unit remained at operational level one with daily monitoring and staff support in place – particularly following the latest stage of the investigation. Alison Kelly, Paul Wedd, Ann Eccles (Designated Safeguarding Nurse) and others had recently attended an incident coordination meeting facilitated by NHS England where it was agreed to instigate a designated officer referral (LADO) which was in progress. Alison Kelly confirmed that she had informed the North Wales Regional Board and Betsi Cadwalader of the investigation and had briefed local Welsh MPs accordingly (Exhibit SLJ10 [INQ0013197]).

60. As these events unfolded, changes to CDOP under Working Together 2018 and the Children and Social Work Act 2017 were being implemented. This meant that CDOP became a distinct set of arrangements rather than the responsibility of the LSCB. The new CDOP arrangements were presented to the LSCB on 11.02.2019 (Exhibit SLJ11 [INQ0013199]). Incidentally, this was the date when the hospital also presented its annual report.

61. On 17.07.2019, Alison Kelly provided a verbal update as to progress on the Police investigation. She confirmed that detailed and complex Police enquiries were still ongoing and stressed that the hospital's primary concern was to support staff and assist the Police. A healthcare professional (**LL**) had recently been re-arrested in connection with the investigation. We were told a LADO investigation was underway. The SCP executive noted that a multi-agency coordination meeting had been convened but that no further meetings were planned at that point. Gill Frame highlighted that North Wales Safeguarding Board had requested Information pertaining to the case and it was agreed that an exert from the minutes would be released following approval of the content by the hospital. Further information on the investigation could also be accessed via the hospital's website (Exhibit SLJ12 [INQ0013187]).

62. On 14.11.2022 the SCP received a presentation following the CQC Inspection at the hospital and the action plan that flowed from it. CQC had conducted an Inspection in February 2022 and took enforcement action, rating the service overall as inadequate as concerns were found in maternity services and trust-wide governance processes. An unannounced inspection was also undertaken in July 2022 to follow-up progress and the SCP received the update in regard to the action plan.

Epilogue

63. Since LL's offending began, there have been three versions of Working Together and statutory changes which transformed LSCB's into SCP's. The arrangements to CDOP also changed once the LSCB's were disbanded.

64. Whilst these changes have affected the Cheshire West LSCB/SCP, it was considered to be running well prior to the changes and day to day, operationally, things remain much the same.

65. That said, at the time of the offending and now, the appropriate route for concerned professionals to take would have been an immediate LADO referral. The Councils current

LADO (Paul Jenkins) has been in place since 2014. Ultimately with all child protection matters, the starting point of our ability to protect any child is a timely safeguarding referral.

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: 16. 04. 2024.