Witness Name: Emma Kate Taylor
Statement No: 2
Exhibits: 0
Dated: 06.09.2024

THIRLWALL INQUIRY

SECOND WITNESS STATEMENT OF EMMA KATE TAYLOR

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

1. Where the content of this witness statement is within my personal knowledge it is true. Where it outside my personal knowledge, and derived from other sources, it is true to the best of my information and belief.
2. This statement was taken from me by TEAMS interview.
3. I make this statement in response to the Inquiries further Rule 9 request dated 6 August 2024.

Introduction

4. As I said in my original statement, I started work with Cheshire West and Chester Council ("the Council"), on 1 December 2014. I became a member of the Local Safeguarding Children Board ('LSCB') with my appointment. I attended a LSCB development day on 12 January 2025, and the first formal LSCB meeting I attended was 23 February 2015.
5. My function as a member of the LSCB was to help it deliver upon its responsibility to work with other partners across the Borough to ensure that safeguarding systems, policies, processes and practice were effective. As I was the Head of Children's Social Care, my role was to oversee statutory safeguarding services for children in the Council. My involvement with the LSCB was in that role and I was required to contribute to the LSCB's meetings and work.
6. I did not have a direct role or involvement in the Child Death Overview Panel ('CDOP').

Meetings of the LSCB

7. The LSCB met regularly during the period mentioned. As indicated in my first statement, I have left the Council's employment and am reliant upon them to provide me with information for the purposes of this statement. I am informed, and have no reason to dispute, that there were LSCB meetings on the following dates between September 2015 and June 2017:

   - 29 June 2015
   - 18 September 2015
   - 7 December 2015
   - 22 January 2016 (development day)
   - 7 March 2016
   - 27 May 2016
   - 26 September 2016
   - 5 December 2016
   - 23 January 2017 (development day)
   - 7 March 2017
   - 5 June 2017
   - 27 June 2017
   - 20 October 2017

8. I attended the LSCB meeting which took place on 18 September 2015. This was a standard LSCB meeting. As the notes make clear, I was attending in my capacity as 'Head of Children's Social Care for 'Cheshire West and Chester'. I am informed that on 3 October 2016, Sue Eardley sent an email addressed to Hayley Frame and Anne McKenzie at CDOP. That email has been given Inquiry number INQ0012781. I do not believe I was sent that email. I am informed by the Council that following receipt of the 6 August 2024 Rule 9 Request, they undertook a search of their email systems to ascertain whether that email was sent or forwarded to me. I am informed, and have no reason to disbelieve, that they have found no evidence the email came to me.

9. On 2 February 2017, there was a joint meeting between the Cheshire West and Chester LSCB, and the I&S Safeguarding Board. Importantly, although I attended on behalf of the LSCB, this was not a standard Cheshire West LSCB meeting. It was a joint meeting with the neighbouring Board in I&S. These meetings were established following the death of a teenage girl I&S) who lived in Cheshire but spent time living

with foster carers in I&S. These meetings took place once a year and were designed to allow for wider safeguarding discussions between I&S and Cheshire West and Chester. The attendance list makes it clear that there were Cheshire attendees - Gill Frame, me and Sian Jones. There were also I&S attendees – Jenny Williams and Non Davies.

10. I was present at that meeting. There is reference to a Serious Case Review concerning I&S The Review report had been published. It related to the I&S of the teenage girl and there were cross-border issues in the case. I cannot assist the enquiry on the reference to the "*current CP review on* I&S *where CoCH are involved*". I do not know what child protection review this refers to. However, the note indicates that it was a I&S child, rather than one who lived in Cheshire, hence it was not the responsibility of Cheshire West and Chester Council. I believe it is unlikely that this note refers to anything the Inquiry is looking at because it pre-dates the sharing of the CoCH's Royal College of Paediatrics and Child's Health Review Report.

11. Finally, the meeting of 2 February 2017 also addressed the independent review of Part 4 of the LADO process. This related to a specific issue regarding the LADO process in I&S. It resulted in the production of updated guidance, following the review into I&S I&S death, a copy of which was tabled at the meeting.

12. I have been shown a document (INQ0006378) which appears to show the CoCH plan for releasing their report from the Royal College of Paediatrics and Child Health. It is entitled "*Communications Planning Neonatal Services* January 2017". I refer to it at 10 above. Page 6 refers to contacting Hayley Frame, Chair of the LSCB. I was not aware of this communication/contact being made by CoCH. Importantly, however, INQ0006378 names Hayley Frame as the contact for Cheshire CDOP and as the contact for Chair of the LSCB. In fact, Hayley Frame was the Chair of CDOP. The Chair of the LSCB at the time was Gill Frame. Despite their surnames, the two individuals are not related.

13. INQ0006378 indicates that some communication was made with CDOP on Monday 6 February 2017. The status column reads '*Done*.' The following line refers to the Chair of the LSCB and there is no corresponding '*Done*' entry in the status column. It would appear from this document that information was not passed to the LSCB on Monday 6 February 2017. Whether or not this happened is outside my knowledge.

14. On 7 February 2017, I was copied into an email sent by Fiona Reynolds (the Cheshire West and Chester Director of Public Health) to three Councillors. It enclosed a copy of the Royal College of Paediatrics and Child Health Invited Review Report. I do not have

a specific recollection of receiving this email. I do recall, however, the issues identified in the report. What I cannot be certain of is when those issues first came to my attention. That said, the email record is clear, and I have no doubt that I received the email. Further, as the email referred to an embargoed report, and I sat close to Fiona Reynolds at work, I believe that I would have read it. It is clearly an important and sensitive document, and it is not my professional practice to ignore important sensitive documents.

15. Having re-read the report for the purposes of this statement - I believe I would have looked at it through the lens of my statutory accountability at the time as I was responsible for Children's Services on behalf of the Council. Looking at the report itself, there was clearly an issue with the Neonatal Unit at CoCH. However, the report did not indicate any children's safeguarding issues that required interventions from the operational teams and services that I was responsible for. Importantly, there was no suggestion in the report that the increased number of child deaths came down to the actions of an individual, whether this be a parent, carer or a professional working with children. If it were the former, it would trigger child protection procedures and the Council's Children's Services would be required to intervene. If it was the latter, it would be a matter for the LADO which also sits within the Council's Children's Services. Instead, the report pointed towards different kinds of problems at CoCH. The problems highlighted the need for other professional interventions, rather than statutory children's services; hence at this point the report would not have put the CoCH on my safeguarding radar.

16. The issues raised in the report did not indicate any children's safeguarding concerns within the CoCH that required further action in terms of child protection processes in respect of parents, carers, or professionals. I note that I was copied into a message from Fiona Reynolds to members of the Council. Given that the report identified that 'something' was a problem, not a 'someone', I believe I was copied in for information.

17. That said, I do recognise the issues that were identified in the report, anxiety amongst the staff at the hospital about workloads and capacity, the rotas; and the reference to CDOP not detecting a statistical spike. What I cannot now be sure of, due to lapse of time, is whether this report was the first time those issues came to my mind, or whether it was subsequent events.

18. Following receipt of that report, I do not recall being involved in discussions with Fiona Reynolds or others on the email distribution list. My first memory of a discussion relating to these issues was an LSCB meeting that took place on 5 June 2017. INQ0012008 does indicate that CDOP also discussed this report on 23 March 2017.

19. The documentation shows that CoCH released the Royal College of Paediatrics and Child Health Invited Review Report to statutory partners in February 2017. It was then considered by CDOP in March 2017 and by LSCB in June 2017. I remember the June 2017 LSCB meeting because Alison Kelly presented a briefing regarding the report and investigations, which had then led to the CoCH inviting the police to become involved.

20. Returning to the email of 7 February 2017, I did not reply to it. I do not recall being copied into any other email replies. I understand that the Council has undertaken an email search and cannot find any evidence of me replying or me being copied into the replies of others. I have no reason to doubt that this information is accurate.

21. Turning to the actions of others on the 7 February 2017 email, I believe this is set out in document INQ13059. There are exchanges between Fiona Reynolds, Hayley Frame, Gill Frame, Donald Reed. Later, Helen Bromley and Del Curtis became involved with copy emails being sent to me and others. This culminated in an email from Del Curtis approving the "*way forwards*". That is dated 8 March 2017. From my point of view, I cannot see that it would be necessary for me to act on the report because there were no children's safeguarding issues. However, the emails show there was a clear plan of action and that was for Gill Frame to talk to CDOP.

Inquiry document – INQ0013059

22. I have referred to this email above.

23. I am aware of the historic geographical issue for CDOP. CDOP would review every child who had died where they had lived in the geographical area that CDOP was responsible for. For every that child who died, local CDOP processes would be followed. Therefore, Cheshire CDOP did not deal with children who lived out of its area, although they died in its area. This meant that a child who lived in North Wales, but who died at CoCH, would not be reported to the Cheshire CDOP or examined. Instead, it would go through the equivalent CDOP process in North Wales. For a child who was born and subsequently died in hospital, it would be reported to, and examined by, the CDOP where their parents lived. This meant that Cheshire CDOP did not have a full overview of all the deaths that occurred at CoCH because it was only responsible for the children, or families, who had lived in Cheshire prior to their death. This geographical issue has subsequently been addressed.

24. Moving on in the email chain, Fiona Reynolds described the plan that the CoCH had to undertake a review. Concern was expressed about the Cheshire CDOP. I was not told

anything about discussions between Fiona Reynolds and Hayley Frame regarding the next steps. I was unaware what reviews that been taken to that point.

25. The email continues, suggesting that there would be a recommendation CDOP reviews files to provide external scrutiny. There is a suggestion that the matter would also be brought to People's Scrutiny. As to the external scrutiny CDOP might provide, that is a CDOP matter – I cannot assist further. CDOP had skilled individuals available who would be acting on this. The assurance that can be offered sits in the email trail describing what will happen. CDOP would look at its own procedures and examine the files. CDOP then discussed matters on 24 March 2017 – please see above.

26. The reference to 'People's Scrutiny' is a reference to the Council's scrutiny committee. At the time, the Council had a People Directorate and activity was overseen by a scrutiny committee of Elected Members; similar to a parliamentary select committee, but at local government level. A reference to People's Scrutiny is therefore to the scrutiny committee responsible for the People Directorate which included both adult and children's social care, plus public health.

27. The email trail ends with Del Curtis' email of 8 March, thanking Fiona Reynolds for a copy of the report. I do not know and have no information about what Neonatal discussions were ongoing across the STP footprint. I believe that 'STP' stood for Strategic Transformation Plan, but I do not know how this fitted in with what Del was saying.

28. As to the scrutiny I could offer, I was not an Elected Member of the Local Safeguarding Children's Board, and neither was I an Elected Member of the Council. At the time the Council received the report (February 2017), there was an apparent problem regarding infant mortality at the CoCH, rather than a children's safeguarding matter involving parents, carers or professionals. As such, I do not recall becoming involved in discussions referring to the report until the June 2017 LSCB meeting.

29. The Cheshire CDOP met on 24 March 2017, as I have mentioned above. The minutes of that meeting were not shared with me. It was usual practice for me not to be sent CDOP minutes. I do not recall having seen CDOP minutes.

30. On 5 June 2017, Alison Kelly presented a draft briefing paper to the LSCB. I was present at that meeting. What was said at the meeting and by whom is captured in the minutes – INQ0013195.

31. I do not have any specific recollections to add to what is shown in the official minutes.

32. Looking back, it appears CoCH did not share a full picture with statutory partners of what was happening until February 2017. They knew about the statistical spike in infant mortality before then, however, did not share this information with either CDOP or the LSCB. It also appears that they did not share their suspicions that it was a 'someone' rather than a 'something' until the June 2017 briefing. For completeness, prior to that, they had said to the Council (email 18/5/2017 – INQ0013117) that the investigation was going to be widened, but in these terms: "*We have now asked for the input of Cheshire Police to seek assurances that enable us to rule out unnatural causes of death*." I do not know if CoCH, or individual staff members there, suspected 'someone' at that time. However, if at any point an individual was suspected of harming a child in any way the Council's LADO should have been consulted.

33. Reflecting on this, it has highlighted that within the safeguarding children's system, how important it is for all partners to communicate and share all relevant information. Without that, the professionals cannot collectively analyse the information with curiosity and objectivity, so the most appropriate action can be taken to safeguard children.

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.

Personal Data

Signed: ________________________________

6 September 2024

Dated: _________________________________