SHERIFFDOM OF GLASGOW & STRATHKELVIN AT GLASGOW

[2023] FAI 13

GLW- B384-22

DETERMINATION

BY

SHERIFF PRINCIPAL C D TURNBULL

UNDER THE INQUIRIES INTO FATAL ACCIDENTS AND SUDDEN DEATHS ETC (SCOTLAND) ACT 2016

into the death of

LAUREN WADE

28 February 2023

FINDINGS

The sheriff principal, having considered the information presented at the inquiry, determines in terms of section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 (hereinafter referred to as "the Act") that:-

[F1] In terms of section 26(2)(a) of the Act, Lauren Wade (hereinafter referred to as "Lauren"), born 8 October 2012, died at the Royal Hospital for Sick Children, Yorkhill, Glasgow at or about 08:07 hours on 20 March 2015.

[F2] In terms of section 26(2)(c) of the Act, the cause of Lauren's death was complications of malnutrition.

[F3] In terms of section 26(2)(e) of the Act, Margaret Wade having Lauren examined by a medical practitioner on or about 5 February 2015 was a precaution which (i) could

reasonably have been taken; and (ii) had it been taken, might realistically have resulted in Lauren's death being avoided.

[F4] In terms of section 26(2)(f) of the Act, there were no defects in any system of working which contributed to Lauren's death.

[F5] In terms of section 26(2)(g) of the Act, the following facts are relevant to the circumstances of Lauren's death:

1. No further visit by the health visitor to the Wade home took place after 4 July 2014; and
2. No further assessment of Lauren by the health visitor took place on or around 4 July 2014, or subsequently.

RECOMMENDATIONS

The sheriff principal, having considered the information presented at the inquiry, makes no recommendations in terms of 26(1)(b) of the Act.

NOTE

1. Introduction and Contents

[1] This determination is made following the fatal accident inquiry in to the death of Lauren Wade (who I refer to in this determination as "Lauren"), who died on 20 March 2015 from complications of malnutrition. Lauren was just over two years and five months old when she died. This determination comprises 31 parts and four appendices, namely:

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3.	The Legal Framework	paragraphs	[3] – [6]
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6.	Lauren and her Family	paragraphs	[14] – [17]
7.	Older Siblings – Head Lice & Hygiene	paragraphs	[18] – [20]
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9.	Health Visitor Involvement	paragraphs	[25] – [44]
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16.	GP Involvement	paragraphs	[129] – [148]
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Appendices

A1. The Legal Framework

A2. List of Witnesses

A3. The Criminal Charges

A4. Agreed Narrative

2. Participants and Representation

[2] The procurator fiscal represents the public interest in a fatal accident inquiry. In this inquiry, the procurator fiscal was represented by Ms Brown, procurator fiscal depute. In addition, Glasgow City Council (represented by Ms McKinlay, advocate); Greater Glasgow & Clyde Health Board (hereinafter referred to as "GGHB") (represented by Mr D.Blair, advocate); Lauren's mother, Margaret Wade (represented by

Ms Guinnane, advocate); and Margaret Wade's partner, Marie Sweeney (represented by Ms MacQueen, advocate) participated in the inquiry. I am grateful to all those appearing and to those instructing them for their respective contributions, and for the assistance they gave to me during the course of the inquiry.

3. The Legal Framework

[3] Fatal accident inquiries are governed by the terms of (a) the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 (hereinafter referred to as "the Act"); and (b) the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 (hereinafter referred to as "the Rules"). In this determination (and the appendices), unless otherwise stated, references to sections are to sections of the Act; and references to rules are to rules within the Rules.

[4] The form of determination required by rule 6.1 (i.e. Form 6.1) stipulates the inclusion of the legal framework in terms of which the inquiry proceeds. In the majority of inquiries, that will be of limited interest. In this determination I have set out the legal framework in Appendix 1.

[5] The present inquiry was a discretionary one in terms of section 4. Such an inquiry is to be held into the death of a person which occurred in Scotland if the Lord Advocate considers that the death was sudden, suspicious or unexplained or occurred in circumstances giving rise to serious public concern; and the Lord Advocate decides that it is in the public interest for an inquiry to be held into the circumstances of that death.

[6] Section 1(2) provides that an inquiry is to be conducted by a sheriff. In terms of section 3(5) of the Courts Reform (Scotland) 2014 Act, the sheriff principal of a sheriffdom may exercise in his or her sheriffdom the jurisdiction and powers that attach to the office of sheriff. As has long been the case, inquiries attracting a significant degree of public interest are regularly presided over by sheriffs principal. The procedure at an inquiry is to be as ordered by the sheriff (see, in particular, rule 3.8.(1) and rule 5.1) or, in this case, the sheriff principal.

4. The Inquiry Process

[7] A notice of an inquiry was given by the procurator fiscal under section 15(1) on 4 March 2022. I pronounced a first order on 17 March 2022, assigning a preliminary hearing and the date for the commencement of the inquiry.

[8] Preliminary hearings took place on 6 May 2022 and 30 June 2022. The participants entered into an extensive joint minute of agreement. As a consequence, it was not necessary for the participants to formally present information to the inquiry concerning the facts and productions stated within the joint minute, which was read to the inquiry.

[9] It is worthy of note that a number of the matters agreed by way of the joint minute were drawn (almost verbatim) from the terms of an agreed narrative in the criminal proceedings (discussed below in Part 20). As they are agreed facts relative to the death, I regard myself as compelled to include them within my determination and do so. I have also included (as Appendix 4) the agreed narrative (anonymised and

redacted where appropriate) read to the High Court of Justiciary following upon the pleas of guilty by Margaret Wade and Marie Sweeney to the charges set out in Appendix 3.

[10] The inquiry heard evidence from nine witnesses over four days. Details of the witnesses who gave evidence are set out in Appendix 2. I thereafter received written submissions from the participants and subsequently heard from the participants on the terms of those submissions.

5. The Issues and Matters in Dispute

[11] As required by rule 3.1.(2), the first notice must set out any issues identified by the procurator fiscal which it is anticipated the inquiry should address. Those issues, however, will often be identified without input from the other participants in the inquiry. To address this, at the preliminary hearing on 6 May 2022, I directed the procurator fiscal to lodge a draft note of the matters likely to be in dispute at the inquiry. The participants were directed to discuss and agree, insofar as possible, the terms of that draft note in advance of the preliminary hearing assigned for 30 June 2022.

[12] The issues for the inquiry to address agreed by the participants can be summarised as follows:

1. When and where Lauren's death occurred.
2. The cause of Lauren's death.
3. The precautions, if any, which could reasonably have been taken, and which, had they been taken, might realistically have resulted in

Lauren's death being avoided. In particular, the inquiry was invited to consider the following matters:

3.1 Lauren was assessed by the health visitor at the age of 5 months as being in the 'Core' programme for health visiting. It is for the inquiry to consider whether there were subsequent missed opportunities to reassess and provide further support;

3.2 The extent to which there was or was not a holistic approach to the family with regards to communication between those who were involved in Lauren's care; and

3.3 The extent of assessment of Lauren at the home visits.

4. The defects, if any, in any system of working which contributed to Lauren's death, including the extent of any co-ordination between social work and health after the joint visit on the 4 July 2014.

5. Any other factors relevant to the circumstances of Lauren's death, including: -

5.1 Knowledge of dental hygiene issues in Lauren's older siblings and repeated issues with head lice and hygiene;

5.2 The lack of engagement by Margaret Wade with the offers of referral to Triple P and Child Smile programme refused;

5.3 The relevance of any mental health issues suffered by Margaret Wade and the possible impact on the family;

5.4 The level of visibility of Lauren to social work; and

5.5 The lack of knowledge of Marie Sweeney as partner (of Margaret Wade) and co-parent (to Lauren and her siblings), residing with Margaret Wade and her children;

[13] The consolidated list of issues agreed also set out the matters which the participants viewed as likely to be in dispute. These can be summarised as follows:

1. The effectiveness of social work and health contact with Lauren during her life, and systems in place for establishing the full circumstances of her family and her household at that time;

2. The systems in place to ensure that GGHB and social work had a clear understanding of their roles and responsibilities towards Lauren during her life, and whether they fulfilled those roles, with reference to the joint visit to Lauren's home and lack of follow up by either GGHB or social work;

3. The effectiveness of those assessments of Lauren as carried out by health visitors at her home, including Lauren being recorded as 'Core' within the Health Plan Indicator (HPI) system, thus identifying her as not needing additional support, and later accumulated signs of neglect not resulting in a re-assessment;

4. The lack of formal notifications of concern by Glasgow City Council's education department to GGHB and social work.

5. The adequacy of the response by Glasgow Health and Social Partnership (HSCP) following Lauren's death.

6. The extent of the involvement social work had with the family.

6. Lauren and her Family

[14] Lauren was born at Princess Royal Maternity Hospital, Glasgow on 8 October 2012. At the time of her birth she weighed 2.68 kgs (or, just under 6 lbs). Her full name was Lauren Lee-Anne Debbie McMillan Wade. Lauren was the third born child of Margaret Wade. Margaret Wade provided no information to either GGHB or Glasgow City Council regarding the identity of Lauren's father. During her lifetime, Lauren was registered with a GP practice based at Townhead, Glasgow.

[15] Margaret Wade's older children, Lauren's older siblings, are CW (born 13 October 2004) and MW (born 9 July 2007). CW was 8 years of age and MW 5 years of age when Lauren was born. CW and MW both attended a primary school in Sighthill, Glasgow. CW commenced primary 1 in August 2009. She was a pupil in primary 6 at the date of Lauren's death. MW commenced primary 1 in August 2012. She was a pupil in primary 3 at the date of Lauren's death.

[16] Margaret Wade and her partner Marie Sweeney lived at a flat in Sighthill, Glasgow (hereinafter referred to as "Flat 17/4") between 12 April 2004 and 25 February 2011, when the flat was abandoned by them. CW and MW lived there also from their respective dates of birth until the flat was abandoned. There was no evidence before the inquiry as to where Margaret Wade, Marie Sweeney, CW and MW lived in the period between 25 February 2011 and 23 September 2011, although there is a suggestion in the

Criminal Justice Social Work Report relative to Margaret Wade (see paragraph [150] below) that they lived with Marie Sweeney's mother in that period.

[17] From 23 September 2011 until Lauren's death[1], Margaret Wade was the tenant of a second flat in Sighthill, Glasgow (hereinafter referred to as "Flat 3/2"). When and where Lauren's death occurred was a matter of agreement among the participants in the inquiry. I have accordingly found, in terms of section 26(2)(a) of the Act, that Lauren died at the Royal Hospital for Sick Children, Yorkhill, Glasgow at or about 08:07 hours on 20 March 2015 (see Finding [F1] above). As at the date of her death, Lauren resided at Flat 3/2 with Margaret Wade, Marie Sweeney, CW and MW.

7. Older Siblings – Head Lice & Hygiene

[18] The agreed Crown narrative in the criminal proceedings[2] states that a lack of personal hygiene was noted in respect of both CW and MW at school and that they both had endured repeated head lice infestations since the end of 2007, including November 2007, March 2009, November 2009, September 2012, October 2012, August 2013, February, May, June, November and December, all 2014 and March 2015, which on occasion were so significant that the children had to be sent home from school.

[19] The episodes of and subsequent to September 2012 are considered below in Part 10. Carol Murray was the family health visitor from MW's birth (in July 2007) until March 2013. She gave evidence to the inquiry. She stated that whilst she was Lauren's

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[1] The circumstances of which are considered below at Part 19

[2] See Appendix 4

health visitor there were issues with head lice with CW and MW. She was not asked about similar issues arising prior to Lauren's birth.

[20] The evidence given to the inquiry in relation to these issues is set out below in Parts 9 and 10.

8. Older Siblings – Other Issues

[21] CW had 10 teeth extracted under general anaesthetic in 2007 and 2009. On being examined on 29 March 2015 after Lauren's death, CW was noted by the doctor to be obese and suffering from a moderately severe infestation of nits. The doctor who examined CW considered that she had moderate evidence of chronic neglect of her health needs, particularly her weight and her hair. On attending for dental treatment in April 2015 four of CW's molars were found to be affected by decay.

[22] In September 2010 a dentist noted a precursor to decay in one of MW's front teeth. This had turned to decay by February 2011. The condition of the tooth had worsened by February 2012 when MW was seen at the dentist for a check-up. This school dental examination resulted in a letter being sent home in May 2012 to arrange for dental treatment. The appointment was not made until November 2012. MW's teeth continued to cause concern. MW's last dental appointment prior to Lauren's death was on 6 February 2014. Due to CW and MW's dental issues, Margaret Wade was asked if she wanted to enrol Lauren in the Child Smile Programme. This offer was refused.

[23] MW was not seen again by a dentist until April 2015. By that time MW had decay in nine of her primary teeth, six of which required fillings and three of which had to be removed under general anaesthetic.

[24] In January 2014, MW was seen by Dr James Andrew at the Royal Hospital for Sick Children, Yorkhill, Glasgow in connection with her poor diet. Advice was given regarding MW's diet and a referral was made to a paediatric dietitian. MW was seen by a dietician and by a consultant paediatrician in August 2014. By that time, MW's diet had changed sufficiently in that her weight had improved and she was discharged from any follow up in that regard.

9. Health Visitor Involvement

[25] The inquiry heard evidence form two health visitors. Carol Murray and Irene Solley. Carol Murray was the health visitor for Lauren from her birth until March 2013. Irene Solley was the health visitor for Lauren from around 1 November 2013 until Lauren died. The evidence suggests that no health visitor was allocated to Lauren between March and November 2013 (a period of some 7 months).

[26] At the time of giving her evidence, Carol Murray was employed by GGHB as a health visitor. She has been employed as a health visitor since 2003. She was a general nurse before she was a health visitor. She has worked in health care since 1980. She was the health visitor for the Wade family when CW and MW were babies. Health visitors are responsible for children from the point in time they are discharged by the midwives (at 10 days old) until they start primary school. The health visitor's duties are to seek

out and address health needs; optimise development; vaccination; safety; and child protection. Child protection matters would be escalated to social work as appropriate.

[27] The witness would have been informed of Lauren's birth. She would have arranged to visit between day 10 and day 14. The witness had access to the GP system, although she would not access it as a matter of course. The witness was asked if she would also have been involved with Margaret Wade, as a new mother. She responded that she was. She would make sure that Margaret Wade had recovered from the delivery and was given general health promotion advice in relation to smoking, diet, etc. She would also have enquired as to Margaret Wade's financial situation – to ensure she had sufficient money and was in receipt of all benefits to which she was entitled.

[28] The witness was asked if she would also look at the accommodation. She would visit the house and look at the rooms she was taken into. She would not ask to see another room, however, if anything caused concern she may ask to see other rooms. The health visiting team at Townhead, Glasgow also had two staff nurses. The witness would delegate work to them. The witness would do the new baby and first follow-up visits; the staff nurses would then do the follow-up visits, weekly for the first 6 weeks, and developmental checks.

[29] The witness was aware that whilst she was Lauren's health visitor there were issues with head lice with CW and MW. The school had told her of this. The witness had spoken to Margaret Wade and told her that the whole family needed treatment and had explained how to apply the treatment. Margaret Wade was receptive to this advice. The witness felt that she had a good rapport with Margaret Wade.

[30] The witness did not know that Margaret Wade had a partner who lived with her. The witness had seen Marie Sweeney in the house. The witness knew her. She had been introduced at around the time of CW's birth as Margaret Wade's cousin. Marie Sweeney was sometimes there when the witness had visited Lauren. The witness saw no interaction between Marie Sweeney and Lauren.

[31] The witness carried out the first visit on 19 October 2012. The purposes of the visit were to introduce the family to the health visiting service; to carry out a wellbeing check in respect of mother and baby; to discuss feeding; to carry out a head to toe examination of the baby; to discuss safety regarding formula feeds / sterilising; to discuss safe sleeping arrangements for the baby; and to try to identify any general risks.

[32] The joint minute entered in to by the participants in the inquiry provided that certain records were admitted in to evidence without the need to be spoken to by a witness. Those records include the Family Health Record relative to Lauren, which discloses that the witness subsequently visited on 2 November 2012; 7 November 2012; and 15 November 2012.

[33] The witness described the interaction between Margaret Wade and Lauren as good. Margaret Wade was attentive to Lauren, who was well presented.
Margaret Wade was ready for visits and had her "red book" (that is the personal child health record) available. The witness had no concerns while she was Lauren's health visitor. She described the Wade property at Flat 3/2 to be satisfactory. She had no concerns regarding it. The witness last visited Lauren on 15 November 2012.

[34] A staff nurse assessed Margaret Wade for post-natal depression on 22 November 2012. The witness confirmed the score (zero) was as good as it could be. The witness confirmed that there would be a discussion to make sure the score was accurate. The witness confirmed that she never had any concerns about Margaret Wade's mental health or that she might be suffering from post-natal depression. A staff nurse also saw Lauren on 29 January 2013.

[35] The Health Plan Indicator ("HPI") was developed for use by health practitioners to enable them to allocate to a core, additional or intensive programme of support, depending upon the child's assessed level of need. In relation to Lauren, on 14 March 2013, some four months after she had last seen by a health visitor, the witness allocated Lauren to the core programme of support. The witness explained that the prior assessments carried out determined the programme Lauren was allocated to. This allocation was to be reviewed when Lauren was one year old (i.e. in October 2013). Such a review is not documented. On the evidence placed before the inquiry, I am satisfied that it did not take place. No health visitor was in place for Lauren in October 2013 (see paragraph [25] above).

[36] During Lauren's life (i.e. 2012 to 2015), core families could receive little or no health visitor support between the 6–8 week check and the 27–30 month review (in respect of which see paragraphs [127] – [128] below). In Lauren's case, there was no contact by the health visiting team (including staff nurses) between 29 January 2013 and the home visit by Irene Solley on 27 June 2014, albeit Lauren did receive immunisations in March and October 2013 (see paragraph [130] below).

[37] The witness explained that a child might be allocated to the additional programme of support if there was any identified need, for example post-natal depression, the child not meeting milestones, not thriving, medical conditions, any housing issues or bereavement within the family. Housing might be an issue if, for example, there was no heating, the front door was not secure or if there were rent arrears. A child might be allocated to the intensive programme of support if there were additional agencies involved, any child protection issues or complex health conditions. The witness explained that Lauren could have been reassessed at any time and as many times as necessary, if there was any change of circumstances.

[38] At the time of giving her evidence, Irene Solley had retired. She started work as a health visitor in 1975 or 1976. Her evidence was that she retired shortly after she turned 70, in or around September or October 2014. She recalled being the health visitor for Lauren Wade. Her evidence was that she worked for GGHB between 2013 and 2015 and that she was Lauren's health visitor at the time of her death. The apparent contradiction between this evidence and that in relation to the date of her retirement was not resolved.

[39] The witness confirmed that she was based at Springburn. Lauren was transferred to her from another area. The witness did not know why. The witness was referred to the entry in Lauren's records of 1 November 2013, which is in the following terms:

"Record to be transferred to I. Soley (sic) HV at Springburn child in core programme SAA up to date, all communications up to date."[3]

The witness already had her own caseload. She thought that 30 – 40 cases had been transferred to her at that time. The relevant records needed to be transferred to her. The witness thought that this had taken some time – not months – probably two to three weeks.

[40] The expectation of the witness was that she would go with the previous health visitor to meet the family, for a handover. She was told that there was to be no handover. The witness persisted. She went to Townhead. She spoke to the health visitor responsible for the records. The witness thought that it was Carol Murray – she couldn't remember her name. The witness wanted some kind of handover. She was told by the staff nurse that the nursing officer had said that there was to be no handover.

[41] In the witness' recollection there were three categories of child "critical, additional or core". From the witness's perspective, core was the least "problematic". It indicated no problems arising. The witness stated that she had Lauren down for a 27 month review in March 2015. The two health visitors based at Springburn only had one staff nurse to assist them. The witness thought quite a lot of people had left around this time. The witness stated that she had agreed with her nursing officer to visit critical and additional transfers in. She did not visit those assigned to the core category. The evidence before the inquiry did not disclose the identity of the "nursing officer". If any issue arose with the core cases, the witness would visit them.

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[3] HV is an abbreviation for health visitor; SAA is an abbreviation for single agency assessment

[42] The 12 – 15 month section of Lauren's health promotion programme contains no entries. The witness explained that at that time (i.e. October 2013 – January 2014) they would not be doing this. Health visitors complained that it was not done. They were told it was not necessary, and the child would be seen later. The witness said that that would be at 27 months (i.e. around January 2015). The health visitor's objection was that there was too long between assessments.

[43] When a child was transferred between areas the first health visitor's continuity was lost. The witness agreed that that would only apply if there had been regular contact with the first health visitor.

[44] The witness's involvement in the visit of 27 June 2014 is considered below in Part 13. The witness's involvement in the visit of 4 July 2014 is considered below in Part 14. The witness's involvement with Lauren subsequent to the visit of 4 July 2014 is considered below in Part 15.

10. School and School Nurse Involvement

[45] The inquiry heard evidence from the head teacher and deputy head teacher of the primary school attended by CW and MW; and from the school nurse whose responsibilities included that school.

[46] Anne Healey was the head teacher of the primary school attended by CW and MW between 2010 and 2015. She had previously been a head teacher for four years in Aberdeen and prior to that a deputy head teacher in Barrhead. She started as a teacher around 1975. Her duties were to manage the school. She was responsible for the

welfare of the children and staff. In relation to the welfare of the children she had to make sure that they were well educated, safe, happy and achieving. Her deputy was Yvonne Adams. The school nurse for the primary school at the relevant time was Sharon McIntyre.

[47] The witness knew CW and MW. She knew their younger sister, Lauren also. The witness spoke to Margaret Wade regularly. Margaret Wade came to the school to discuss the girls' education. The witness saw Lauren quite frequently until she was around 1½ years old. She did not see Lauren in the last year of her life. She had been told that someone else was looking after her.

[48] A class teacher would bring any concerns to the head teacher or her deputy. In November 2012, concerns were brought to the witness's attention in relation to CW and MW's clothing, their personal hygiene and head lice. These concerns were raised with Margaret Wade, who was belligerent when the witness had spoken to her. She "took the huff". The witness contacted the school nurse following a report from the dentist about severe tooth decay in MW. The witness also raised CW and MW's personal hygiene and head lice issues. Within a week of the concerns being raised with the school nurse, Margaret Wade brought CW and MW in to the school to see the witness and her deputy. CW and MW had new uniforms and were very clean. The witness was pleased that Margaret Wade had taken steps to address the issues raised with her.

[49] The witness said that the head lice issue in November 2012 was very bad. CW and MW were sent home. The school would not routinely contact the school nurse over head lice. If head lice were going around the school they would not speak to the school

nurse. If it was an ongoing issue (with a pupil), the school would speak to the school nurse with a view to having support provided and appropriate treatment given. CW and MW were not the only children in the school about whom staff had concerns relative to personal hygiene. They never particularly clean – a lot of children in the school were like that. As CW got older she got better. She helped MW. Their personal hygiene improved.

[50] The school had quite a lot of input with CW and MW in 2014. Principally in relation to head lice and hygiene issues. An arrangement was made for the school nurse to meet Margaret Wade at the school. The school nurse had been prepared to meet Margaret Wade at home but appointments were cancelled. The school nurse was going to give the family continuous support in relation to head lice. The witness recalled that Margaret Wade kept her hood up during a meeting. She was not very clean. The staff assumed that Margaret Wade had her hood up because she had head lice, however, they did not see any.

[51] The witness was asked what circumstances might result in a school making a referral to the social work department. They would do so if they tried to work with parents, but nothing changed, if there was abuse or if an allegation was made. They would not normally refer for a health issue. CW and MW were happy and doing well at school. Social work would not have taken a referral about head lice seriously. In all respects CW and MW appeared happy. They talked about home, did their homework and they talked about dancing. Their hygiene improved as they got older.

[52] There was a lot of interaction between the school and Margaret Wade. She came to the school frequently. This was unusual. Margaret Wade was what the witness described as a "needy" parent. She came in a lot more than others did. The witness was asked if she knew that Margaret Wade lived with a partner. The witness answered that Margaret Wade did not tell her that. She thought that MW had told her teacher that she had two mums. Both women (i.e. Margaret Wade and Marie Sweeney) came to school shows. The fact that someone had a partner made no difference as to how the school dealt with them. The witness's view of CW and MW was that they were lovely girls. They were polite, did their homework, were conscientious and had friendship groups.

[53] There are no entries in the school chronology between that of 24 June 2014 (referring to the visit by the school nurse of 23 June 2014 and her subsequent referral to social work – see Part 12 below) and that of 29 January 2015. The witness was asked if there were no concerns when the girls returned after the summer holidays in 2014. She replied that there were none.

[54] The school had been contacted by social work in August 2014. They had visited the home. All was fine. They were not to be involved further with CW and MW. The witness stated that she had spoken to social work in August 2014. She spoke to them in August because she knew that there had been a visit over the summer. There is no mention of an update in August from social work in the chronology. The witness did not know why the August discussion was not there. She speculated it may be because it was in the holiday period. The witness was not aware of any further involvement by social work after August 2014.

[55] The final entry in the chronology is of 29 January 2015, less than two months prior to Lauren's death. It records that the witness contacted the school nurse regarding concerns that both CW and MW had recurring sickness and diarrhea. The witness advised Margaret Wade to contact her doctor. Margaret Wade said that she had done so. Margaret Wade, CW and MW were each seen by Dr Campbell on 5 February 2015. This consultation is considered at paragraphs [145] to [148] below.

[56] Yvonne Adams was the deputy head teacher at CW and MW's primary school between 2011 and 2015. That was her first deputy head teacher role. She has been a teacher for 34 years.

[57] The witness knew CW and MW as deputy head teacher. Both the head teacher and the witness had taught both children also Hygiene and head lice issues were brought to the witness's attention. Other pupils and other families had similar issues, which would come and go, however, with CW and MW it seemed to recur more frequently. The school nurse was involved. She was to provide additional advice. Margaret Wade was sometimes receptive to advice. Sometimes not fully. That was not unusual.

[58] The witness described Margaret Wade presenting as "grubby". She never saw Margaret Wade as what she would refer to as clean. There were other families in the school like that. The witness described CW and MW as "grubby" also. The witness knew that CW and MW had a younger sister (Lauren). The witness both saw Lauren and met her. Margaret Wade would collect CW and MW from school. She had Lauren in a buggy. She brought Lauren to assembly. The witness recalled Lauren being

unsettled on one occasion. She had taken Lauren to allow Margaret Wade to watch the show. Lauren also presented as "grubby". The witness was not aware of Lauren having issues with head lice. She stated that Margaret Wade did have such issues.

[59] The school prepared pastoral care notes. The purpose of those notes was to record anything which happened that warranted noting and to create a picture over time. It was the witness who kept the notes up to date. In relation to CW and MW, the entries in the chronology were mainly in relation to hygiene and head lice. There were "gaps" in the chronology between the entries of 12 November 2012 and 5 November 2013; and between 5 November 2013 and 26 February 2014. The witness suggested that there was nothing in particular (in those gaps) that would have merited noting. The chronology was a bullet point of the main things that had happened.

[60] For the first half of 2014, the chronology contains a number of entries relating to head lice and hygiene. The witness recalled that period. On 26 February 2014 the witness contacted the school nurse, Sharon McIntyre, by e-mail to express concerns about head lice and hygiene of CW and MW and of Margaret Wade. The school was concerned that Margaret Wade was unable to deal with head lice and asked the school nurse for advice. The school pointed out that problem was on going and that there was a baby in the family. The baby was mentioned because it was part of the school's job was to support the whole family.

[61] On 28 February 2014 the witness contacted the Wade family's health visitor to express concerns in relation to hygiene and head lice. The health visitor agreed to arrange a joint visit to the family home with the school nurse. The witness was

asked why the school asked the school nurse to visit. She replied that the school was concerned. They did not know the home situation. The only concern was head lice.

[62] On 24 April 2014 Margaret Wade spoke to the witness regarding her concerns about MW, who Margaret Wade described as underweight and "hyper". The doctor had referred MW to a dietician. Margaret Wade said that she and MW were to attend Triple P (otherwise referred to as "PPP") (see paragraph [75] below). On 30 May 2014 the witness contacted the school nurse, Sharon McIntyre, by e-mail to express continued concerns regarding the hygiene of Margaret Wade and all three children and the continued presence of live head lice. The witness asked the school nurse if support could be obtained from the health visitor. The witness told the school nurse that the school were concerned that Margaret Wade was not coping and felt that she was scared to ask for help. The witness thought that Margaret Wade was in a vulnerable position. The witness described Margaret Wade as "clearly dirty … her nails are black" and having "live insects on her head" when she was in the witness's room.

[63] On 5 June 2014 the school nurse phoned and gave an update on MW's treatment plan following a doctor's appointment. The following day, 6 June 2014, the school nurse contacted the school to advise that she would be making a joint visit with the health visitor to the Wade home on 16 June 2014. The chronology records that on 9 June 2014 the school nurse attended at the school to measure the height and weight of CW and MW. Anne Healey asked the school nurse to check their heads for lice. The school nurse could see no live lice, only eggs which appeared dead.

[64] The chronology records that on 16 June 2014 both CW and MW had live head lice. Anne Healey phoned Margaret Wade who said that she had treated both CW and MW. Anne Healey phoned the school nurse and asked her to come to school to meet with Anne Healey and Margaret Wade. Following an explanation of how to apply head lice treatment it was agreed that Margaret Wade would do this and the school nurse and health visitor would go to the Wade home on 19 June 2014 to check that the treatment had been successful. On 18 June 2014 Margaret Wade attended at the school and advised that she had treated CW and MW and cancelled the planned visit by the school nurse (the explanation offered being that Margaret Wade had to take her mother to hospital). On 19 June 2014 the school nurse phoned the school. The witness gave the school nurse an update and asked her to reschedule a visit to the Wade home. The school nurse visited the Wade home on 23 June 2014. That visit is considered below in Part 11.

[65] It was suggested to the witness that the persistent head lice suggested that Margaret Wade was unable to properly treat her children. The witness explained that Margaret Wade had heard that conditioner "did the same job" as head lice treatment. The school nurse offered support. The school could see that Margaret Wade was trying. Asked about Margaret Wade's hair (in the context of head lice) the witness explained that Margaret Wade had started to wear a hood. She had not done so previously. Asked if she knew why that was the case, the witness replied that Margaret Wade had told her that she was allergic to the sun.

[66] The witness was asked about the absence of entries between those relative to the visit on 23 June 2014 and that of 29 January 2015 (see paragraph [55] above). If there had any other issues regarding head lice those would have been entered into the chronology. The witness was asked if the head lice problem appeared to have cleared. She thought that it had.

[67] The witness had a lot of interaction with Margaret Wade. If the children were off school Margaret Wade would come in and explain why. She was proactive. She would tell the school about medical issues. She told them about appointments made for the dentist and dietician. Margaret Wade would also come in and talk to the staff in the playground. The witness was asked if she was aware that Margaret Wade lived with a partner. She responded that there were rumours. The witness was asked if she had seen the partner with the children. She explained that she seen a lady pick them up once but did not know who it was.

[68] The witness was asked about circumstances which might give rise to a referral to social work. She gave examples of a child making a disclosure in relation to mistreatment; if things went on for some time and were not resolved; if parents did not engage at all; if children talked of physical or sexual abuse; if they talked of "people visiting" or of anything that sounded strange. Asked if persistent head lice might result in a referral to social work, the witness explained that, if the issue was not resolved over an extensively long period and all avenues had been exhausted, it might.

[69] The witness understood that Margaret Wade had been referred to the Triple P programme by the school nurse and that Margaret Wade was happy to engage with it.

The witness did not expect to be told what happened at Triple P. It was between the parent and those who delivered the Triple P programme. The school may be told that the programme had been completed. The witness had no recollection of any feedback regarding the Wade family's engagement with the Triple P programme.

[70] Sharon McIntyre was the school nurse responsible for the primary school attended by CW and MW. The witness was a school nurse from 2007 to 2017. In that role she would have responsibility for a high school and its feeder primaries.

[71] The witness was asked about proactive nursing, particularly checking hair and nails. She confirmed that there was. On occasions there would be home visits and the school nurses would also check pupils in schools. If the head teacher was concerned about a pupil the school nurses could see them in school. In relation to head lice, they could see a child in school and also check their height and weight and carry out a general check. They would not take the child out of class in relation to head lice. The purpose of that was not to stigmatise.

[72] The witness confirmed that she dealt only with school aged children. If the family had a pre-school child they would be the responsibility of the health visitor. Asked about the relationship between the school nurse and the health visitor, the witness explained that they would work together. The school nurses would communicate with health visitors; they would either work jointly or find out what the other knew. Generally health visitors knew more. They had more checks to do. They got to know families better than the school nurses did.

[73] The witness was aware of the Wade family and that referrals had been made in relation to CW and MW. The only issues raised with the witness were the children's dress at school, personal hygiene and head lice. The witness spoke to the interaction between her, the school (particularly Anne Healey) and the then health visitor, Carol Murray on 1 November 2012 regarding CW's dress at school and her personal hygiene. The witness was asked if she would tell Carol Murray every time there was a welfare concern. She responded that she had made Carol Murray aware that there was an issue regarding the family. She did not think that she would speak to Carol Murray every time the school contacted her. The witness was asked why she would contact the health visitor. She said that she would do so if she felt there was a problem with a parent not engaging or not carrying treatments as advised.

[74] The witness was asked about an entry in the chronology of significant events relative to MW. This document was written retrospectively on 23 March 2015, after Lauren's death. The entry put to the witness was that of 6 November 2013. The relevant entries in MW's progress notes (which it is agreed were made contemporaneously), those of 5 November 2013 and 6 November 2013, were put to the witness also. The former records that the witness left a phone message for Margaret Wade asking her to contact the witness "possibly for PPP". The latter records a phone call from Margaret Wade "she declined PPP".

[75] The witness was asked about Triple P. The purpose of the programme was to help parents deal with their children. It was often delivered by health care assistants who worked with the health visitors. It promoted a way of working with children. It

was not adversarial. It was designed to deal with children's behaviour. The type of behaviour would depend on the age of the child. The witness was asked if she had made a referral to Triple P. She explained that she would not do so if the parent declined. It was a voluntary programme.

[76] The witness was asked if she knew if CW and MW had a younger sister and if she had ever seen her. The witness recalled seeing Lauren once – in a buggy – when she saw Margaret Wade at the school. Lauren was asleep.

[77] On 16 June 2014, the witness received a phone call from the school. CW had been seen to have crawling lice. The witness met Margaret Wade in the school. Margaret Wade kept her hood up at all times. The witness discussed with Margaret Wade the use of head lice treatment (Hedrin) and how to apply it. Margaret Wade assured the witness that she would do apply the treatment. A home visit was arranged for 19 June 2014. The witness stated that Margaret Wade had appeared receptive to what the witness had told her. The fact that the witness had arranged a home visit suggested that she had felt Margaret Wade needed further advice or help. At that time, home visits were fairly rare. The witness's view was that, on average, she carried one out each month, if even that. MW's progress notes record a message from Margaret Wade cancelling the visit arranged for 19 June 2014. The witness returned Margaret Wade's call and left a message.

[78] The witness stated that she had arranged an unannounced joint visit with the health visitor. This was arranged after the visit was arranged for 19 June 2014 was cancelled. The witness wanted to see the family home. The witness wanted to be

accompanied by the health visitor as there was a pre-school child in the household. By this time there had been a number of referrals for head lice. The witness wanted to see the home circumstances and to speak to Margaret Wade on her own. Treating the children alone for head lice was not enough. Margaret Wade could re-infect them. The witness was asked how many times she had seen Margaret Wade before. She thought once or twice, at the school. The witness found it slightly suspicious that Margaret Wade would sit indoors with her hood up. The witness was attending with the health visitor to offer support to the whole family. She thought that the health visitor's assistant could apply head lice treatment. The witness had done so before herself. The witness hoped to try and persuade Margaret Wade to apply treatment properly. The witness's involvement in the visit of 23 June 2014 is considered below in Part 11.

11. Visit of 23 June 2014

[79] The evidence of Sharon McIntyre was that a joint visit to the Wade home with the health visitor had been arranged for 23 June 2014 at 09:00 hours. No health visitor attended. This is considered below (at paragraphs [89] to [91]).

[80] Sharon McIntyre decided to proceed with the visit in the absence of a health visitor. She attended the property at around 09:05 hours. She recalled there being a controlled entry. She was buzzed in. No-one asked who she was. The property was a flat. The door of the flat was ajar. The witness rang the doorbell, knocked the door and chapped the letterbox. She recalled shouting who she was. The day of the visit was a school day. The witness could hear children's voices shouting, "Someone's at the door".

She heard an adult voice saying “leave it”. A child’s voice then said “The door’s open”. MW then opened the door and told Margaret Wade who the witness was. The witness gained entry to the property. One of the children came to the door. The witness was not happy about that and about the door being ajar.

[81] Margaret Wade came to the door. The witness thought that she was dressed, not in night clothes. The witness told Margaret Wade why she was there. Margaret Wade told the witness that she was “just up” and had treated the head lice. The witness asked if she could come in. Margaret Wade did not want the witness to come in. The place was a mess, really untidy. The witness told Margaret Wade that did not matter, she was not there to criticise. Somewhat reluctantly, Margaret Wade then let the witness in.

[82] The witness was asked how she found the flat. There was a pile of toys by front door. The witness walked along the hall – there were toys and shoes there– it was untidy, but how a house would be with children. In the living room there was a large pile of clothes in the corner to shoulder height. A cot was beside door, the side tables were messy and cluttered, one ashtray was visible and full. There were cigarette butts on the floor. The carpet was dirty and had debris on it: drinks bottles, paper, toys and hair. There was a mattress in middle of floor and a television on in the corner of the room. The witness thought that she had asked about the mattress and was told the children sat on it and watched television. She did not think that Margaret Wade had said why the clothes were there, or why the ashtray was overflowing. There were pictures of the children pinned to the walls. There were fresh flowers in the window. These looked out of place. One of the girls had won these at a dance competition.

Margaret Wade stated that she had spent £300 on dance outfits. The witness thought that that was a lot to spend when the room looked like it did, describing it as grubby, if not dirty. The witness did not go into any other room. She did not ask to.

[83] The witness discussed head lice with Margaret Wade who said that both girls had been treated but not herself and the baby (i.e. Lauren). The witness explained that all four should be treated together and suggested treating all four that day with the treatment being repeated in seven days. The witness discussed the use of a Nitty Gritty comb and left one. She suggested that she could look at the girls' hair and treat it. Margaret Wade refused. The witness's recollection was that Margaret Wade said she could do it herself. Margaret Wade also refused an offer that the witness's colleagues treat the children at home. The witness noted that, superficially, there was nothing to see in CW or MW's hair. She described it as the hair of children who had just woken up.

[84] CW and MW were present when the witness visited. They were not dressed to go out. The witness could not remember if they were in pyjamas or in vests and pants. Margaret Wade said that CW and MW were not at school as they each had a cough. CW and MW seemed cheery and lively. They went to watch a DVD in a bedroom. Margaret Wade's hair was tied back, perhaps gelled back or grubby. It looked very matted at the back. The witness advised her about treating the whole family for head lice, not just CW and MW. The witness's recollection was that Margaret Wade seemed to be receptive to that advice. Asked if she saw head lice, the witness stated that she did not see anything obvious. The witness recalled Lauren trying to crawl up on her.

Lauren was in a vest and nappy. She was grubby. The witness held Lauren off. She did not want Lauren crawling over her.

[85] The witness was asked if Margaret Wade was the only adult in the house. She responded by saying that at that point she was, then another female appeared. The witness's notes of the visit recorded that Margaret Wade's "cousin then came in, smoking in living room and in bedroom with children". There was a discussion about cigarettes. Margaret Wade told the witness that the other female was her cousin. At no point did Margaret Wade say she was living with that person. The witness did not know if Margaret Wade had a partner. If she had known that the lady was her partner she would have included her in the discussion.

[86] The witness thought that Margaret Wade was proud of her children but, at the time of the visit, was probably not coping. The witness thought that CW and MW had been treated for head lice but probably re-infected by Margaret Wade, her partner (Marie Sweeney) and / or Lauren. The witness's impression was that Margaret Wade and Marie Sweeney were not treating themselves hence the re-infection.

[87] After the visit to the Wade home, the witness contacted the health visitors (at 11:45 hours) and then the social work (at 11:55 hours). The involvement of the social work department is considered below in Part 12. The witness could not recall which health visitor she had spoken to. The notes record that the health visitor would visit that day (i.e. 23 June 2014) or the day after. In the event, the health visitor (Irene Solley) visited the Wade home on 27 June 2014 (see Part 13 below).

[88] The witness was asked why she had contacted social work. She stated that the house gave her concern, although everything suggested by the school and the health visitor said it was fine. When the witness saw the house, it was clear to her that it was not fine. The witness's view was that matters needed to be looked into and the family needed help beyond that which could be given by a school nurse. The witness felt that social work needed to be involved. There were safety issues - the main one being the open front door. The house was grubby, dirty and messy. To the witness, what she saw indicated a home life that was not particularly organised – seeing a mattress on the living room floor, the baby's pot there, debris on the floor, hairbrush contents and cigarette butts. The witness stated that everyone's home could be untidy. This was different.

[89] In relation to the visit on 23 June 2014, I am satisfied on balance that the witness Sharon McIntyre is wrong in her recollection that she had arranged a joint visit for that date. Her evidence was that she had arranged to go with Anne-Marie Crawford who the witness stated she had been told was the health visitor. That evidence is supported by the school nursing notes, however, those notes relate to the visit scheduled for 19 June 2014. Considering that Lauren had been allocated to Irene Solley by 1 November 2013 (see paragraph [25] above), quite why Anne-Marie Crawford was agreeing to conduct a joint visit the following June was unexplained. The health visiting records make no mention of the visit scheduled for 19 June 2014. The school nursing records disclose that on 24 June 2014 Sharon McIntyre received a message from Anne-Marie Crawford advising that Irene Solley was Lauren's health visitor.

[90] The school nursing records make no mention of the organisation of the visit of 23 June 2014. There are no entries between the cancellation of the visit scheduled for 19 June 2014 and the entry relative to the visit of 23 June 2014. In evidence, Sharon McIntyre could not recall if the scheduled visit of 19 June 2014 was to be a joint one. Her evidence was that she thought, but was not certain, that the joint visit was arranged after Margaret Wade had cancelled. The witness stated that she had no recollection beyond what was written in the notes.

[91] In the foregoing circumstances, I have reached the conclusion that, insofar as it being a joint visit with the health visitor, the witness conflated the scheduled visit of 19 June 2014 with the visit of 23 June 2014. I have concluded that the health visitors were not aware of the visit on 23 June 2014. Ultimately, having regard to the issues before the inquiry, little if anything turns upon this conclusion.

[92] On the morning of 25 June 2014, Sharon McIntyre discussed matters with Irene Solley. She explained that Irene Solley worked in the same suite of offices as she did. She went to speak to Irene Solley and told her she had made a referral to social work. The house was unkempt. There was a pre-school child there that Irene Solley was responsible for. The witness explained that that week was important. She worked term time. She was about to be off for six weeks. She wanted to hand over the case to Irene Solley and a colleague (Linda McHaffie). The subsequent school nursing involvement is considered below in Part 15.

12. Social Work Involvement

[93] Social Care Direct is part of Glasgow City Council. It is the centre for receiving all social work services referrals. It provides a filter for referrals being made to social work. Social Care Direct can refer the matter to the Duty Social Work Team, or to a third party or provide advice if that would resolve the matter. The Wade family were not known to social work until Sharon McIntyre made the referral discussed in paragraph [87] above.

[94] Sharon McIntyre contacted the social work department at 11:55 hours on 24 June 2014. She spoke with Janet Burn who indicated that she would pass the referral to the duty social worker. The first entry of 26 June 2014 within the GCC social work records sets out the referral details provided by Sharon McIntyre on 24 June 2014. That entry was made by Celine Johnston who had discussed matters with Sharon McIntyre on the morning of 25 June 2014. The account of the visit by Sharon McIntyre on 23 June 2014 is broadly consistent with that given in evidence by Sharon McIntyre (see Part 11 above), however, there is one noticeable difference. The social work records note Lauren as "very (quiet) and looked tired".

[95] Celine Johnston made an unannounced home visit to the Wade home on the morning of 26 June 2014 to assess the home conditions as well as the condition of the children and mother. She did not obtain access and left a message requesting a call back. On 26 June 2014 Celine Johnston spoke with Anne Healey.

[96] On 27 June 2014, given the nature of the concerns raised, the case was reassigned to the North East Children and Families Team. Celine Johnston did not give evidence to

the inquiry. The only social worker to give evidence was Martin Cullen. His involvement was limited to the visit of 4 July 2014, which is considered below in Part 14. After the entry in the social work records relative to that visit, there are no entries until those of 20 March 2015, the date of Lauren's death.

13. Visit of 27 June 2014

[97] On 26 June 2014 Irene Solley spoke to Margaret Wade by phone and arranged to visit her on 27 June 2014 at 10:30 hours. When making this arrangement, Irene Solley was unaware that Lauren had been seen by a GP the previous day. Shortly before 12 noon on 25 June 2014 Lauren (accompanied by Margaret Wade) attended at the GP practice for an emergency appointment. Lauren was seen by Dr Ayesha Siddiqui. The GP notes record that Lauren had had diarrhoea for two days. Her sisters had coughs. Lauren had started coughing around 24 hours earlier. She was not vomiting. There was a query as to whether she was teething. On examination, Lauren's tonsils were seen to be enlarged. The doctor recorded that she appeared well. A paracetamol sugar free suspension was prescribed.

[98] Irene Solley, accompanied by a student (who did not give evidence to the inquiry and who was not identified), visited the Wade home on 27 June 2014 at 10:30 hours. Two people left the house as they were entering. On entering the house all the doors were closed apart from that to the living room. Margaret Wade, Lauren and MW were in the living room. The oldest child, CW was apparently asleep in a bedroom.

Irene Solley did not see CW. Margaret Wade did not wish Irene Solley to enter the bedrooms or the kitchen.

[99] The living room had piles of clothing in one corner. Margaret Wade stated that the clothes were all clean and she would put them away. Lauren was fairly well dressed but playing with a battery. Irene Solley took this from her and explained to Margaret Wade that poison leaked from batteries and could burn Lauren's throat and stomach. She also explained that social work had been contacted and would also be visiting. Irene Solley made an arrangement to return on 4 July 2014. This was acceptable to Margaret Wade. Irene Solley indicated that she wished to see the rest of the home when she returned as she felt the house was unsafe for children as it was grossly untidy.

[100] In evidence, Irene Solley was asked if it would have made a difference if she had been aware of the circumstances of Lauren's attendance at the GP on 25 June 2014. She responded that she would probably want to have known a bit more. Her evidence was that Lauren was well when she saw her on 27 June 2014. There was no cough. The GP would have told the witness to visit if they had had a concern.

14. Visit of 4 July 2014

[101] Irene Solley's note of the visit of 4 July 2014 is brief. She recorded that she made a joint visit with a male social worker. The home was very much improved, the rooms clean, tidy and orderly. The children were chatty and had a good rapport with the social worker and Irene Solley. Irene Solley noted that further support would be required

from the school nurse in relation to head lice to make sure the children's heads were clear before going back to school.

[102] In her evidence to the inquiry, Irene Solley explained that neither she nor the social worker in attendance (Martin Cullen) knew what to expect. The social worker was not allocated. He knew very little. The witness explained to Martin Cullen that the house had been very dirty and that she had told Margaret Wade that she wanted the house tidy and to see the other rooms.

[103] The witness explained that she was invited into each room. The children were there. Everything was neat and tidy. The children were lovely. The witness recalled Lauren skipping with her mum. The witness told Margaret Wade that she was really pleased. The vaccinations of the children had all been carried out. The witness had checked this. Lauren was not ill in any way. She was a bouncy, happy, spirited child, as were the older children. There was nothing suspicious.

[104] The witness was asked if she had examined the girls at all. She explained that the Head lice were to be treated before the holidays. The witness thought that her rapport was such she did not want to raise this. The school nurse had said she would go in again. The witness wanted to build a relationship with Margaret Wade. She did not think that raising the issue of head lice was the correct thing to do at that time.

[105] The visit on 4 July 2014 lasted 30 to 45 minutes. Asked if there was any conversation with Martin Cullen in relation to follow-up, the witness's recollection was that Martin Cullen had stated he was not the allocated social worker and that it would be the allocated social worker who would follow matters up. Asked if she arranged to

go back, the witness said that she went back to the school nurse who told her the head lice issue had cleared up. The witness did not think that further action was required at that time. She was still waiting for a report from the allocated social worker. She did not receive anything. She thought social work would continue with the case and they would contact her, although she also stated that she did not expect a response from social work. Her clear evidence, however, was that the case would sit with social work.

[106] The witness was asked if she had any concerns that although the house had been tidy it may go backwards. The witness responded that she had no such concerns. She explained that when the allocated social worker went back or the school nurse, she would receive feedback. The social work department never contacted her again.

[107] Martin Cullen's note of the visit of 4 July 2014 is equally brief. In his evidence to the inquiry he confirmed that he had prepared it when he went back to the office. The note records that he met with Irene Solley to carry out a home visit in light of previous concerns regarding the standards within the family home and the hygiene of the children. The family home was in a much improved state according to Irene Solley with all the washing and clutter cleared away. Martin Cullen and Irene Solley were shown around every room in the house. There were no issues or concerns at all. Martin Cullen noted that the children were to get support for head lice which Irene Solley would deal with. CW and MW presented very well and appeared very interested in participating in the conversation and showing off their rooms. Martin Cullen noted that Lauren was asleep on the couch during the visit.

[108] Martin Cullen gave evidence to the inquiry. He had been a social worker, employed by Glasgow City Council, between November 2004 and March 2016. As at July 2014 he was a social worker in the children and families team. He recalled participating in a joint visit with Irene Solley at the home of Margaret Wade on 4 July 2014. A duty visit was arranged – the family were not allocated to a social worker. The witness was part of the duty team that day (this team worked on a rota basis). The worker who had been allocated to attend could not go. The witness was asked to attend at short notice by his team leader, Gregor Donaldson. The witness needed to leave almost immediately.

[109] The witness's recollection was that he was not told very much about the purpose of the visit. He was told the basic outline. The health visitor was there. There were concerns regarding standards in the family home. The witness had had no prior contact with the Wade family. Irene Solley took the lead. The witness gained entry to the property. It was the first time he had been there. Margaret Wade let him in. She did not introduce herself.

[110] The witness's view was that the property was not the best furnished, but it was more than appropriate. There were no concerns from what the witness saw. He stated that if you had not been aware of the issues you would not have thought there were any. The children were very happy and very engaging. They were inquisitive and curious in relation to the witness and Irene Solley being there. They engaged throughout the visit. Lauren was sleeping in a cot in the living room. It was suggested to the witness that

Lauren had been up “skipping about” (a phrase used by Irene Solley). The witness responded that that was not his recollection.

[111] The witness’s memory of Margaret Wade was that she was not very communicative. She talked to Irene Solley but did not really respond to the witness. The witness did not regard this as surprising. He explained that a social worker is not always someone people want to see. He described Margaret Wade as quiet and withdrawn, but speaking to Irene Solley.

[112] The witness considered the safety of persons living in the property. He explained that everyone has different standards. The witness estimated being in the property for about 45 minutes. Asked if he had concerns regarding the children or their health, he responded that he had none in terms of the environment. He took in what was there. There was nothing he saw regarding the children’s presentation to cause him concern. He was looking at the children’s needs and seeing if they were met. He observed the environment, looked at each room and at how the family engaged with him and with each other.

[113] The witness recalled that at the end of the visit Irene Solley had thanked him for coming out and said that they (i.e. the health visitors) would continue to work with the family. There was no need for further involvement by social work. The witness could not recall the precise words used. There was no obvious requirement for social work to continue to be involved. He reported back to Gregor Donaldson. That was the end of the witness’s involvement. The witness viewed it as a positive visit. If he had had concerns he would have fed those back.

[114] It will be apparent that there were inconsistencies between the evidence given to the inquiry by Irene Solley and that given by Martin Cullen in two material respects. First, in relation to Lauren's presentation on 4 July 2014. Second, in relation to what was agreed at the end of the visit.

[115] Lauren's presentation is, in and of itself, not particularly significant, however, I prefer the evidence of Martin Cullen in this regard. He recorded the position in the note he made upon his return to the office. Irene Solley did not note the position regarding Lauren (her comment that the "children were chatty" clearly relates to CW and MW, not to Lauren – who was under the age of 2 at the time of the visit). On occasions in her evidence Irene Solley (perhaps unsurprisingly) stated that she could not recall much more than had been noted at the time. Martin Cullen was very much an observer in the meeting. For all these reasons, and for those in relation to what was agreed at the end of the visit (in relation to which, again, I prefer Martin Cullen's account), I am satisfied that Lauren was asleep during the visit on 4 July 2014.

[116] As indicated above, in relation to what was agreed at the end of the visit, again, I prefer Martin Cullen's account. On the basis of what was observed, there was no need for further involvement by social work. There was an outstanding health issue, namely, head lice which was a matter for the school nurses and health visitors (this is considered below in Part 15). The condition of the Wade property did not give rise to any concerns on the part of Martin Cullen, an experienced social worker (or, for that matter on the part of Irene Solley, an experienced health visitor). In the event, the health issue was taken forward by the school nurses. Moreover, I can see no basis for Irene Solley's

assertion that she expected a report from the allocated social worker. Her position in that respect appeared to change in evidence. She concluded by saying that she did not expect a response from social work.

15. Events Post 4 July 2014

[117] There are three discrete chapters of evidence following the visit of 4 July 2014 that merit consideration. A hospital visit on 9 July 2014; the interaction between the school nurses and the health visitors in July 2014; and the review of Lauren that should have been carried out when she was between 27 and 30 months old. In this part I consider each chapter in turn.

The Hospital Visit

[118] Shortly before 5 pm on 9 July 2014, Margaret Wade took Lauren to the Emergency Department at the Glasgow Royal Infirmary. The attending clinician noted that Lauren had tripped and fallen in the living room, hitting her forehead on a table. Lauren suffered a laceration to her forehead, which was dressed at triage. There was no suspicion of a non-accidental injury. Lauren was discharged with paediatric paracetamol and no follow-up. An emergency attendance letter was sent from the Emergency Department to Lauren's GP.

[119] The inquiry heard evidence from Dr Tracey McLaughlin, who was a partner in the GP practice whilst Lauren was a patient there. Dr McLaughlin explained that letters such as that written by the Emergency Department in relation to Lauren in July 2014

were brought to the attention of GPs. A GP would read each letter that came in and decide if further action was required. If the GP determined that no action was required the letter would be filed. If the GP felt that action was required, they would usually take responsibility for it. The letters would not usually be shown to the health visitors. In this case, Dr McLaughlin's view was that there was no value in a health visitor seeing this letter. She regarded it as a simple trip. If a doctor had thought that a health visitor should see the letter it would be passed on and an entry would be made in the patient's notes.

[120] Irene Solley only became aware of the hospital visit after Lauren had died. She was not made aware of this at the time. She described the injury as "not very serious, (a) small laceration". In her view, there was no reason for the child to be referred back to her. It is notable that that view coincided with the view expressed by Dr McLaughlin. The decision to refer the matter to the health visitor was for the GP who considered the letter, exercising professional judgement. There is no evidence before the inquiry to suggest that the decision taken (i.e. not to refer to the health visitor) was anything other than an appropriate one.

[121] Asked if she had been aware of the letter would it have prompted her to take action, Irene Solley responded that she would have gone back to the house again, however, at that age, children trip. She then stated that she should have been contacted about the letter and was not. I confess to having a difficulty following this answer, in light of Irene Solley's evidence that there was no reason for the child to be referred back to her. It seems to me to contradict entirely that position (a position also supported by

the evidence of Dr McLaughlin) and is, perhaps, influenced by Lauren's subsequent death and the condition of the Wade home at that time. Irene Solley did not see Lauren after the joint visit on 4 July 2014.

Interaction between School Nurses and Health Visitors

[122] I am fortified in the conclusion I have reached in relation to what was agreed at the end of the joint visit on 4 July 2014 by the subsequent interaction between the school nurses and the health visitors. That interaction was between Irene Solley and a school nurse, Linda McHaffie (see paragraph [92] above) on 30 July 2014.

[123] The entry in the school nurse records (made by Linda McHaffie) is in the following terms:

> *"Discussion with Irene Solley HV states she didn't know if head lice had been treated and had been cleared in time for returning to school. Telephone call to mum's mobile number and mum states hair is clean and free from head lice after treatment. Will share info with Irene Solley HV."*

The entry in the health visiting records (made by Irene Solley) is in the following terms:

> *"Passed information of older children onto school nurse for delousing heads. Nurse phoned mum who stated all heads are clear. However advised school nurse to check same before children return to school to prevent further infestation of other children."*

[124] Linda McHaffie did not give evidence to the inquiry. The school nurse who did (Sharon McIntyre) did not speak to the events of July 2014 (or subsequent to then). In evidence, Irene Solley stated that she thought that the school nurse was going in to the Wade home again before the end of the summer holiday. It was put to the witness that

it appeared she had never been told that a check was made. The witness responded that she expected the school nurse to check.

[125] Whilst there are many unsatisfactory aspects to this exchange and the surrounding events, in light of subsequent events, nothing turns upon them. It is not entirely clear who initiated the exchange on 30 July 2014. On balance, it appears to have been Irene Solley, who passed on the details of the older children to the school nurse "for delousing heads". The children (i.e. CW and MW) being of school age, this would be a matter for the school nurse, not the health visitor. Standing the history of the matter, the school nurse's acceptance of Margaret Wade's assertion that "all heads are clear" is surprising. The health visitor's apparent scepticism in relation to this is recorded in the final sentence in the health visiting records. I have been unable to determine as to whether a further check was, in fact, carried out. There is no mention of one in the school nurse records. No witness who gave evidence to the inquiry spoke to one being carried out.

[126] In the absence of evidence on this matter, the court requires to draw conclusions from what did not happen, as opposed to what did. CW and MW returned to school in August 2014. Anne Healey was asked if there were any concerns when CW and MW returned. She replied that there were none. In light of the history of this matter it is improbable that CW and MW had ongoing issues with head lice. If they had done, the school and the school nurse would have become involved. There is no evidence to suggest that they did. To that extent, there is no basis upon which to conclude that what was said by Margaret Wade to the school nurse on or around 30 July 2014 (as recorded

by both the school nurse and the health visitor), namely, that the children's hair was clean and free from head lice after treatment was untrue. That issue having been resolved, and the health visitor being satisfied with the condition of the Wade property following the joint visit, the evidence before the inquiry disclosed no reason for further school nursing or health visiting involvement from August 2014 until, in the case of the health visitor, Lauren's 27 – 30 month review fell due.

The 27-30 Month Review

[127] In what is described as a Chief Executive letter dated 30 April 2010[4] and in a subsequent policy update, published on 18 January 2011[5], it was resolved that a new child health review for children aged 24-30 months should be added to the Scottish Child Health Programme. The Scottish Government set up a short-life working group in late 2011 to produce national guidance on the content and delivery of the 24-30 month review. After consideration, the guidance recommended that the first invitation for the review would be issued when children attained 27 months. NHS Boards were to aim to ensure that reviews were completed by the time children attained 30 months. The review was, accordingly, to be known as the 27-30 month review. The 27-30 month review should be offered to all children, regardless of their circumstances.

[128] Lauren attained the age of 27 months on 8 January 2015. Within Lauren's family health records is a letter addressed to the parent / carer of Lauren Wade dated "February

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[4] http://www.sehd.scot.nhs.uk/mels/CEL2010_15.pdf
[5] http://www.scotland.gov.uk/Resource/Doc/337318/0110676.pdf

2015". The letter contains "blanks" in the spaces provided for the location, date and time of the review. It was suggested to Irene Solley that this appeared to be a copy of a letter sent to Margaret Wade. The witness said that at that time health visitors would phone to arrange an appointment. The witness stated that she had this check "in" for March 2015, at which time Lauren would have been 29 months old.

16. GP Involvement

[129] In relation to Lauren's involvement with her GP practice, I have already considered Lauren's attendance with a GP on 25 June 2014 (see paragraph [97] above) and the GP practice's involvement relative to her attendance at the Emergency Department on 9 July 2014 (see paragraph [119] above). In this part I consider additional matters of relevance in terms of the GP practice's involvement with Lauren, MW, Margaret Wade and the consultation which took place on 5 February 2015, only 6 weeks before Lauren died.

Lauren

[130] Dr McLaughlin carried out a check of Lauren on 5 December 2012. The witness explained that this was a combined appointment. This check was usually carried out at six weeks. In this case it was carried out at eight weeks. Nothing turns on that timing. This check was combined with Lauren's first set of immunisations. Lauren's second set of immunisations were administered by a health visitor on 16 January 2013. Her third

set of immunisations were administered by Dr McLaughlin on 20 March 2013. Her 13 month immunisations were administered by Dr McLaughlin on 30 October 2013.

[131] Until the entry of 25 June 2014 (see paragraph [97] above), the only other entry in the GP notes was that made on 9 January 2013. Lauren was seen by Dr Daniel McGhee who noted, "*mild upper respiratory infection – chest clear – well looking baby*". The witness confirmed that (according to the records) the last GP contact with Lauren was the appointment on 25 June 2014.

MW

[132] Dr McLaughlin saw MW on 30 October 2013. She explained the visit. Three issues were discussed. The first two (nosebleeds and some back pain) are unremarkable. The third complaint was behavioural. MW was acting up at home. The witness did not think that autism or ADHD were likely. The witness would contact the health visitor about the possibility of the Triple P programme. The programme was there to provide parents with support for difficult behaviours. It was a voluntary programme. The witness discussed matters with the health visitor shortly thereafter. As MW was at school it was a matter for the school nurse. The witness then discussed matters with the school nurse who was to try and engage the family in the Triple P programme.

[133] Dr McLaughlin saw MW again on 11 November 2013. There were two issues. A lump behind MW's ear and the school's comment. The witness noted this as "School commented on recently looking white and not finishing meals. Diet really poor, eats little. Dentition awful." The witness wondered if a dietician may be helpful and

undertook to write to Yorkhill (that is the Royal Hospital for Sick Children). Following the consultation with MW, the witness made a further entry in the records, which is in the following terms:

> *"Note poor dental hygiene and now also low weight/dietary concerns. Spoke again to school nurse who has advised that mum declined Triple P input. I informed her of today's consult to update her. A weight review in 4/52 (i.e. 4 weeks) – I will speak to them about Triple P and also about dental hygiene (not raised today). If family not engaging will consider social work referral."*

[134] The witness explained that she wanted an update from the school nurse. She considered a social work referral. She described non-engagement as a marker and not a good one. She saw MW again on 10 December 2013. She explained that this was a review appointment. The witness determined that social work involvement was not required at that stage. She arranged to see the family to discuss the outcome of MW's hospital appointment, which was scheduled for 13 January 2014. The witness was asked about head lice. She stated that she would have noted that if she had seen any.

[135] Dr McLaughlin spoke to the clinic letter sent by the Royal Hospital for Sick Children following MW's appointment on 13 January 2014. In the section headed "Follow-up" (which the witness confirmed referred to follow-up by the hospital) it noted that the clinician had asked Margaret Wade "to engage once again with the Triple P programme). The witness was then referred to the clinic letter sent by the Royal Hospital for Sick Children following MW's appointment on 7 April 2014. In the section headed "Follow-up" it noted "Mother (i.e. Margaret Wade) is re-referred to Triple P programme". The letter also noted that Margaret Wade had been contacted by Triple P to attend an appointment, however, she had not been able to do so due to lack of child

care for her other children. Dr McLaughlin saw MW (who was accompanied by Margaret Wade) on 20 January 2014 to review the position.

[136] Dr McLaughlin spoke to the clinic letter sent by the Royal Hospital for Sick Children following MW's appointment on 18 August 2014. The letter noted that things had settled considerably and that MW seemed to have matured significantly over the holidays. MW was discharged and did not require to attend again. The witness did not involve social work during her treatment of MW.

Margaret Wade

[137] Dr McLaughlin's referral to the Royal Hospital for Sick Children in respect of MW (which was sent on 18 November 2013) noted that Margaret Wade had a history of depression. The witness was asked how she knew this. She explained that she was also caring for Margaret Wade. She spoke to a number of entries in Margaret Wade's medical records. Those records were admitted in to evidence without the need to be spoken to by a witness. The entries spoken to by Dr McLaughlin commenced with that of 6 August 2023. Prior to considering those entries, it is appropriate to have regard to certain earlier entries which may be of significance.

[138] Margaret Wade's medical records are unremarkable until 25 March 2011 when she was prescribed diazepam. The medication section of the notes records the fact that she had been prescribed diazepam on one occasion in March 2001; and on another occasion in January 2004. There are no accompanying consultation (or other) records related to those prescriptions. On 25 March 2011 Margaret Wade reported having had

panic attacks for two weeks. She was prescribed diazepam. There were further prescriptions of diazepam on 31 March 2011, 12 May 2011 and 24 May 2011. The consultation entry in relation to the last of those prescriptions notes "*advised no further diazepam after this script*".

[139] On 12 September 2011 Margaret Wade requested, and was prescribed with, diazepam. Shortly thereafter, on 15 September 2011, Dr Shona Ness made a note "*stop prescribing diazepam for mgt (i.e. Margaret Wade) unless reviewed at risk of abusing*". The medical records contain two further entries which mention panic attacks in May 2012. Dr Ness prescribed diazepam (for emergency use only) on 29 May 2012. There was no further prescription of diazepam until 6 August 2013.

[140] In evidence, Dr McLaughlin spoke to her consultation with Margaret Wade on 6 August 2013. Margaret Wade attended due to depression. Margaret Wade's hood was up. The witness noted that Margaret Wade had a history of this. She prescribed fluoxetine, which is principally for depression, and diazepam, which is more for anxiety. The witness could not recall seeing Margaret Wade prior to then.

[141] Dr McLaughlin next saw Margaret Wade on 23 September 2013. Diazepam was discussed again. It is highly addictive and not suitable for long-term use. The witness highlighted the risks to Margaret Wade and decided to review in four weeks, again prescribing fluoxetine and diazepam. Dr McLaughlin saw Margaret Wade again on 30 October 2013, discussing her use of diazepam to ensure it was not escalating. She prescribed further diazepam.

[142] Dr McLaughlin appears to have seen Margaret Wade for the last time on 20 January 2014. Margaret Wade did not have an appointment that day. She attended at the GP practice for a review appointment for MW (see paragraphs [134] – [135] above). The witness's note of the consultation with Margaret Wade ends with the phrase "*needs more meds*." There is no medication section entry of that date. The witness explained that such an entry is not always made. It was likely that she had prescribed diazepam to Margaret Wade on 20 January 2014.

[143] In evidence, Dr McLaughlin was asked if there was anything that would have caused her to raise matters with the health visitor. She responded that there was not. She confirmed that cases of depression and anxiety were very common in the GP practice. If the witness had had any particular concerns she would have put those in the notes. The witness was not made aware of the visits to the Wade home on 23 June 2014, 27 June 2014 or 4 July 2014. If she had been made aware of them she would have put any relevant information in to the notes.

[144] Margaret Wade appears not to have seen a doctor between 20 January 2014 and 5 February 2015. There is no record of her being prescribed medication between 10 December 2013 and 5 February 2015 (although see paragraph [142] above in relation to the possible prescription of diazepam on 20 January 2014). Dr McLaughlin agreed that if Margaret Wade was reliant on medication, she was not getting it on prescription from the GP practice.

The Consultation of 5 February 2015

[145] On 5 February 2015 Margaret Wade was seen by Dr A C Campbell. There are also entries on that date in the records of CW and MW. These consultations took place only six weeks before Lauren died. There is no entry in Lauren's medical records on that date, however, having regard to her age and to the fact that both her sisters and her mother were there, it is probable that Lauren was there also.

[146] Dr Campbell did not give evidence to the inquiry. Standing the fact that it is probable that she was the last healthcare professional to see Lauren alive – only six weeks before Lauren died – that is, to say the least, surprising.

[147] The entries relative to CW (who had an infection of the tissue folds around the nail of the middle finger of her right hand, for which she was prescribed an antibiotic) and MW (who had a sore throat and chest, for which she was prescribed paracetamol) are unremarkable. Neither entry records anything of note in relation to the appearance of CW and MW.

[148] All the entry in Margaret Wade's medical records 5 February 2015 notes is, "*In with daughters. Asking for meds*". The medication records disclose that Dr Campbell prescribed fluoxetine and diazepam to Margaret Wade on 5 February 2015**.** Dr Campbell prescribed 21 diazepam tablets and 56 fluoxetine tablets, the latter to be taken once a day. Margaret Wade was next seen by a GP shortly after Lauren's death.

17. Margaret Wade

[149] Margaret Wade was 34 years of age when Lauren died in March 2015. She did not give evidence to the inquiry (albeit she was represented). In the particular

circumstances of this inquiry, the failure to adduce Margaret Wade as a witness is, I regret, a decision I cannot comprehend. In reality, no evidence was adduced at the inquiry in relation to Lauren's presentation after the joint visit on 4 July 2014 – more than 8 months before she died. As will be seen from the terms of Part 20 below, the condition of the Wade home deteriorated dramatically over that period. Margaret Wade may have been able to explain why that was the case.

[150] Out with her medical records, which I have already commented upon, the only background information available to me in relation to Margaret Wade is the Criminal Justice Social Work Report prepared in relation to her for the purpose of the criminal proceedings (which are considered below in Part 21). That describes Margaret Wade as having a caring and supportive childhood; and supportive relationships with her parents and sisters. The report records that Margaret Wade and Marie Sweeney had been in a relationship since they were teenagers. Margaret Wade reported not having worked since she was 17. She appeared before the High Court of Justiciary as a first offender.

[151] At the time the Criminal Justice Social Work Report was prepared (January 2019) Margaret Wade stated that she was in good health, however, she had suffered from periods of low mood and panic attacks while pregnant with CW (in 2004). She was prescribed diazepam then (see paragraph [138] above) but stopped taking it after two weeks. She told the social worker that she became significantly depressed in 2014 and that this was a contributory factor in her own personal care and that of her children. She

described agoraphobic type symptoms and stated that she was unable to leave her flat unless accompanied.

[152] The criminal justice social work report makes reference to a psychological report relative to Margaret Wade dated 6 May 2016. This report was not before the inquiry. According to the Criminal Justice Social Work Report, it suggests that Margaret Wade met the diagnostic criteria for panic disorder, agoraphobia and major depressive disorder. It suggests the onset of these difficulties date from 2004 (panic disorder and agoraphobia) and 2012 (major depressive disorder).

18. Marie Sweeney

[153] Marie Sweeney was 33 years of age when Lauren died in March 2015. She did not give evidence to the inquiry (albeit she was represented). In the particular circumstances of this inquiry, the failure to adduce Marie Sweeney as a witness is, I regret, equally incomprehensible.

[154] The only background information available to me in relation to Marie Sweeney is the Criminal Justice Social Work Report prepared in relation to her for the purpose of the criminal proceedings (which are considered below in Part 21). She reported that her mother provided a loving and caring environment when she was a child; and of maintaining a close, loving relationship with her mother, step-father and siblings. She is described as spending the majority of her working life unemployed. She appeared before the High Court of Justiciary with one, minor previous conviction (for theft when she was 17 years old).

[155] She described having positive mental health during the period in which the offences occurred (2007 to 2015), with some situational stresses which she coped with. She required to care for her mother between July and November 2014. This placed greater responsibility upon Margaret Wade to care for the children. In the report, Marie Sweeney attributed blame to Margaret Wade and accepts little, if any, responsibility for the tragic events which came to pass.

19. Lauren's Death

[156] In mid-March 2015, Lauren had been poorly with symptoms of a cold or viral illness for a number of days. During that time she had not been eating as she usually would. Paracetamol was obtained from the pharmacy which was given to Lauren every six hours.

[157] Lauren received her evening dose of paracetamol at approximately 20:00 hours on 9 March 2015. She fell asleep on the couch within the living room at Flat 3/2 between 20:30 hours and 20:45 hours. Margaret Wade brought a mattress through to the living room to be near Lauren while she slept. That night, Margaret Wade and Marie Sweeney slept on that mattress on the floor beside the couch.

[158] At approximately 07:00 hours on 20 March 2015 Margaret Wade was awoken by her phone alarm. She went through to waken CW and MW for school. Marie Sweeney took the mattress back to their bedroom and on her return noticed that something was not right with Lauren. Lauren's colouring was not as it should be. Marie Sweeney found Lauren to be freezing to the touch. Lauren's chest was not rising and falling.

Marie Sweeney called for help from Margaret Wade who returned to the living room. Margaret Wade and Marie Sweeney attempted to rouse Lauren without success.

[159] At around 07:30 hours, Marie Sweeney called 999 and asked for an ambulance to come to Flat 3/2. She reported that a young child was not breathing. She was instructed to carry out cardiopulmonary resuscitation (CPR). Margaret Wade was present with Marie Sweeney during the call. Both Margaret Wade and Marie Sweeney attempted CPR upon Lauren.

[160] A single crewed ambulance arrived at Flat 3/2 at around 07:55 hours. During CPR Lauren had aspirated but was asystole with rigor mortis. The paramedic continued CPR with assistance from a paramedic from a two crewed ambulance which had also attended. Lauren was transported to the Royal Hospital for Sick Children, Yorkhill, Glasgow. The paramedics who attended noted Lauren to be skinny, dirty and unkempt with a large and noticeable lice infestation on her hair, head and face. The paramedics noticed that the cover Lauren had been lying on was brown and dirty and covered in lice, fleas and nits. The paramedics' shirts were similarly covered. The ambulance which transported Lauren to hospital had to be cleaned and decontaminated.

[161] Examination at the hospital showed no obvious signs of trauma or injury to Lauren but she was found to be dirty and malodorous. Lauren was very pale with severely matted, dirty hair, with bald patches and thousands of head lice. Her vest was old and discoloured and her nappy was soaking wet, with faecal staining at the back.

[162] On arrival at hospital, further attempts were made to perform CPR. These were discontinued at 08:07 hours. Lauren's death was declared by Dr Jennifer Scarth, Consultant Paediatric Intensivist at Royal Hospital for Sick Children, Yorkhill, Glasgow.

20. The Wade Home

[163] On being notified of Lauren's death, Police Scotland attended Flat 3/2. Police who attended there found the flat to be extremely dirty, chaotic and in disarray. Police officers saw hundreds of visible flies and insects throughout the flat. Rubbish and clothing were strewn throughout. All of the rooms in the flat were found to be littered with the remnants of food and food containers at various stages of decomposition, in addition to dirty crockery.

[164] The kitchen was so full of bags of rubbish that there was barely enough space to open the kitchen door. The bags of rubbish were piled high to the extent that they reached beyond the kitchen work tops. The presence of decaying food had attracted flies and other insects. There were numerous empty pot noodle cartons all with flies. The fridge contained a limited quantity of food which was mostly out of date. On examination some of the waste material was found to be dated 2013. Two unopened bottles of Hedrin (a treatment for head lice) were found within one of the kitchen cupboards.

[165] Bedroom 1 was identified as MW's bedroom and contained two beds with the floor littered with clothing, toys, and waste materials. The carpet was almost invisible due to the volume of items on the floor. There was a small fish tank within the

bedroom. The water within it was black. It was obvious that the tank had been unattended for some time.

[166] Bedroom 2 contained a double bed and cot which appeared not to be in use. The mattress from the double bed was found lying against the wall. The cot was full of various items of bedding and clothing. The cupboard above the bed contained several empty boxes and blister packs of Diazepam, together with a baby bottle containing what had the appearance of sour/curdled milk.

[167] Bedroom 3 was used by CW and contained one bed. This room was the least cluttered of all the rooms but still contained toys, clothing and other waste materials. The bathroom, toilet and storage cupboards were full of clutter and had not been cleaned for some time.

21. The Criminal Proceedings

[168] Lauren's death, and the circumstances relating to it, were investigated by the Homicide Unit of the Crown Office and Procurator Fiscal Service ("COPFS"). Margaret Wade and Marie Sweeney appeared on petition at Glasgow Sheriff Court on 3 July 2017 charged with the murder of Lauren Wade and with contraventions of section 12(1) of the Children and Young Persons Act 1937 ("the 1937 Act"). They were committed for further examination and released on bail. Both Margaret Wade and Marie Sweeney were subsequently indicted on charges of culpable homicide charge in relation to Lauren's death and contraventions of section 12(1) of the 1937 Act in relation

to CW and MW. COPFS took the view that a charge of culpable homicide more appropriately reflected the most up to date medical evidence.

[169] Guilty pleas were tendered on behalf of Margaret Wade and Marie Sweeney at a preliminary hearing in the High Court of Justiciary on the 20 December 2018. Margaret Wade and Marie Sweeney pled guilty to separate contraventions of section 12(1) of the 1937 Act in relation to Lauren, CW and MW. The terms of the charges to which Margaret Wade and Marie Sweeney pled guilty are set out in Appendix 3. An agreed narrative was read to the court. The terms of the agreed narrative are set out in Appendix 4.

[170] On 20 December 2018 the diet was adjourned until 18 January 2019 for sentence and for the preparation of Criminal Justice Social Work Reports in relation to both Margaret Wade and Marie Sweeney. Bail was refused and both Margaret Wade and Marie Sweeney detained in custody. On 18 January 2019 Margaret Wade and Marie Sweeney were each sentenced to 6 years and 4 months imprisonment, backdated to 20 December 2018.

22. Health and Social Care Partnerships

[171] Since Lauren's death (but not as a consequence of it) local authorities and health boards are required to plan and deliver community health and social care services together. By virtue of the Public Bodies (Joint Working) (Scotland) Act 2014, an Integration Joint Board was established on 6 February 2016 to which was delegated certain functions of Glasgow City Council and GGHB. This involved the integration of

all community health and social care services for older people, carers, the physical and learning disabled, those with addiction or mental health issues, homelessness, children and families and criminal justice.

[172] The aims of the health and social care integration were to (i) transform and improve the quality and consistency of services for patients/service users, carers and families; and (ii) provide joined-up quality services where people are cared for in their own homes or in a homely setting where it is safe to do so and ensure resources are used effectively and efficiently to deliver services that meet needs. The work to plan and deliver these services is directed by the Glasgow City Integration Joint Board with Glasgow City Council and GGHB delivering services under the banner of the Glasgow City Health and Social Care Partnership.

23. Post Mortem

[173] Lauren's body was subject to a preliminary external examination at the Southern General Hospital, Glasgow by Dr Dawn Penman, Consultant Paediatric and Perinatal Pathologist on 20 March 2015. A single doctor post mortem examination was carried out at the Southern General Hospital, Glasgow by Dr Amanda Murphy, Consultant Paediatric and Perinatal Pathologist on 24 March 2015. A double doctor post mortem examination was carried out at the Southern General Hospital, Glasgow by the said Dr Amanda Murphy and Dr Marjorie Turner, Forensic Pathologist on 2 April 2015.

[174] The cause of Lauren's death was initially certified as "1a: Unascertained pending further investigation." The cardiac pathology was reviewed by Professor Mary

Sheppard and Professor Sebastian Lucas. Reports were prepared by Dr Roger Malcomson, Paediatric and Perinatal Pathologist. Following additional investigations by Dr Murphy, the cause of Lauren's death was noted as: "1a: Complications of malnutrition".

[175] The cause of Lauren's death (certified as set out in the preceding paragraph) was a matter of agreement among the participants in the inquiry. I have accordingly found, in terms of section 26(2)(c) of the Act, that the cause of the death was complications of malnutrition (see Finding [F2] above).

[176] Samples of blood, urine and hair collected at post mortem were analysed for alcohol, prescription drugs, drugs of abuse and beta-hydroxybutyrate (BHB) by Dr Fiona Wylie and Dr Hazel Torrance, Forensic Toxicologists, both University of Glasgow.

[177] An examination of Lauren's hair at post mortem led to the conclusion that Lauren had suffered from a head lice infestation over a period of time lasting between 6 and 17 months. Lauren's body measurements indicated a mild degree of undernourishment without significant stunting, consistent with acute malnutrition. Her skin fat was reduced. Prominent steatosis (fatty change) within the left ventricular heart muscle and liver, together with changes in the brain were likely to be a consequence of malnutrition. Recent necrosis in the cardiac papillary muscles and widespread neuronal injury in the brain suggest that the death occurred in the context of cardiac dysfunction related to the malnutrition, which is a complication of malnutrition. Infection can also be a complication of malnutrition. In those with significant malnutrition, sepsis and

infection are the usual causes of death from immunosuppression and reduction in antioxidant defences as a complication of malnutrition. The latter factors allow hypoxic / ischaemic injury to occur from a variety of sources. Death from malnutrition accordingly occurs as a consequence of a number of factors which are the result of malnutrition.

[178] Margaret Wade and Marie Sweeney did not provide Lauren with an appropriate diet for a growing child which resulted initially in under-nutrition and later acute malnutrition. Lauren's living conditions and lack of personal hygiene also placed her in an infected environment and combined with immunosuppression left her open to opportunistic infection. There was significant damage to Lauren's heart. There may well also have been terminal / late sepsis. Complications arising from malnutrition caused her death.

24. Significant Case Review & Changes Made

Significant Case Review

[179] The terms of paragraphs [180] to [182] below were matters of agreement between the participants. They are included in this determination for that reason only. There follows, at paragraphs [183] to [193], what may be described as changes made to systems that have been made subsequent to Lauren's death and related matters. Thereafter, at paragraphs [194] to [196], I offer certain observations in relation to reviews such as that carried out in this case and their relevance to fatal accident inquiries.

[180] Police Scotland referred the case to the Child Protection Committee (CPC) requesting that consideration be given to a Significant Case Review (SCR) being undertaken. In June 2015, the CPC Review Panel discussed the case, and all agreed that the case warranted a full SCR. The purpose of the SCR was to discover whether lessons could be learned about the way local practitioners and agencies worked together, following the death of the deceased.

[181] The terms of reference for the SCR Panel were: -

- To provide an overview of the family context prior to Child B's (Lauren Wade's) birth.
- To consider the visibility of the child and family in the community, particularly health and education services.
- To review information about the contact the family had with agencies from 2012 until 2014.
- To review information, from the time of mother's pregnancy with Child B, with a particular focus from July 2014 until March 2015.
- To consider what assessments were made when Child B had lice and what actions were taken as a result of these assessments.
- To review communication between partner agencies.
- To consider how effective the assessment process was in identifying risks and in decision making.

[182] The SCR Panel reached certain conclusions. A number of questions remained. A table of learning points identified by the SCR review panel and an action plan were produced. Certain actions were completed between February 2016 and December 2018.

Changes Made

[183] Since Lauren's death, and the completion of the SCR, health visiting services in Glasgow (and across Scotland) have been significantly overhauled. In particular, the following changes to systems have been made. A national Universal Pathway Model for all families has been introduced. The pathway consists of 11 visits within the first five years of life for all families – eight of which are in the first year; and one of which is an antenatal home visit. All visits are home visits as opposed to clinic contacts. All visits are carried out by a health visitor. The pathway also introduced two additional Child Health Reviews at the ages of 13-15 months and 4 years of age (pre-school). This work is based on robust evidence which included reviews of a number of child deaths. As well as ensuring universal provision, reduced caseload size allowed health visitors to focus on families where additional or more intensive support is required. The pathway also emphasises early identification in relation to mental health, substance misuse, learning difficulties and domestic violence. During the 6-8 week review, information is to be provided to parents regarding *Childsmile*, a national programme to improve dental health amongst children.

[184] The Universal Pathway provides a redefined Health Plan Indicator (HPI):

> "An additional HPI indicates that the child (and/or their carer) requires sustained (>3 months) additional input from professional services to help the child attain their health or development potential. Any services may be required such as additional HV support, parenting support, enhanced early learning and childcare, specialist medical input, etc."

[185] A Universal Caseload Weighting Tool has been developed. This is a validated tool which, based on levels of deprivation, sets safe caseload size and facilitates the allocation of numbers of health visitors based on levels of complexity and deprivation per locality and Health Board area. A further 200 health visitors have been secured and funded for GGHB as a result of this tool.

[186] A revised curriculum of education and training, in line with the values of the Universal Pathway, has been introduced for all health visitors trained in NHS Scotland.

[187] A national review of the Health Plan Indicator was carried out and revised guidance issued, emphasising the requirement to assess the whole family and family circumstances as opposed to individual children. Health Plan Indicators are a guide to health visitors, developed to indicate a programme of support based on the child and family's assessed level of need. Assessments are updated at each visit and require to be flexible and dynamic to reflect the child and family's changing situation and circumstances. Indicators have 2-3 levels of assessment – core (indicates routine visits over five years); additional which could indicate either health issues / concerns or multiagency involvement is required. In GGHB the additional indicator is divided into two parts: (i) 'additional low'; and (ii) 'additional high', to depict the difference between low level health concerns and more multiagency and partnership requirements for support.

[188] Within the Universal Pathway, a specific timeline was formally introduced across Scotland where all health visitors pause and review the allocation of the Health Plan Indicator and their assessment to ensure that this accurately reflects family needs and is accurately recorded in records. This takes place at six months postnatally.

[189] GGHB produced a National Practice Model Guidance for Children & Families. This set out Wellbeing Indicators by which the welfare of children should be assessed. The expectation is that at all contacts with children and families a health visitor will consider all of these Wellbeing Indicators. In terms of the National Practice Model Guidance, an assessment should result in: (i) an analysis of the needs of the child and the parenting capacity to respond appropriately to those needs within their family context; (ii) identification of whether and, if so, where intervention will be required to secure the wellbeing of the child; and (iii) a realistic plan of action (including services to be provided), detailing who has responsibility for action, a timetable and a process for review. This assessment affects what HPI is assigned to the child.

[190] GGHB's Positive Parenting Programme ("Triple P") has been updated to reflect National Practice Model Guidance. GGHB has implemented a computerised record-keeping system, known as EMIS. This is used by health visitors, school nurses and oral health professionals. It allows professionals to review records completed by professionals in other disciplines. Parts of the EMIS records are available on the computerised Clinical Portal, which can be accessed by professionals in an acute clinical setting. Similarly, users of EMIS can access records entered on the Clinical Portal, which is accessed by GPs and Accident & Emergency staff. EMIS includes a Significant Event

Chronology, which records all significant developments in a child's health. EMIS also allows one healthcare professional to send a message to another, notifying them of any issues of significance. Any telephone discussions between professionals can be recorded on EMIS, to ensure a shared record is kept.

[191] Following Lauren's death, the Glasgow City Health and Social Care Partnership carried out a review in July 2015 to identify if the system of HPI allocation in the North East of Glasgow was performing effectively. The findings identified that 93% of children reassessed had an appropriate HPI. 7% of children required their HPI to be changed to 'Additional'.

[192] Since the SCR in 2015, and the creation of the Glasgow City Health and Social Care Partnership, the arrangements for Children's Services and the support to families has profoundly changed and transformed in Glasgow. The aspiration was to ensure better outcomes for children, young people and their families and tackle inequality and poverty. The investment in health visiting is part of that reform enabling the service to connect more children and families with early help. There is a robust, coherent and co-ordinated approach to tackling poverty and enhancing local family support.

[193] In or around 2017, funding was provided to the Pupil Equity Fund which is distributed directly to schools to give to families negatively impacted by poverty. GCC has implemented an initiative to ensure that families are in receipt of all of the State benefits to which they are entitled. This benefit maximisation initiative targets those families most affected by poverty. GCC has implemented Family Group Decision Making in order to assist and support vulnerable parents, children and their extended

family and to enable children to continue to remain with their birth family. GCC has invested heavily into third sector partners. This allows early support and interventions with vulnerable families without the need for statutory interventions. GCC has invested in kinship care to keep children within their birth families where possible.

Observations

[194] The procurator fiscal proposed to lead evidence relative to the SCR. In exercise of my inquiry management powers (see rule 2.6, and in particular rule 2.6.(1)(a)(iv)) I indicated that I was not prepared to hear such evidence. A number of people were interviewed in relation to the SCR. Notably, the SCR panel appears to have interviewed a number of people who did not give evidence to this inquiry. Weight also appears to have been placed by the SCR panel upon reports and chronologies provided by certain agencies. It is clear from the terms of the SCR that it had before it information which was not before this inquiry. Indeed, in certain respects it appears to have had regard to information which was not only not before this inquiry but was not also before the High Court in sentencing Margaret Wade and Marie Sweeney.

[195] The SCR served a different purpose from this inquiry. It is, in my view, wholly inappropriate for evidence of a separate inquiry, such as the SCR, to be adduced before a fatal accident inquiry. If changes have been made, they ought to be a matter of agreement or of evidence. The conclusions drawn by the SCR, with respect, cannot inform a fatal accident inquiry. If, in the public interest, the procurator fiscal reaches the conclusion that certain evidence should be put before a fatal accident inquiry, it is incumbent upon the procurator fiscal to put that evidence before the inquiry in an

appropriate form. Seeking to introduce it through the lens of a report by a separate inquiry is inappropriate. If there are witnesses or documents before that inquiry that may be of benefit to the fatal accident inquiry, they should be presented.

[196] For the avoidance of any doubt the observations I make are directed only to reviews such as the SCR in this case. The position is entirely different where an inquiry has been carried out by an external agency such as, for example, the AAIB (see *Inquiry in to the Deaths of Gary Arthur & Others* [2019] FAI 46) or the MAIB (see *Inquiry in to the Deaths of Paul Alliston & Others* [2022] FAI 8). Such reports dealing with technical matters can be of considerable benefit to a fatal accident inquiry and may considerably restrict the matters in dispute. If, as in the inquiry into the *Deaths of Gary Arthur & Others*, participants take issue with any aspects of such a report, those matters in dispute can be explored in the inquiry. In respect of such inquiries I draw attention to the observations made at paragraph [133] of my determination in the *Inquiry into the Deaths of Gary Arthur & Others* relative to the approach commended by the then Lord Chief Justice (Lord Thomas of Cwmgiedd) at paragraphs 55 to 57 of the judgment of the court in *R (Secretary of State for Transport) v Her Majesty's Senior Coroner for Norfolk* [2016] EWHC 2279 (Admin). In relation to reviews such as the SCR, I would very much hope that the procurator fiscal has regard to the observations I make in this determination and bears them in mind in future inquiries.

25. Conclusions on the Matters in Dispute

[197] I set out above (see paragraph [13]) the six matters which the participants viewed as likely to be in dispute. I now deal with each of those in turn.

[198] The first matter is the effectiveness of social work and health contact with Lauren during her life, and systems in place for establishing the full circumstances of her family and her household at that time.

[199] The extent of social work involvement with the family is considered below (see paragraph [204]). This issue has been considered previously in Part 12 above. Save for the submissions made on behalf of Margaret Wade in relation to reasonable precautions (which I address below in Part 27), the participants in the inquiry did not suggest that the social work contact with Lauren was in some way ineffective. The joint visit of 4 July 2014 is suggested to be another relevant fact by the Crown. This is considered below in Part 29.

[200] The extent of health contact with Lauren during her life has been considered. Four matters relative to this are suggested to be other relevant facts by the Crown. These are considered below in Part 29. No participant in the inquiry suggested that there was a defect in any system of working (see below at Part 28). I have found that to be the case (see Finding [F4] and Part 28 below). It follows that there were no defects in the systems in place for establishing the full circumstances of Lauren's family and her household at the relevant time.

[201] The second matter is the systems in place to ensure that GGHB and social work had a clear understanding of their roles and responsibilities towards Lauren during her life, and whether they fulfilled those roles, with reference to the joint visit to Lauren's home and lack of follow up by either GGHB or the social work department. The

submissions of participants did not suggest any defect in those systems. This issue is also addressed by Finding [F4] and Part 28.

[202] The third matter is the effectiveness of those assessments of Lauren as carried out by health visitors at her home, including Lauren being recorded as 'Core' within the Health Plan Indicator (HPI) system, thus identifying her as not needing additional support, and later accumulated signs of neglect not resulting in a re-assessment. The fourth matter is the lack of formal notifications of concern by Glasgow City Council's education department to GGHB and the social work department. Each of these matters are suggested to be other relevant facts by the Crown. These are considered below in Part 29.

[203] The fifth matter is the adequacy of the response by Glasgow City Health and Social Partnership following Lauren's death. The submissions of participants did not suggest that there was, in fact, a dispute in relation to this. A considerable number of steps were taken following Lauren's death. These are set out, in detail, in Part 24 above. I cannot determine if the response was adequate, however, as will have been noted, I make no recommendations in terms of section 26(1)(b) of the Act.

[204] The sixth matter is the extent of the involvement the social work department had with the Wade family. There had been no referral of the family to the social work department prior to that made on 24 June 2014. The extent of the involvement the social work department had with the family is considered above

in Part 12. The submissions of participants did not suggest that there was any dispute in relation to this.

26. Conclusions on the Issues

[205] I set out above (see paragraph [12]) the five issues for the inquiry to address agreed by the participants. I now deal with each of those in turn.

[206] The first issue was when and where Lauren's death occurred. A finding to this effect requires to be made in terms of section 26(2)(a) of the Act. This issue is addressed by Finding [F1] and paragraph [19] above.

[207] The second issue was the cause of Lauren's death. A finding to this effect requires to be made in terms of section 26(2)(c) of the Act. This issue is addressed by Finding [F2] and Part 23 above.

[208] The third issue was the precautions, if any, which could reasonably have been taken, and which, had they been taken, might realistically have resulted in Lauren's death being avoided. A finding to this effect can be made in terms of section 26(2)(e) of the Act. This issue is addressed by Finding [F3] and in Part 27 below.

[209] The fourth issue was the defects, if any, in any system of working which contributed to Lauren's death. A finding to this effect can be made in terms of section 26(2)(f) of the Act. This issue is addressed by Finding [F4] and in Part 28 below.

[210] The fifth issue was the identification of any other facts relevant to the circumstances of Lauren's death. A finding to this effect can be made in terms of section 26(2)(g) of the Act. This issue is addressed by Finding [F5] and in Part 28 below.

27. Reasonable Precautions

[211] I turn now to consider whether there were any precautions which could reasonably have been taken, and which, had they been taken, might realistically have resulted in Lauren's death being avoided (see section 26(2)(e) of the Act)

[212] In this regard, the inquiry was invited to consider three matters (see paragraph [12] above). First, whether there were missed opportunities to reassess Lauren (as additional, as opposed to the core HPI allocated to her when she was 5 months old) and provide further support. Second, the extent to which there was or was not a holistic approach to the family with regards to communication between those who were involved in Lauren's care. Third, the extent of assessment of Lauren at the home visits.

[213] With the exception of Margaret Wade, no participant in the inquiry suggested that there were any reasonable precautions which could reasonably have been taken, and which, had they been taken, might realistically have resulted in Lauren's death being avoided. The submissions made on behalf of Margaret Wade appear to suggest five precautions, each of which I consider in turn below.

The First Suggested Precaution

[214] The first suggested precaution is that Lauren's death might have been avoided had "the (social work and health visiting) agencies involved in the visit … on 4th July [2014] … gathered together all available information concerning [Lauren] and her siblings based on the direct social work referral made by the School Nurse McIntyre and visited the family home again after the visit on 4th July [2014] in order that health

visiting could assess [Lauren] and re-categorise her needs from core to additional or intensive levels of support." There are, in effect, two separate parts to this suggested precaution (part of this suggested precaution replicates the second suggested precaution, which is considered below at paragraphs [218] to [221]).

[215] First, it is implicit in the suggested precaution that the social work department and / or the health visitor failed to "gather together" all available information concerning Lauren and her siblings in advance of the joint visit on 4 July 2014. The submissions made on behalf of Margaret Wade do not expand upon this part of the suggested precaution.

[216] Having regard to the reasons underlying the visit of 4 July 2014 (and the visit of 27 June 2014 which preceded it), I am far from persuaded that it was either practicable or reasonable to gather together all the information in question. Be that as it may, having regard to the outcome of the visit of 4 July 2014, and the conclusions I have drawn in relation to events subsequent to it, gathering together all available information concerning Lauren and her siblings in advance of the joint visit on 4 July 2014 would not realistically have resulted in Lauren's death being avoided.

[217] Second, it is suggested that a further visit to the Wade home should have taken place after 4 July 2014. For the reasons I give below in Part 29 (see paragraphs [240] to [244]), I have concluded that a further visit to the Wade home should have taken place after 4 July 2014 (see Finding [F5]). I cannot, however, say that had such a visit taken place Lauren's death might have been avoided. The evidence before the inquiry was not sufficient to allow me to so conclude.

The Second Suggested Precaution

[218] The second suggested precaution is that Lauren's death may have been avoided if "her Health Visiting assessment had been reviewed and she had been re-categorised from core to additional …". In support of that suggested precaution Margaret Wade submitted that the re-assessment of the core status would have resulted in the re-categorisation of Lauren, given the well-being indicators which by June 2014 had been activated, namely, unsafe and unhygienic home conditions, history of maternal mental health issues around numerous requests for medications leading to a perceived risk of over dependency on anti-depressants and diazepam, endemic lice infestations and dietary concerns about the older siblings. Proceeding on the hypothesis that Lauren's "core" status ought to have been reviewed in July 2014, I turn to consider each of the factors prayed in aid by Margaret Wade in support of her assertion that the status ought to have changed.

[219] First, unsafe and unhygienic home conditions. By 4 July 2014 that issue had been addressed. Second, a history of maternal mental health issues around numerous requests for medications leading to a perceived risk of over dependency on anti-depressants and diazepam. This is considered above at paragraphs [137] to [142]. As at July 2014, Margaret Wade had not visited the GP in almost six months. Whilst the risk of over dependency on anti-depressants and diazepam was, properly, considered by the GP, the evidence before the inquiry does not suggest it arose. Third, lice infestations were an issue as at July 2014, however a plan was in place in relation to this (see Part 15

above) which, I have determined, was addressed by August 2014. Fourth, the dietary concerns about MW were being addressed as at July 2014. Indeed, the following month MW was seen by a dietician and by a consultant paediatrician by which time her diet had changed sufficiently in that her weight had improved and she was discharged from any follow up in that regard (see paragraph [24] above).

[220] In addition to those factors, consideration requires to be given to the fact that Lauren, herself, had no identified needs justifying a re-categorisation from core to additional; and to my conclusion (see paragraph [126] above) that the evidence before the inquiry disclosed no reason for further school nursing or health visiting involvement from August 2014 until, in the case of the health visitor, Lauren's 27 – 30 month review fell due.

[221] Drawing all that together, I am not satisfied that a review of Lauren's core status in July 2014 would necessarily have resulted in Lauren being re-categorised as additional. Even assuming that it was, one then enters the realm of speculation as to what would have happened next. The conclusion I reached at paragraph [126] suggests little, if anything, more and the possibility of it returning to "core" after August 2014. However, that too is speculation. In my view, it cannot be said that the second suggested precaution would realistically have resulted in Lauren's death being avoided.

The Third Suggested Precaution

[222] The third suggested precaution is that Lauren's death could have been avoided if the health visiting service had carried out four separate actions (i) undertake a further

follow-up visit to the family home to see if the home conditions were sustained; (ii) review the child and family records for history; (iii) re-assess the health needs of Lauren and her HPI and undertake a developmental assessment, including a weight and height check; and (iv) and liaised with the GP. It will be noted that this suggested precaution overlaps with both the first and the second suggested precautions. I have addressed parts (i), (ii) and (iii) already. I now consider Part (iv).

[223] Part (iv) is to have liaised with the GP. The submissions assert that the GP could have liaised with the health visiting service to "confirm" the mental health condition of Margaret Wade. The GP involvement is set out in Part 16 (and elsewhere as explained in paragraph [129]). Margaret Wade is considered in Part 17. The immediate problem in relation to this suggested precaution is that Margaret Wade was the person best placed to explain what her mental health condition was. She participated in the inquiry but chose not to give evidence. Out with the parts of this determination I refer to above, I am unable to make any findings in relation to Margaret Wade's mental health. On the basis of that which I have been able to determine, it cannot be said that the third suggested precaution would realistically have resulted in Lauren's death being avoided.

The Fourth Suggested Precaution

[224] The fourth suggested precaution is that Lauren's death may have been avoided if she had seen a medical practitioner on or about 5 February 2015. The consultation on that date is considered above at paragraphs [145] to [148].

[225] It is beyond peradventure that Margaret Wade could have asked Dr Campbell to examine Lauren on 5 February 2015. For reasons unexplained, she chose not to do so. The post-mortem evidence (see paragraph [177] above) is that Lauren had been suffering from a head lice infestation from at least September 2014. That Lauren was not examined by Dr Campbell that day rests entirely with Margaret Wade. Had Dr Campbell examined Lauren on 5 February 2015, there is a realistic possibility that her death would have been avoided. I have found accordingly (see Finding [F3]).

The Fifth Suggested Precaution

[226] The fifth suggested precaution is that Lauren's death may have been avoided if the social work team leader had followed up the visit on 4 July 2014 by communicating with the health visiting service to determine if the family home had been re-visited.

[227] As set out in paragraph [217] above, for the reasons I give below in Part 29 (see paragraphs [240] to [244]), I have concluded that a further visit to the Wade home should have taken place after 4 July 2014 (see Finding [F5]). I cannot, however, say that had such a visit taken place Lauren's death might have been avoided. The evidence before the inquiry was not sufficient to allow me to do so.

[228] The observations I have made in this part consider, as best I can on the evidence presented, the issue of whether there were missed opportunities to reassess Lauren (as additional, as opposed to the core HPI allocated to her when she was 5 months old) and provide further support. I decline to offer any view on whether there was a holistic approach to the family with regards to communication between those who were

involved in Lauren's care or on the extent of assessment of Lauren at the home visits. Neither was addressed in submissions by the participants.

28. Defects in any System of Working

[229] The fourth issue raised was the defects, if any, in any system of working which contributed to Lauren's death. In this regard, the inquiry was asked to consider the extent of any co-ordination between the social work department and health after the joint visit on the 4 July 2014.

[230] None of the participants suggested that there was a defect in any system of working which contributed to Lauren's death. Defects may be inherent in certain of the precautions suggested by Margaret Wade. I have addressed those suggested precautions in Part 27. The only precaution I have accepted could have been taken (see paragraphs [224] – [225] above) does not involve a defect in a system of working.

[231] I am satisfied that there were no defects in any system of working which contributed to the death and have found accordingly (see Finding [F4]).

29. Other Relevant Facts

[232] In her submissions to the inquiry, the procurator fiscal identified seven facts relevant to the circumstances of Lauren's death. I consider each of these in turn.

Allocation of Health Plan Indicator

[233] The expert health visiting witness for GGHB, Deborah Balshaw, agreed that as at 14 March 2013 an allocation of a "core" HPI was appropriate given the family circumstances. The issue of re-categorisation from "core" to "additional" is considered

above at paragraphs [218] to [221]. I am not satisfied that a review of Lauren's "core" status in July 2014 would necessarily have resulted in Lauren being re-categorised as "additional". It is, however, appropriate to record that GGHB accept that Irene Solley should have re-assessed Lauren's HPI. Accordingly, I am satisfied that the allocation of the Health Plan Indicator (or the absence of a review of the allocated indicator) is not a fact relevant to the circumstances of Lauren's death. The issue of a re-assessment of Lauren is considered below at paragraphs [246] to [248].

Communication between GP and Health Visitor

[234] I am satisfied that such communications as there were between the GP and the health visitor were appropriate and that no matters were not communicated which ought to have been. The professional judgment of the GP and the health visitor in this regard must be respected. I am satisfied that there is nothing within the communications between the GP and the health visitor as to constitute a fact relevant to the circumstances of Lauren's death.

Lack of Engagement with Triple P

[235] Margaret Wade was offered the Triple P Programme on four occasions. She refused the offer on three occasions but on the third occasion she expressed interest in the programme. Despite receiving correspondence in relation to the programme on this occasion, Margaret Wade did not engage with it. The programme is a voluntary one. It is telling that, in her submissions to the inquiry, Margaret Wade stated that, "The

multiple offers and refusals of the Triple P programme would not have prevented the death of Lauren." I am satisfied that Margaret Wade's failure to engage with the Triple P Programme was not a fact relevant to the circumstances of Lauren's death.

Change of Health Visitor

[236] The change of health visitor from Carol Murray to Irene Solley is considered above in Part 9. I am satisfied that the change of health visitor was not a fact relevant to the circumstances of Lauren's death, however, there are two matters of concern connected with this which it is appropriate are recorded.

[237] First, the absence of an allocated health visitor between March and November 2013. I recognise that health visitors will move on for any one of a number of reasons and that it may take time to replace them. In any such "gap" it is essential that a named individual is responsible for a case load. How such "gaps" are filled in practice would be a matter for GGHB. I did not hear evidence upon this issue, however, it is a matter that should be addressed.

[238] Second, the absence of any form of handover. I have no reason to disbelieve Irene Solley's evidence that she asked for and was specifically told she was not to receive a handover. That is an entirely unacceptable state of affairs. Whilst, as opined by Deborah Balshaw, a handover might only be in respect of children with an additional or intensive HPI, there should be a handover.

Joint Visit on 4 July 2014

[239] The expert witness in social work for the procurator fiscal, Maggie Mellon was of the view that there was a lack of a plan between Irene Solley and Martin Cullen as to what was to happen after the joint visit. I consider the visit of 4 July 2014 in detail in Part 14 above. Having had the benefit of hearing the evidence of Irene Solley and Martin Cullen, and having considered what happened subsequent to the visit of 4 July 2014, I am satisfied that it was entirely clear as to what would happen subsequently. There was a clear decision as to what would happen; that did, in fact happen, and the social work department closed the case, which (in the circumstances I have found established) was an appropriate course of action in Maggie Mellon's view.

[240] There is one further matter which can conveniently be considered relative to the joint visit on 4 July 2014. That is the issue of whether a further visit to the Wade home should have taken place after 4 July 2014.

[241] By 16 June 2014, Margaret Wade knew that the school nurse wished to carry out a home visit (see paragraph [77] above. An arrangement was made with Margaret Wade for that visit to take place on 19 June 2014. Margaret Wade cancelled that visit (see paragraph [77] above). The visit by the school nurse on 23 June 2014 was unannounced (see Part 11 above). Margaret Wade was reluctant to let the school nurse in, but relented. The house was "a mess" (see paragraph [81] above). The school nurse was sufficiently concerned to make a referral to the social work department (see paragraph [87] above).

[242] The joint visit by the health visitor and the social work department on 27 June 2014 proceeded by arrangement with Margaret Wade (see paragraph [97] above). Notwithstanding that, Margaret Wade did not wish the health visitor to enter the bedrooms or the kitchen. An arrangement was made for the health visitor to return. The health visitor made it clear that she wished to see the rest of the home when she returned. She felt the house was unsafe for children as it was grossly untidy (see paragraph [99] above).

[243] The joint visit by the health visitor and the social work department on 4 July 2014 (see Part 14 above) also proceeded by arrangement with Margaret Wade (see paragraph [99] above). The condition of the house was very much improved (see paragraph [101] above). The issue of the condition of the house deteriorating subsequent to the visit on 4 July 2014 was specifically raised with the health visitor. She stated that she had no concerns in this regard. In the circumstances outlined above, coupled with the circumstances that led to the unannounced visit by the school nurse, the health visitor should have been concerned and should have visited the Wade home again. Deborah Balshaw accepted that an unannounced visit should have been considered.

[244] In these circumstances, I have found that a further visit to the Wade home should have taken place after 4 July 2014 (see Finding [F5]). This is a fact which is relevant to the circumstances of Lauren's death.

The Lack of Formal Notification of concern by Glasgow City Education Department

[245] This can be dealt with briefly. Apart from hygiene issues, the school had no concerns about the wellbeing of either MW or CW. The concerns noted by teaching staff in relation to CW and MW did not reach the threshold required to trigger a Notification of Concern in terms of GCC's Management Circular No.57 (January 2009). This is not a fact which is relevant to the circumstances of Lauren's death.

Reassessment of Lauren

[246] The evidence of Deborah Balshaw was that Lauren should have been re-assessed after the joint visit on the 4 July 2014. I accept that evidence. Irene Solley had no understanding as to the reason why the condition of the Wade home had deteriorated to the extent it had (by the time of the visit on 27 June 2014). She had had no prior dealings with the Wade family. In Deborah Balshaw's opinion it would have been prudent for Irene Solley to undertake a further assessment to ensure that 'core' status was still appropriate. I accept that evidence also. There should have been a curiosity as to the reasons why the condition of the Wade home had deteriorated to the extent it had (by the time of the visit on 27 June 2014).

[247] In these circumstances, I have found that an assessment of Lauren should have taken place on or around 4 July 2014 (see Finding [F5]). This is a fact which is relevant to the circumstances of Lauren's death.

[248] In the absence of submissions from the participants on the remaining facts said to have relevant to the circumstances of Lauren's death (identified in paragraph [12] above), I do not propose to comment upon them.

30. Recommendations

[249] No participant in the inquiry invited me to make recommendations. Standing the extent of the changes that have taken place since Lauren's death that is unsurprising. I make no recommendations in terms of section 26(1)(b) of the Act.

31. Conclusion

[250] Lauren Wade died on 20 March 2015. She was two years and five months old when she died. The cause of Lauren's death was complications of malnutrition. That a child should die in such circumstances in Glasgow in the 21st century is difficult to comprehend. Regrettably, having carefully considered the evidence and the voluminous productions before the inquiry, I cannot say exactly how that happened.

[251] Lauren's death was the fault of Margaret Wade and Marie Sweeney. They each accepted their guilt to wilfully ill-treating, neglecting and exposing Lauren (and her siblings) in a manner likely to cause her unnecessary suffering or injury to health. They each received lengthy prison sentences.

[252] Margaret Wade and Marie Sweeney did not give evidence to this inquiry. In my view, efforts should have been made to compel them to do so. Why they did not give evidence was not explained. The present inquiry was a discretionary one in terms of section 4 of the Act. Lauren's death occurred in circumstances which ought to give rise to serious public concern. Absent evidence as to what happened in the Wade home

between 4 July 2014 and Lauren's death, just over eight months later, the court has been unable to make findings beyond those which it has. That is a matter of considerable regret.

[253] The court extends its sympathies to all those affected by Lauren's tragic death.

Sheriff Principal C.D.Turnbull

Glasgow, 28 February 2023

APPENDIX 1

The Legal Framework

[A1] The purpose of a fatal accident inquiry is set out in section 1(3). It is to (a) establish the circumstances of the death or deaths; and (b) consider what steps (if any) might be taken to prevent other deaths in similar circumstances. It is not the purpose of a fatal accident inquiry to establish civil or criminal liability (see section 1(4)). A fatal accident inquiry is inquisitorial, not adversarial (see rule 2.2.(1)).

[A2] Section 1(2) provides that an inquiry is to be conducted by a sheriff. In terms of section 3(5) of the Courts Reform (Scotland) 2014 Act, the sheriff principal of a sheriffdom may exercise in his or her sheriffdom the jurisdiction and powers that attach to the office of sheriff. Inquiries which raise issues of particular significance and those which may attract a significant degree of public interest are regularly presided over by sheriffs principal. The procedure at an inquiry is to be as ordered by the sheriff (see, in particular, rule 3.8.(1) and rule 5.1) or, in this case, the sheriff principal.

[A3] As soon as possible after the conclusion of the evidence and submissions in an inquiry, the presiding sheriff must make a determination setting out certain findings and such recommendations (if any) as the sheriff considers appropriate. A determination under section 26 is to be in Form 6.1 (see rule 6.1)

[A4] The findings the sheriff is required to make are set out in section 26(2), namely, (a) when and where the death occurred; (b) when and where any accident resulting in the death occurred; (c) the cause or causes of the death; (d) the cause or causes of any accident resulting in the death; (e) any precautions which (i) could reasonably have been

taken; and (ii) had they been taken, might realistically have resulted in the death, or any accident resulting in the death, being avoided; (f) any defects in any system of working which contributed to the death or any accident resulting in the death; and (g) any other facts which are relevant to the circumstances of the death.

[A5] The making of recommendations is discretionary. The recommendations which the sheriff is entitled to make are set out in section 26(4). The recommendations must be directed towards (a) the taking of reasonable precautions; (b) the making of improvements to any system of working; (c) the introduction of a system of working; and (d) the taking of any other steps which might realistically prevent other deaths in similar circumstances. Recommendations may (but need not) be addressed to (i) a participant in the inquiry; or (ii) a body or office-holder appearing to the sheriff to have an interest in the prevention of deaths in similar circumstances.

APPENDIX 2

Witnesses

[A6] The following witnesses gave evidence to the inquiry:

1. Anne Healey, Head Teacher
2. Yvonne Adams, Deputy Head Teacher
3. Sharon McIntyre, School Nurse
4. Carol Murray, Health Visitor
5. Irene Solley, Health Visitor
6. Martin Cullen, Social Worker
7. Maggie Mellon, Social Work Expert
8. Dr Tracey McLaughlin, GP
9. Deborah Balshaw, Health Visiting Expert

APPENDIX 3

The Criminal Charges

[A7] Margaret Wade and Marie Sweeney pled guilty to three charges under section 12(1) of the Children and Young Persons (Scotland) Act 1937, one relating to Lauren; one relating to CW; and one relating to MW. Those charges were in the following terms:

> "(001) On various occasions between 23 June 2014 and 20 March 2015 at Flat 3/2, [redacted] Sighthill, Glasgow, you MARGARET WADE and MARIE SWEENEY, both having attained the age, or having charge or care of such a child or young person namely, LAUREN WADE (Dob: 08-October-2012), now deceased, daughter of you MARGARET WADE then residing with you both at Flat 3/2, [redacted] did wilfully ill-treat, neglect and expose LAUREN WADE in a manner likely to cause her unnecessary suffering or injury to health in that you did fail to provide said Lauren Wade with adequate or appropriate nutrition and fluids, fail to bathe her and otherwise keep her clean, fail to maintain her personal hygiene, fail to provide her with adequate accommodation in that said Flat 3/2, [redacted] was not appropriately maintained, was untidy, unclean and infested with flies, insects and similar thus causing her to reside in an unsafe and unhygienic environment, and fail to attend to her health needs by failing to provide appropriate medical and dental care or treatment as recommended or required and the said LAUREN WADE sustained infections and infestations, became malnourished and fell into such a state of ill health that on 20th March 2015 at Flat 3/2, [redacted] she died. Contrary to Children and Young Persons (Scotland) Act 1937 s.12(1).
>
> (002) On various occasions between 30th August 2007 and 20 March 2015 at Flat 17/4, [redacted], and Flat 3/2, [redacted], both Sighthill, Glasgow, you MARGARET WADE and MARIE SWEENEY, both having attained the age of 16, and having parental responsibilities in relation to a child or young person under that age, or having charge or care of such a child or young person namely, CW (Dob: 13-October-2004), did wilfully ill-treat, neglect and expose CW in a manner likely to cause her unnecessary suffering or injury to health in that you did fail to provide said CW with adequate or appropriate nutrition and fluids, fail to provide her with adequate accommodation in that said Flat 17/4, [redacted] and

Flat 3/2, [redacted] were not appropriately maintained, were untidy, unclean and infested with flies, insects and similar thus causing her to reside in an unsafe and unhygienic environment, and fail to bathe her and otherwise keep her clean, fail to maintain her personal hygiene, fail to provide her with clothing appropriate for her size and for the weather and fail to attend to her health needs by failing to seek and provide appropriate medical and dental care or treatment as recommended or required. Contrary to Children and Young Persons (Scotland) Act 1937 s.12(1).

(003) On various occasions between 30th August 2007 and 20 March 2015 at Flat 17/4, [redacted] and Flat 3/2, [redacted] both Sighthill, Glasgow, you MARGARET WADE and MARIE SWEENEY, both having attained the age of 16, and having parental responsibilities in relation to a child or young person under that age, or having charge or care of such a child or young person namely, MW (Dob: 09-Jul-2007), did wilfully ill-treat, neglect and expose MW in a manner likely to cause her unnecessary suffering or injury to health in that you did fail to provide said MW with adequate or appropriate nutrition and fluids, fail to provide her with adequate accommodation in that said Flat 17/4, [redacted] and Flat 3/2, [redacted] were not appropriately maintained, were untidy, unclean and infested with flies, insects and similar thus causing her to reside in an unsafe and unhygienic environment, fail to bathe her and otherwise keep her clean, fail to maintain her personal hygiene, fail to provide her with clothing and footwear appropriate for the weather and fail to attend to her health needs by failing to seek and provide appropriate medical and dental care or treatment as recommended or required. Contrary to Children and Young Persons (Scotland) Act 1937 s.12(1)."

APPENDIX 4

Agreed Narrative

[A8] The agreed narrative (anonymised and redacted where appropriate) read to the High Court of Justiciary following upon the pleas of guilty by Margaret Wade and Marie Sweeney was in the following terms:

"History of the accused

The accused Margaret Wade is 38 years old, her date of birth being 29 September 1980. She resides with her partner and co-accused Marie Sweeney at [address] Glasgow. She is unemployed and receives state benefits. She has no previous convictions.

Margaret Wade is the mother of three children including the deceased Lauren Wade whose date of birth was 8 October 2012 and date of death 20 March 2015. Her other children are [CW] born 13 October 2004, the child referred to in charge (2) and [MW], born 9 July 2007, the child referred to in charge (3).

Marie Sweeney is 37 years old, her date of birth being 2 October 1981. She resided at [address] Glasgow. She is unemployed and receives state benefits.

The accused Marie Sweeney was the tenant of [Flat 17/4] between 12 April 2004 and 25 February 2011. She lived at that address with her partner Margaret Wade and the two older children from their respective dates of birth until the flat was abandoned by them. Thereafter the accused Margaret Wade was the tenant of [Flat 3/2] from 23 September 2011 until the date of Lauren's death on Friday, 20 March 2015.

The accused have been in a same sex relationship for more than 15 years and regarded themselves as the parents of all three girls, and had parental responsibilities or were in

charge of or had care of each from their dates of birth until Lauren's death on 20 March 2015, when [CW] and [MW] were removed from them.

The children were both placed in foster placements until being allowed to reside with [redacted] from 28 January 2016. The accused continued to have supervised contact with them.

History of the deceased Lauren Wade

Lauren Wade was born on 8 October 2012 and died on 20 March 2015 at just under two and a half years old from complications of malnutrition. She lived with her parents and the accused in this case at Flat 3/2, where she died.

Lauren was last seen by her General Practitioner on 25 June 2014 when the accused Margaret Wade requested an emergency GP appointment for her because of previous diarrhoea and vomiting and a cough. She was examined and noted to be teething and had diarrhoea and coughing but no vomiting. She was prescribed teething gel, paracetamol and a cough syrup.

On 9 July 2014 the deceased now 21 months old attended Glasgow Royal Infirmary Emergency Department at 1755 hours. The accused Wade reported that the deceased had tripped and hit her head on the table. There was no suspicion of Non Accidental Injury and she was discharged home. She was not seen by any medical practitioner after that date.

History of the case

Both accused appeared on petition at Glasgow Sheriff Court on 3 July 2017 charged with murder of Lauren and contraventions of s 12 of the Children and Young Persons Act

1937 s 12(1) (*sic*). They were committed for further examination and released on bail with a special condition related to contact with [CW] and [MW] being supervised by the Social Work Department or an adult approved by them, which was later changed to allow witness [redacted] to be one of those permitted to supervise contact.

Timing of the plea

Although the accused had appeared on petition for murder of Lauren Wade, the Crown took the view that the most up to date medical evidence led to the conclusion at indicting that a charge of culpable homicide was appropriate.

This case was due to call first at a Preliminary Hearing at Glasgow High Court on 1 June 2018. At that time the defence were awaiting a report from an expert in paediatric pathology and the Crown were awaiting production of a further expert report. These reports became available in late August and early September and it became apparent to parties that further consideration of both reports by experts who had previously reported to the Crown was necessary.

Supplementary reports became available in time to allow parties to have a detailed discussion about resolution of the case, leading to a plea being tendered at this Preliminary Hearing.

Overview

The three charges relate to three separate children but as might be expected the circumstances of each offence overlap and the charges refer to the same basis ill

treatment and neglect which exposed each of the children to the likelihood of unnecessary suffering or injury to health, and led ultimately to the death of Lauren Wade.

The accused failed to provide the children with adequate or appropriate nutrition, failed to provide adequate accommodation, failed to bathe them or keep them clean, failed to provide the older children with appropriate clothing and failed to attend to their health needs by failing to provide appropriate medical and dental care or treatment.

Circumstances of the charges

Nutrition

The most significant effect of the failure of the accused to provide a proper diet for the children is the malnutrition of the deceased which caused complications leading to her death which are discussed in detail later in this narrative.

Prior to going to Primary School [CW] had 10 teeth extracted under general anaesthetic in 2007 and 2009. She was noted to be overweight and on being examined on 28 March 2015 by Dr McKay after Lauren's death she was noted by the Doctor to be obese and suffering from a moderately severe infestation of nits. Dr McKay considered that she had moderate evidence of chronic neglect of her health needs, particularly of healthy weight and healthy hair. When seen for dental treatment in April 2015 all four of her first permanent molars were found to be affected by decay.

The accused Margaret Wade reported concerns that [MW] did not eat much in August 2010 when she was aged 3. At Nursery, it was noted that she ate little and would only

eat toast. [MW] was seen by a Doctor in January 2014 in connection with her poor diet, and the accused Wade advised the Doctor that [MW] had been making her own food choices from the age of two, that she took small portions of unhealthy food and preferred gassy ginger and sports drinks. She was given advice regarding diet and was seen again by a dietician and a consultant paediatrician in August 2014. Her diet and weight had improved and she had made sufficient progress to be discharged from follow up.

In September 2010 a dentist noted a precursor to decay in [MW]'s front tooth which had turned to decay by February 2011 and had worsened by February 2012 when seen for a check-up. The school dental examination resulted in a letter being sent home in May 2012 to arrange dental treatment which was not done until November 2012. [MW]'s teeth continued to cause concern. Her last appointment before Lauren's death was on 6 February 2014 and was not seen again until taken by her foster carers in April 2015 when further treatment was required. At that time [MW] had decay in nine of her primary teeth, six of which required fillings and three of which had to be removed under general anaesthetic.

[MW] was also seen by Dr McKay on 28 March 2015 and was found to be lighter than expected and had mild lice infestation together with dental issues which would highlight moderate neglect in respect of her teeth.

When at school both [CW] and [MW] were noted at various times and by various different teachers to be dirty particularly under the fingernails and on occasion had grubby clothing on. It was noted that on occasion [CW]'s clothing was too small for her,

and that she wore summer dresses when she should have been wearing warmer and more appropriate clothing. [MW] on occasion wore sandshoes in wet weather and did not have a jacket when it was raining.

A lack of personal hygiene was noted in respect of both [CW] and [MW] at school and they both had repeated head lice infestations since the end of 2007, including November 2007, March 2009, November 2009, September and October 2012, August 2013, February, May, June, November and December 2014 and March 2015, which on occasion were so significant that the children had to be sent home from school. Margaret Wade had head lice herself for an unknown period of time.

Examination of Lauren's hair at post mortem leads to the conclusion that she had suffered from an infestation with head lice over a period of between 6 and 17 months.

Living conditions and accommodation

It became apparent to a health visitor as at 29 August 2007 that the living conditions at Flat 17/4 for [CW] and newly born [MW] required to improve, and it was suggested that the accused Margaret Wade ought to establish a household routine to improve the poor hygiene standards at the property. The children continued to live there and on 25 February 2011 the landlord became aware that the property was no longer occupied and carried out an inspection. Photographs of the property (which erroneously bear the date 9 February) are contained in Crown Production 134.

The conditions of that property is similar to the condition of [Flat 3/2] when it was examined by police on 20 May 2015. Images of this flat are shown in Crown Production 12. The first police witnesses at the scene found it to be extremely dirty, chaotic and in disarray. There were hundreds of visible flies and insects throughout the whole flat. There was rubbish and dishevelled clothing lying throughout the property. All rooms were found to be littered with the remnants of food and food containers at various stages of decomposition in addition to dirty crockery.

The police witness DS Cuthbert was appointed initial crime scene manager and described the scene as one of the most disgusting houses that he had ever seen in his police service. It was neither a suitable nor safe environment for children.

The kitchen was so full of bags of rubbish that there was barely enough space to open the door. The bags of rubbish were piled so high that they sat above the kitchen work tops. The presence of decaying food had attracted flies and other insects. There were numerous empty pot noodle cartons all with flies. Pot noodle appeared to be the staple family diet. Within the fridge was a limited quantity of food most of which was out of date. There was also a quantity of medication within the fridge. Some waste material was found to be dated to 2013. Within one of the kitchen cupboards were 2 bottles of Hedrin for the treatment of head lice which had not been opened.

Bedroom 1 was occupied by [MW] and contained two beds with the floor littered with clothing, toys and waste materials. The carpeting was almost invisible due to volume of clutter. There was a small fish tank within the bedroom the water of which was black and obviously unattended for some time.

Bedroom 2 contained a double bed and cot which appeared not to be used. The mattress from the double bed was found lying against the wall.

The cot was full of various bedding and clothing. Above the bed in a cupboard there were several empty boxes and blister packs of Diazepam. There was also a baby bottle containing what appeared to be sour / curdled milk.

Bedroom 3 was occupied by the child witness [CW] and contained one bed. The room is the least cluttered of all rooms but was still cluttered with toys, clothing and other waste material.

The remaining bathroom, toilet, and storage cupboards were full of clutter and had not been cleaned for some time.

It is clear that the failure to provide adequate accommodation was a longstanding issue which did not simply emerge in the days or weeks before the death of Lauren Wade.

After they moved in to [Flat 3/2], a neighbour noted over the years leading up to Lauren's death that on his visits to the door the carpet in the hall was dirty and worn and that the hallway was cluttered with clothes, toys and junk lying about. He also noted a very strong smell coming from the flat.

He was in the living room on 18 March 2015 to help with a new media box and was shocked at the condition of the living room. The carpet was very old and looked dirty. There were piles of toys against a wall as if a space had just been cleared. The furniture in particular the chair and settee were very worn, tatty and dirty and Lauren was lying on the settee sleeping and would then wake up for five minutes and girn before falling asleep again.

A friend of the accused Margaret Wade visited the flat sometime around 2012 and found the house so dirty that she did not want to stay. She had attended with her son and did not want to put him down because of how unclean the house was.

On Monday, 23 June 2014 in response to concerns expressed by the school, the school nurse conducted an unannounced home visit to the locus and found the hall and living room to be in a state of disarray. The nurse did not investigate the kitchen or bedrooms. The witness gave the accused Wade instruction in relation to treatment of the children's hair lice as the accused refused her assistance to administer the treatment saying that they had been treated already.

Details of this visit were passed to the Social Work Department and on 27 June 2014 a follow up home visit was carried out by a Health Visitor, who found the house to be messy with cigarette butts on the floor and several bin bags piled up in a corner and unwashed dishes piled up. The accused Wade was instructed to have the house cleaned as it was not the best of circumstances for the children and was advised a further pre-planned visit would be made on 4 July 2014.

On 4 July 2014 the visit was made to the scene by the health visitor and a social worker. On this visit the house was found to be unrecognisable from the previous visit and was deemed to be clean although they did not inspect all rooms at the locus. It should be borne in mind that some of the refuse found in the house after 20 March 2015 dated back to 2013.

There were no further visits to the locus by the Social Work Department or health visitor after 4 July 2014.

Since that visit the living conditions at the flat deteriorated again and became unclean and infested with flies and insects and caused all three children to live again in an unsafe and unhygienic environment exposing them to risk of infection and infestation and unnecessary suffering or injury to health, and in the case of Lauren may have played a part in her death.

Following police involvement in the case a pest controller was called to fumigate the locus, and he expressed the view that this was worse than all of the other houses he had fumigated to a very considerable extent.

Medical and dental needs

The accused were aware of the dental problems of all three children and failed to take adequate steps to address the dental decay caused to them. They were also aware of the repeated infestations with head lice and failed to take adequate steps to address that. Lauren was plainly unwell for a number of days prior to her death. She was emaciated. A month before Lauren's death Margaret Wade asked a neighbour in the block if Lauren had been disturbing her through the night due to her crying as a result of teething. In the week before she died, Margaret Wade told another neighbour that Lauren had been screaming all night because of teething. In fact Lauren had a full set of teeth by that stage. On 13 March 2015 the accused Margaret Wade reported to her sister that Lauren had a cold. On 17 March 2015 Lauren was seen to be pale and tired looking when the accused Margaret Wade was picking up the children from school, and Margaret Wade said that Lauren had a cold.

Circumstances relating to the death of Lauren Wade

The essential background circumstances of living conditions and neglect are outlined in the previous section.

Lauren Wade had been provided with an inadequate diet by the accused as a result of which she was malnourished over a period of at least weeks before her death and was suffering from malnutrition. Complications arising from that malnutrition caused her death. Lauren Wade was discovered unresponsive sometime around 0700 on 20 March 2015. Calls were made to a neighbour who came in to the flat briefly to see if he could help, and to Margaret Wade's mother and sisters, before the emergency services were called at 0730 by the accused Marie Sweeney, shortly before the neighbour who had come in to help called for an ambulance as well. The accused Marie Sweeney followed advice to provide CPR to Lauren.

Paramedics arrived and noted that the deceased was skinny, dirty and unkempt with a large and noticeable lice infestation on her hair, head and face. They carried out CPR on her as she was conveyed to Yorkhill Hospital in cardiac arrest and resuscitation attempts continued on arrival there. Life was however pronounced extinct at 0807 by the doctor. The paramedics later noticed that the cover the deceased had been lying on was brown and dirty and covered in lice, fleas and nits and their shirts were similarly covered. They had to clean and decontaminate the ambulance.

Examination at the hospital showed no obvious signs of trauma or injury but there was very poor hygiene [Lauren] being dirty and malodorous. She was very pale with severely matted dirty hair, with bald patches and thousands of head lice. Her vest was

old and discoloured and her nappy was soaking wet with faecal staining at the back suggesting it had been on for some time.

Margaret Wade spoke to nursing staff and advised that Lauren had a cold or a viral illness for a couple of days and had not eaten since the previous day. She said she had treated Lauren's sisters for head lice but not Lauren as she had been unwell.

Margaret Wade at that time kept her hood up to disguise her own infestation with head lice and appeared to be dirty and smelled of body odour.

Cause of death of Lauren Wade

At post mortem Lauren Wade was found to be a small for age female child with evidence of severe neglect. She was filthy with severe lice infestation, with thousands of head lice crawling over her hair, face and upper chest. Lice eggs were seen at least 21 cm from the hair root, suggesting that the lice infestation had been present for at least 6 months, but probably for over 17 months. The scalp hair was matted and malodorous. There was hair loss, with regression of the hair line, bald patches, and areas of ulceration. The majority of the hair fell away from the scalp on massaging lice treatment into the hair. Scalp histology showed no evidence of an intrinsic alopecia. Cavities were seen in both upper front teeth.

Lauren was very thin and underweight, with a body weight between the 2nd and 9th centiles (80% of that expected for age) and a Body Mass Index at the first centile for age. The subcutaneous fat thickness was markedly reduced (1 mm on the chest), in keeping with a degree of wasting. The head appeared large (head circumference between 90th

and 95th centiles) in comparison to the body. These findings are in keeping with failure to thrive.

Lauren's condition is shown in the photographs taken on 20 March 2015 at the mortuary in Crown Production 16.

Lauren Wade's home circumstances were unhygienic and she was found to be unkempt, emaciated and had a severe head-lice infestation, consistent with neglect. The body measurements indicate a mild degree of undernourishment without significant stunting, consistent with acute malnutrition. Her skin fat was reduced. Prominent steatosis (fatty change) within the left ventricular heart muscle and liver, together with changes in the brain are likely to be a consequence of malnutrition. Recent necrosis in the cardiac papillary muscles and widespread neuronal injury in the brain suggest that the death occurred in the context of cardiac dysfunction related to the malnutrition, which is a complication of malnutrition. Further, it should be noted that infection can also be a complication of malnutrition. In those with significant malnutrition sepsis and infection are the usual causes of death from immunosuppression and reduction in anti-oxidant defences as a complication of malnutrition. The latter factors allow hypoxic / ischaemic injury to occur from a variety of sources. Death from malnutrition accordingly occurs as a consequence of a number of factors which are the result of the malnutrition.

In addition the living conditions demonstrate neglect. A major factor in the neglect of Lauren Wade was the failure to provide her with an appropriate diet for a growing child which resulted initially in under nutrition and later acute malnutrition. The chaotic living conditions and lack of personal hygiene also placed her in an infected

environment and combined with immunosuppression left her open to opportunistic infection.

There was significant damage to Lauren's heart. There may well also have been terminal/late sepsis. The cause of death is:

1a. Complications of malnutrition.

Police investigation

The accused were initially treated as witnesses and provided statements as such to the police. In a statement noted on 31 March 2015 Marie Sweeney advised "Me and Margaret regard ourselves as parents to all three of Margaret's children. We regard ourselves as a family"

The accounts provided by the accused as witnesses did not explain the condition of the house or the malnutrition from which Lauren Wade was suffering at the time of her death. Reference was made to a problem with the bins being emptied at the block in which the flat was situated, but no difficulty seems to have been experienced by any other resident and no complaint was made to the Housing Association in charge of the block.

During the course of 2017 the accused agreed to take part in Parenting Capacity Assessments carried out by social workers, which ended when criminal proceedings commenced. During these assessments in summary the accused Margaret Wade accepted no responsibility for her failings in basic parenting and said she had no guilt over Lauren's death. Marie Sweeney accepted that she should have been more forceful

in relation to the condition of the house. She accepted that the house was dirty and the children had head lice and she should have intervened.

Criminal proceedings were initiated when both accused were detained on 30 June 2017 in respect of the matters which appeared on the original petition. Both accused exercised their right to make no comment when questioned by the police after detention.