**WEST GLAMORGAN SAFEGUARDING BOARD**

**Child Practice Review Report**

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| **Child Practice Review Report**  **West Glamorgan Safeguarding Children Board**  **Extended Child Practice Review**    **Re: WG CPR S65 2023** |

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| **Brief Outline of Circumstances Resulting In The Review**  *To include here: -*   * *Legal context from guidance in relation to which review is being undertaken.* * *Circumstances resulting in the review.* * *Time period reviewed and why.* * *Summary timeline of significant events to be added as an annex* |
| Legal Context:  The Social Services and Wellbeing (Wales) Act 2014, Working Together to Safeguard People Volume 2 – Child Practice Reviews sets out the requirements to undertake reviews in specific circumstances. Under these regulations an Extended Child Practice Review was commissioned by the West Glamorgan Safeguarding Board (WGSB) on the recommendation of the Practice Review Management Group (PRMG). The criteria for this Review were met under section 7.1 of the above guidance namely:  A Board must undertake an Extended Child Practice Review in any of the following cases where, within the area of the Board, abuse or neglect of a child is known or suspected and the child has:  (a) Died; or  (b) Sustained potentially life-threatening injury; or  (c) Sustained serious and permanent impairment or health or development  and  the child was on the Child Protection Register and/or was a looked after child (including a care leaver under the age of 18) on any date during the 6 months preceding –   1. The date of the event referred to above.   • The date on which the local authority or relevant partner identifies that a child has sustained serious and permanent impairment of health and development.  **Circumstances Leading to the Review**  This Review was commissioned following a referral to the West Glamorgan Safeguarding Board from the Police and Local Authority (LA), dated 14th September 2022. The referral to the Safeguarding Board was triggered following a significant drug overdose whereby Child A was hospitalised, and Adult B died. The Child Practice review was undertaken to understand the lead up to the incident, alleged offence(s) and the response(s) of practitioners and agencies.  **The scope of the Review**  The timeframe for this review was from 1st May 2021 to 12th September 2022.  Chair of Panel – Sam Jones – NPT Education  Independent Reviewers – Joanne Stephens – National Probation Service & Joy Lewis – South Wales Police  Following the decision to carry out this Extended Review a Child Practice Review Panel was formed consisting of the following agencies:  South Wales Police  Swansea Local Authority  Education Swansea  Swansea Bay University Health Board  Swansea Youth Justice Service  National Probation Service  The panel met, constructed, and analysed a multiagency timeline identifying some practice and organisational learning.  **Contact with family –** Despite all efforts being made the family were not contactable to discuss the review.  **Contact with Child A**  Contact was made with Child A to discuss his view on the review and his reflections on the period discussed. Child A is glad the review has taken place and will read the report with a keen interest.  Upon reflection of that time, he states that due to issues at home and a lack of parental structure, he became exposed to the drug scene quite quickly, using illicit substances from a young age (approx. 11 / 12). His drug use escalated, and he became immersed in a lifestyle that was difficult to escape. Each day his focus was obtaining any drugs he could and by any means, often resorting to offending (theft, burglary) in order to get what he wanted. He often supported his parents drug use, who were both entrenched drug users.  At 16, he entered into a “relationship” with Adult B; whilst he can appreciate that practitioners are concerned about the nature of the “relationship”, particularly given the age difference, he feels that they had a ‘connection’ fuelled by their mutual interest in using drugs. On the day when Adult B lost her life, he states there was no suicide pact rather they both decided to use a different drug to their usual choice and to a larger quantity. This sadly led to fatal consequences.  Child A feels that whilst lots of agencies were involved with him during this period, the most support he received was from the Substance Misuse Worker and he is grateful for this. He could not offer any suggestions as to what could have been done differently by any agency, as he states he was too involved in that lifestyle at the time.  **The Learning Event**  The multi-agency learning event took place on the 23rd of January 2024. The event was held Remotely on Teams.  **The Practitioners Event was attended by practitioners from the following agencies:**  South Wales Police  Swansea Local Authority  Education Swansea  Swansea Bay University Health Board  Swansea Youth Justice Service  CAMHS  Probation  Within the learning event the reviewers spent time at the beginning of the day to ensure practitioners understood the purpose of the event: to learn and not to apportion blame.  Some of the attendees only had limited involvement but were invited because they were involved with the family and their contribution was considered pertinent.  **Background**  Child A’s contact with Children’s Services began in 2021 when he was 16yrs of age. Child A was believed to be suffering from epilepsy and was prone to have seizures.  In May 2021 Child A was open to Swansea Youth Justice Service having been made subject to a referral order.  As part of the referral order Child A needed to engage with the Youth Justice Service. At one such meeting Child A made a disclosure to his social worker that he was taking illegal substances and asked if he could speak to the Substance Misuse Worker. A referral was made, and contact established. Child A instantly engaged with the Substance Misuse worker and this practitioner became trusted and relied upon by both Child A and other practitioners working with him.  In the weeks which followed the Youth Justice Service workers became increasingly concerned for Child A and his welfare.  In May 2021 Youth Justice Staff submitted a referral to Children Services (IIAA). The referral outlined the Child Protection concerns over Child A’s home life and his parents’ ability to provide safe care given his situation, substance misuse and recent fits.  In June 2021 YJS made a second referral to children services sighting the concerns about lack of parental care, continuing untreated seizures, substance misuse and lack of support. During the month which followed YJS continued to try to engage with Child A, they attended at the home address on a number of occasions, arranged and facilitated Neurology appointments and acted as a single point of contact for all services.  Child A’s seizures continued and all agencies remained concerned. YJS remained a constant with a number of contacts each week. In August 2021 it was established that Child A’s relationship with his girlfriend (same age) had ended and he was believed to be in a “relationship” with a 28yr old female and he had access to drugs. This female will be referred to as Adult B to protect her and Child A’s identity.  As the weeks continued, concerns continued to escalate in relation to Child A. He was sighted with facial bruising, loss of weight, new clothing and disclosed cocaine usage. Following a review strategy meeting a decision was made for Childrens Services to conduct a Section 47 Enquiry and child protection conference to be arranged. A National Referral Mechanism (NRM) was submitted to the Single Competent Authority (SCA) within the home office outlining suspicions that Child A was the victim of Child Criminal Exploitation. Police reported increased intelligence linking Child A to drug dealing, Child A began living with Adult B and his seizures continued. There were reported domestic related incidents at the home address of Adult B and on the 30th of September 2021 the Section 47 investigation was actioned. A week later Child A was placed on the child protection register under the category of neglect.  During the months which followed Child A continued to reside with Adult B, he was reported missing by services a number of times.  On one such occasion the YJS substance misuse officer informed South Wales Police call handler that Child A was at risk of Child Sexual Exploitation from Adult B; the significance of this was not appreciated by the call handler who insisted that Adult B was his “girlfriend” and had been linked on police systems as such. Police continued to receive information relating to drug dealing and domestic incidents ongoing between Child A and Adult B.  In December 2021 Adult B disclosed that she was pregnant and that the father of the child was Child A. This information was disclosed to a Youth Justice Service Worker. The worker described Adult B as being concerned about the pregnancy (she did not have her child in her care) and Child A was described as being positive about the pregnancy.  The reports of suspected involvement with drug dealers continued and in January Child A was sighted with what appeared to be a black eye. Child A was arrested a number of times for offences relating to thefts. On each occasion he was under the influence of drugs.  In April 2022, Adult B was conveyed to hospital with injuries. She had sustained considerable bruising but refused to disclose what had occurred. On the same day Child A was found injured by a passerby, he was laying on the pavement with an open fracture to his ankle.  Child A was conveyed to hospital where he was admitted. Child A underwent surgery for the open fracture, and whilst as an inpatient he sustained further injury when despite medical advice he stood on his leg. Child A had tried to intervene when his mother had attended to visit him and been refused entry. He required further surgery.  Over the months which followed Child A continued to reside mainly with Adult B, he did on occasions live with his mother who resided on the same street. At times Child A engaged with services, however concern remained regarding the lack of parental care, drug usage, risk of exploitation, frequent arrests and seizures.  In September 2022 both Child A and Adult B overdosed on heroin. It is unclear what led up to this, but Child A subsequently disclosed to a practitioner that this was a suicide attempt. Police and Ambulance service attended and despite the best efforts of all Adult B passed away. Child A was unconscious and gravely ill, he was conveyed to hospital where after receiving treatment he made a full recovery.  Following release from hospital Child A was discharged back to his mother’s address. He was subsequently arrested by police for his part in the death of Adult B (possible suicide pact). |

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| **Practice And Organisational Learning**  *Identify each individual learning point arising in this case (including highlighting effective practice) accompanied by a brief outline of the relevant circumstances* |
| **Gender bias**  The review considered a sixteen-month period following Child A’s arrest on suspicion of being involved in the Mayhill Riot up to the point of Child A’s overdose and death of Adult B.  When Child A began being linked with Adult B, practitioners did not raise concern that Child A was at risk of Child Sexual Exploitation.  The substance misuse worker in YJS did raise this concern, however Adult B was seen as a mother figure and nurturing towards Child A by all other practitioners. During this period, it was established that there was substantial information to suggest that Child A and Adult B were linked to drug dealing. Child A disclosed to many practitioners that he was engaging in sexual intercourse with Adult B but this was never explored as sexual exploitation.  It is noted in the police systems that Adult B was linked as a “girlfriend”.  On one review by a Public Protection Detective Inspector, the concerns regarding CSE were highlighted, and action plan set to investigate. Despite this Child A was not on any Police protocol and did not become subject to a CSE investigation.  The review considered if gender bias was present. The reviewers asked the question; ‘If Child A had been a 16yr old female and Adult B a 28yr old male would this have been viewed differently?’  The consensus seemed to be that it would most likely have been viewed differently.  During the learning event this was explored with practitioners. A number of practitioners voiced that Adult B was vulnerable in her own right and that she was a protective factor.  There seemed to be limited recognition of the significant gender bias, even with the benefit of hindsight.  The reviewers felt that there was clear gender bias present in this case.  **Recognising the risk of exploitation and action taken**  Over the course of the chronology, it was clear that the risks surrounding Child A continued to increase. However, it does not appear that these were acted upon swiftly. The delays in instigation of the Section 47 investigation illustrates the lack of immediacy.  The review also noted that the risk Adult B posed to Child A was not fully recognised or understood by agencies, for example Adult B was part of the Children’s Services Safety Plan and Public Protection Police Officers had linked Adult B as a “girlfriend”.  The use of language across all agencies was commented on by the review. A number of agencies referred to Adult B as “girlfriend”, this normalised the “relationship” to both practitioners and also to Child A. Services did not recognise Adult B as an exploiter either sexually or also criminally. The review noted that there was a lack of professional curiosity, the acceptance by services of this as a “relationship” was a concern.  Likewise, the lack of professional curiosity surrounding the relationship with Child A’s father and the police intelligence. Child A’s father wanted him to run drugs for an English based county line gang. Child A’s new clothing, unexplained injuries, lack of food, disclosures of fear and threats of violence were never thoroughly explored in relation to exploitation.  Within panel meetings and at the learning event there was discussion of why legal action was not taken to remove Child A. Child A was discussed at legal gateway meetings on more than one occasion but the advice, based on legislation and guidance, was that action in the family court was not appropriate in this case. It was queried as to whether Child A’s age was the predominant factor in those decisions and there was some strong feeling that the advice should have been challenged. However, as a panel we recognise that process was followed and actions were taken based on legal advice.  **Disguised Compliance and Professional Curiosity**  Throughout the timeline there is evidence that parents and Child A engaged sporadically with practitioners. This seems to have been considered in isolation, any engagement was seen as evidence of the family working with services.  The review reflected upon the engagement of Child A’s family and found evidence of disguised compliance. It was evident that practitioners felt that there was some degree of this by Child A’s parents. The review felt that Child A’s parents clearly loved their son but did not follow through on assurances being made to practitioners to keep Child A safe and to tend to his basic needs.  During the Initial child protection conference police advised that Child A’s mother had received a caution for possession of heroin six months before. This information was shared but not further discussed. Practitioners at the learning event felt that this information was relevant, not only in the risk surrounding Child A but also providing information about his home life. Heroin is highly addictive and so if Child A’s mother was using heroin at the time of the Conference this should have been explored with her and considered in the safety plan. However, the majority of practitioners accepted mother’s engagement with the conference as positive evidence. This took the focus away from the considerable risk factors surrounding Child A.  The panel also identified a general sense of over-optimism throughout the chronology. There was a lack of general inquisitiveness and insufficient depth of investigation. The panel felt that many practitioners involved with Child A took things at face value without probing for more evidence, be that positive or negative.  Practitioners need to be confident in challenging families and individuals to ensure that the true picture is considered when looking at safeguarding.  The reviewers were aware that there was some evidence of practitioner(s) recognising this disguised compliance and escalating and challenging the status quo with senior staff and managers.  **Impact of Covid on working practices**  The review noted that this timeline took place when covid was still impacting upon how we worked. As a result, a lot of services were not fully engaging in face-to-face work in communities.  Home visits were not being undertaken by all agencies and in particular there was reference, in the learning event, of a service accepting a face time call with Child A whilst another practitioner was present as an appropriate contact.  This lack of home visiting also meant that home conditions, the availability of basic supplies and medicines were never fully explored. Given that Child A presented as losing weight, pale and unwell, a knowledge of what was available to him in the home was important.  Child A was particularly difficult to engage with, it is possible that his lack of engagement with services is learned behaviour from his parents. His distrust of services resulted in Child A only engaging with limited services, in particular he mainly trusted and only engaged with one service/worker – YJS substance misuse worker.  This worker became a single point of contact, however when Child A could not be located by this worker there appeared to be a lack of safety planning. Child A frequently failed to engage with other practitioners. The review noted that this was not questioned, and rather than asking why he didn’t engage and focusing on how to engage him, there was over-reliance on the individual worker. This practitioner carried a lot of risk and worry in relation to Child A  During the learning event some services noted that they had done far more than was documented in the chronology. It was established that during, and post, covid services had embraced different ways of communicating in less formal settings. For example, some practitioners stated that there were regular Teams chats and whilst this was where they shared the work that was being done, it was not recorded on Child A’s formal records.  During the learning event a manager stated that they preferred for staff to be engaging with individuals rather than spending time updating records. Although the contact with service users must be a priority, from the point of scrutiny/audit if there is no record, it didn’t happen.  Staff across all agencies and services need to ensure record keeping is consistent with their professional codes of conduct.  **Non-attendance at appointments**  Throughout the period of this review Child A’s epilepsy presented a constant risk, importantly his risk of seizures increased with his usage of substances. However, he did not attend many appointments. The review noted that although Child A was offered appointments, opportunities were not taken to see him when he was in hospital for other reasons. These other hospital admissions would have provided an opportunity for Child A to be seen as a patient.  Child A’s parents were not consistent in taking him to hospital, as a result he did not attend a number of appointments. When this was explored by YJS it was established that Child A was frightened to attend and disclosed that he feared the unknown and medical appointments were the unknown for him, this was further highlighted in the learning event. It is likely lack of parental support in taking him to appointments reinforced this fear.  On a positive note, once this question was asked of Child A he opened up and this could be addressed. YJS assisted Child A to attend appointments.  **Over-reliance on single agency**  As part of the review a detailed chronology was created, this document was used to inform and assist with discussions at the learning event. It was quickly established that the vast majority of direct contact with Child A was by Youth Justice Service and in particular one member of staff. This one practitioner carried out the majority of contacts with Child A and was used as a single point of contact. Whilst this can be beneficial, it should also be acknowledged that this pressure is substantial and practitioners taking on this level of responsibility require enhanced levels of supervision and support.  During the learning event Practitioners mentioned the family raising that there were too many practitioners for Child A. Practitioners stated that there were a number of services all trying to work with Child A but he would not engage. However, in reality he was only fully engaging with one service and one practitioner. The question needed to be asked of why. Why did Child A only engage with one person?  The reviewers found that this was quite simple, the practitioner listened to Child A, spent time to ask him how he felt, what could be done to improve things and always kept promises. This practitioner was identified by Child A himself, as the only safe adult in his life.  Child A was classed as a non-engager by many agencies and the term ‘voting with his feet’ was heard on many occasions. In reality Child A was a scared young person who lacked parental support. He was distrustful of services and trust needed to be built. This one practitioner spent time doing this.  **Missed statutory timescales.**  During the review it was established that there were considerable delays in Childrens Services progressing the initial referral. From point of referral to inclusion onto the Child Protection Register a period of four months passed. During that time Youth Justice Service continued to raise concerns about the risk to Child A and the police continued to report intelligence linking Child A, Adult B & Child A’s father to drug dealing.  The review noted and understood the pressures upon child protection services, but reflected upon this delay and whether it could have been avoided if swift action was taken at point of referral.  As a child on a referral order with Youth Justice Services, Child A would have had regular contact with a number of practitioners including YJS police officers.  During the learning event the YJS police advised that they didn’t have a great deal of involvement with Child A, despite him being on a referral order. It was discussed that, in part, this was due to working practices changing as a result of COVID. The engagement from Youth Justice Police Officers with Child A was limited and sporadic.  **Suffering trauma on trauma**  From reviewing the chronology and the learning event the review considered that Child A had suffered much trauma in his young life. Child A’s parents had separated early in his life and his father had remained involved with drugs.  Child A’s own medical history resulted in him suffering epileptic seizures, this can be frightening for any young child. But whilst suffering seizures Child A was often alone without any parental support. When Child A suffered a serious open fracture to his leg, he was admitted to hospital. At the same time his brother was admitted to University Wales Hospital in Cardiff and was in a coma. This was an incredibly difficult time for Child A, at that time he needed the support of his family. But understandably his family also needed to be with his brother.  Adult B disclosed to practitioners that she had become pregnant by Child A, whilst it is not known if this pregnancy was confirmed, or when/ how it ended, she did inform practitioners that Child A was happy about the prospect of becoming a father. This would also have caused a substantial amount of trauma to Child A who was himself a child at the time.  **Assumption or Inaccurate records?**  During the learning event it was commented upon that Child A had been a looked after child from birth. It was also stated that he had been on the Child protection register at birth under the category of Neglect, because of parental substance misuse. However, as this had never been raised with panel, further checks were made and Child A had not been a LAC child or on the Child protection register. In fact, he only became known to Children Services in 2021 when he was 16.  It is unclear how this misinformation came into the work with Child A. This may have been because assumptions were made given knowledge of the parent’s history of substance misuse. Alternatively, it may be that at some point a record was made that was inaccurate. It was only after the learning event that Child A’s records were checked again specifically regarding LAC or CP status.  **Adding to the panel membership**  At the start of the review process housing was not identified as playing a role in this case. Therefore, they were not included on the review panel or added any involvements in the chronology. Although they were mentioned in the chronology from the records of other agencies.  Additionally at the learning event through discussion it was evident that there was good practice between Children’s Services and Housing providers. They were in regular contact to promote stable housing for Child A and his family, this focus on stability prevented Child A and his mother becoming homeless.  **Caring for practitioners**  During the learning event it became evident to reviewers that Child A’s trust and engagement with one practitioner had been considerable. The reviewers  sought to understand how this had impacted upon them, as a professional and an individual.  It was established that the work completed with Child A was far outside the role of the practitioner who was utilised as a single point of contact for Child A and was at times undertaking work which should have fallen to other practitioners. This practitioner not only managed this extremely complex and demanding case but was also required to maintain and manage a normal workload. The review found that there needed to be greater partnership working and less reliance upon one individual.  The review also found that where a practitioner is required to work intensely on a case like this, there should be greater management supervision, welfare support and management oversight of workloads. Consideration should be given to cases being jointly worked.  The morning after the overdoses of Child A and the death of Adult B practitioners attended a routine daily tasking meeting. Practitioners were unaware of the incident and this news was given to them in the form of a police report. This report was read many times as other services joined the meeting. The police report was factual and made references to Adult B as the deceased.  Whilst the review understands the need for practitioners to share information in a partnership setting, it also recognises the impact vicarious trauma can have upon practitioners. The review felt greater care and consideration should have been given to staff welfare and other means to communicate this news with certain practitioners should have been considered.  The review noted that practitioners who work with children do so because they are passionate about child protection. Understanding the impact this can have upon practitioners own mental health should be a priority for management. |

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| **Improving Systems and Practice**  *In order to promote the learning from this case the review identified the following actions for the SCB and its member agencies and anticipated improvement outcomes*: |
| (What needs to be done differently in the future and how this will improve future practice and systems to support practice)   * **Gender Bias** – Practitioners and supervisors need training and better understanding of what Child Sexual Exploitation (CSE) looks like. Cases which do not fall into the ‘stereotypical’ CSE category should be focused upon.   This has to include an older female ‘perpetrator’; with an older victim (teenage/adolescent).   * **Recognising the risk of exploitation and action taken** – training required to fully understand CSE as a modern slavery/human trafficking offence. An National Referral Mechanism (NRM) was submitted in relation to Child Criminal Exploitation (CCE) but should have been identified and referred at a much earlier stage.   Police and YJS officers should have been identifying and acting on the CSE risk. No CSE investigation took place, despite this being requested by a supervisor.  Following a child practice review, WB18 2015, the safeguarding board set up a multi-agency group focusing on exploitation. This group produced Exploitation guidance that was first published/circulated in January 2020. It has been reviewed and updated in 2023 and it is recommended that this is recirculated across agencies as reminder of practice.  In addition Western Bay Safeguarding Board (now WGSB) developed, and has been delivering multi-agency exploitation training since 2019.   * **Disguised compliance and Professional Curiosity –** these areas have been highlighted in previous WGSB practice reviews including N56 2020 and S58 2020. Professional curiosity was also highlighted in the high-profile practice review relating to Logan Mwangi. In this case the impact of Covid was also recognised as impeding professional curiosity.   WGSB produced a short practice guide relating to Professional curiosity in 2023 and it is recommended that this be re-issued across all services/agencies.   * **Impact of Covid on working practices** – it is recognised that Covid did impact the way all agencies worked, but it is notable that numerous agencies failed to actually go into the home to establish the living conditions. Covid restrictions did allow for visits of this nature providing appropriate PPE was used and all hygiene rules were followed. Additionally, recordings were lacking and not on the appropriate systems. Teams chats were used for updating colleagues. This meant that the child’s full record was incomplete. * **Non-attendance at appointments –** Child A missed numerous appointments, particularly with regard to his seizures. YJS staff took the lead in getting Child A back on the Neurology lists and helping Child A to access those appointments.   In 2016, following a Child Practice Review, Swansea Bay University Health Board put in place a ‘Was Not Brought’ policy. This applied to all children (under 18s). It recognises that children are reliant on an adult e.g. parent/carer to access health appointments. This policy is very clear on actions to be undertaken for children who are under safeguarding processes and not brought to health appointments, with a robust pathway for practitioners to follow.   * **Over-reliance on single agency** – it is important that a multi-agency approach is used to engage with children and families, where there are concerns as in this case. Not only was one agency the main point of any contact, in addition it was actually one individual worker who shouldered most of the load. Section 47 was supposed to be undertaken, but was not within timescales, predominantly because of the lack of engagement by other practitioners. * **Missed statutory timescales** – agencies need to remind staff of the fact that statutory timescales have to be met. Meetings were taking place when the S47 hadn’t been completed. There was no consequence to these missed timescales. * **Assumption or Inaccurate records?**   Information shared at the learning event indicated that many practitioners had thought that Child A had been LAC from birth and also that he had been on the child protection register at birth under the category of neglect because of parental substance misuse.  This was re**-**checked in panel meetings as this was not known prior to the learning event. In fact, as the chronology had indicated, Child A didn’t become known to Children’s Services until 2021, aged 16.  Practitioners should be reminded of the need to check records, avoid assumptions or rely on word of mouth.   * **Adding to the panel membership**   At the learning event it was commented that housing had significant involvement with Child A. This was also recorded by other agencies within the full chronology. However, housing had not been identified at the start of the review process as having involvement.  The WGSB will need to consider how to ensure all relevant agencies are included in practice review panels going forward.   * **Suffering trauma on trauma –** incidents/occurrences should not be looked at in isolation. Agencies should have accessed training on ACEs and trauma. A trauma informed approach is essential to prevent compounding and adding to the suffering of an individual. * **Caring for practitioners –** Where practitioners are asked to undertake intensive work such as in this case, greater first line supervision is required. Managers should be holding regular check in’s with practitioners and also reviewing the case and their workload. Where appropriate, Managers should be advocating on behalf of the practitioner with other agencies.   Training is required to understand vicarious trauma. Cases such as this can impact considerably on staff, and it is vital that staff are supported and their own mental health and wellbeing considered. All check in’s and supervision should be held in a supportive fashion and documented. |
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| **STATEMENT BY REVIEWER(S)** | | | | | |
| **REVIEWER 1** | | Joanne Stephens | **REVIEWER 2 *(as appropriate)*** | Joy Louise Lewis | |
| **Statement of independence from the case**  *Quality Assurance statement of qualification* | | | **Statement of independence from the case**  *Quality Assurance statement of qualification* | | |
| I make the following statement that.  prior to my involvement with this learning review:-   * I have not been directly concerned with the child or family, or have given professional advice on the case * I have had no immediate line management of the practitioner(s) involved. * I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review * The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference | | | I make the following statement that  prior to my involvement with this learning review:-   * I have not been directly concerned with the child or family, or have given professional advice on the case * I have had no immediate line management of the practitioner(s) involved. * I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review * The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference | | |
| **Reviewer 1**  *(Signature)* | **Joanne Stephens** | | **Reviewer 2**  *(Signature)* | | **Joy Louise Lewis** |
| **Name**  *(Print)* | Joanne Stephens | | **Name**  *(Print)* | | Joy Louise Lewis |
| **Date** | 01.08.24 | | **Date** | | 01.08.24 |

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| *Chair of Review Panel (Signature)* | **Sam Jones** |
| **Name**  *(Print)* | Sam Jones |
| **Date** | 01.08.24 |