GLOUCESTERSHIRE SAFEGUARDING CHILDREN PARTNERSHIP LOCAL CHILD SAFEGUARDING PRACTICE REVIEW PROCEDURES

Locally, safeguarding partners must make arrangements to identify and review serious child safeguarding cases which, in their view, raise issues of importance in relation to their area. They must commission and oversee the review of those cases, where they consider it appropriate for a review to be undertaken.

2021

Gloucestershire Safeguarding Children Partnership

Local Child Safeguarding Practice Review (LCSPR) Procedure

Contents

Introduction 2
Safeguarding Practice Review Procedure 3
Multi-Agency Notifications to the National Panel 4
Rapid Review 5
Local Child Safeguarding Practice Reviews 6
Sign Off & Governance of Review Process 7
Publication and imbedding of learning 7
Out of County Incidents 7
Out of Country Incidents 8
Children Placed in Gloucestershire buy Other Local Authorities (OLA's) 8
Links with other Statutory Review Processes 8
Appendix 1 10
  GSCP Rapid Review Report 10
Appendix 2 13
  Rapid Review Process and Timeline 13

Version Control

Revision	Date	Comment
1.0	April 2020	Executive Approved
1.1	Feb 2021	Changes to GSCP from GSCE. Revision to GSCP Structures and subgroups
1.2	Sept 2021	Inclusion of approved Multi Agency SIN decision process

Governance Note:

- This procedure is set out in line with the most current Working Together to Safeguard Children Guidance. Where it refers to Working Together it is considered to be referring to the current guidance as set out below:
    - **Current Guidance**: Working Together to Safeguard Children 2018 July 2018 as amended December 2020

Introduction

Under Working Together guidance the local Safeguarding Partners must have a process in place to identify, review and respond to serious safeguarding incidents that are referred to the partners for consideration of a Local Child Safeguarding Practice Review (LCSPR).

16C (1) of the Children Act 2004 (as amended by the Children and Social Work Act 2017) states:

- Where a local authority in England knows or suspects that a child has been abused or neglected, the local authority must notify the Child Safeguarding Practice Review Panel (National Panel) if –

  (a) The child dies or is seriously harmed in the local authority's area, or

  (b) While normally resident in the local authority's area, the child dies or is seriously harmed outside England. (This includes Wales)

Serious harm includes (but is not limited to) serious and/or long-term impairment of a child's mental health or intellectual, emotional, social or behavioural development. It should also cover impairment of physical health. This is not an exhaustive list. When making decisions, judgment should be exercised in cases where impairment is likely to be long-term, even if this is not immediately certain. Even if a child recovers, including from a one-off incident, serious harm may still have occurred.

The local authority must submit a Serious Incident Notification (SIN) for any event that meets the above criteria to the (National) Panel. They should do so within five working days of becoming aware that the incident has occurred. The local authority should also report the event to the safeguarding partners in their area (and in other areas if appropriate) within five working days.

The local authority must also notify the Secretary of State and Ofsted where a looked after child has died, whether or not abuse or neglect is known or suspected.

Note: Whilst the duty to designate what constitutes a Serious Incident and therefore the submission of a Serious Incident Notification lies with the Local Authority the Gloucestershire Safeguarding Children (GSCP) Executive has agreed that in the spirit of a shared and equal duty to safeguard children the decision on threshold for a serious incident will be a multi-agency one, therefore this procedure also sets out the SIN decision making arrangements for the GSCP.

Others who have functions relating to children (any person or organisation with statutory or official duties or responsibilities relating to children) should inform the safeguarding partners of any incident which they think should be considered for a child safeguarding practice review and the submission of a SIN.

Safeguarding Practice Review Procedure

LCSPR activity within the GSCP is divided into five areas.

1) **Notification** - Safeguarding Partners notify cases which meet a Serious Incident Notification (SIN) threshold. In some circumstances a referral from the Child Death Review process may also require consideration for a SIN (Appendix 3)
2) **Multi Agency SIN Decision** - The GSCP will collectively consider all serious safeguarding cases against the threshold for a SIN.

3) **Rapid Review** – Where a safeguarding incident meets threshold for a SIN the GSCP must convene a Rapid Review. The Rapid Review assesses the case and provides a report to the GSCP via the QiiP. That report is submitted to the National Panel. A Rapid Review will bring together the most appropriate practitioners and professionals from the partnership on a case by case basis ensuring the right front line professionals are in attendance. In the main, but not always, Rapid Reviews will be chaired by an independent Rapid Review Chair, as an element of their Independent Scrutiny Function, appointed by the Business Unit and approved by the QiiP. The Chair will produce the Rapid Review Report. The Rapid Review will assess the case and consider if a LCSPR is required.

4) **Local Child Safeguarding Practice Review (LCSPR)** – Where a Rapid Review considers a serious safeguarding incident requires a LCSPR it will make that recommendation in =its report to the National Panel. Where a Rapid Review reports that a LCSPR is needed it is expected that the report will set out why and what focus the LCSPR should take. LCSPRs will look in detail at an aspect of the incident and should not be a larger rerun of the Rapid Review. An independent Chair can be appointed to oversee and lead the LCSPR and produce a formal report as required by Working Together guidance.

5) **Publication** – Following formal sign off by the GSCP QiiP and Executive the LCSPR Reports and Response Plans are sent to the National Panel seven working days prior to publication. The Executive must approve and sign off on all LCSPR publication Plans

The overall administration of the process sits with the GSCP Business Unit supported by the QiiP with Governance oversight from the GSCP Management Group. Overall responsibility for the process sits with the QiiP and its Chair.

A safeguarding Review update report is provided to the GSCP Executive on a quarterly basis to ensure oversight and governance into ongoing reviews, identify trends, and determine priorities co-ordinating activity of subgroups to complete necessary development.

GSCP Management Group provides governance for outstanding actions, holding agencies to account for delivery. Progress will form part of the regular updates reported to the Executive. Ownership of the tracker sits with the partners as delegated to the QiiP and its members.

Multi-Agency Notifications to the National Panel

Serious Incident Notifications

The statutory guidance on Serious Incident Notifications to the Child Safeguarding Practice Review Panel is set out in the Children Act 2004, 16C (1) (as amended by the Children and Social Work Act 2017).

The GSCP Executive, under its shared and equal duty to safeguard children, has determined that in Gloucestershire the following arrangements will form part of their Local Child Safeguarding Practice Review procedures and their Working Together published arrangements.

1. Responsibility to notify rests with the local authority, however the Executive would expect that any decision to submit a Serious Incident Notification has been discussed and agreed with the other statutory partners, the Constabulary and the Clinical Commissioning Group, prior to submission .
2. The Clinical Commissioning Group and the Constabulary will bring to the Local Authority's attention any incidents that they feel meet threshold for notification promptly in order to meet the statutory timeframe of 5 working Days from being aware of the incident.
3. The submission of a SIN initiates a Rapid Review notification from the National Panel. A Rapid Review must therefore be convened and a Report sent to the National Panel within 15 working days from the date of notification from the National Panel to the partnership.
4. In order to support the Rapid Review process and to ensure oversight by the QiiP a copy of the Serious Incident Notification must be sent to the GSCP Business Unit.
5. Where a case has been identified for notification the *QiiP Subgroup* statutory partners will respond promptly to a meeting request with the nominated SIN Lead/s for the Local Authority's Childrens Social Care and the GSCP Executive Business Manager to discuss and collectively agree whether the incident meets threshold for a Serious Incident Notification.
6. All multi-agency decisions to submit a SIN will be communicated by the Business Manager or the GSCP Statutory Review Coordinator, in their absence, to the Chair of the Management Group and safeguarding leads for the statutory partners.
7. Where there is a sibling group consideration should be given as to whether all the children are notified or not: this will be dependent on whether all the children have been seriously harmed. All children notified will have to be included in any following processes such as a Rapid Review.
8. Where a collective decision cannot be reached by the QiiP statutory members and the SIN Lead/s this will be escalated to the Executive by the Business Manager. The following applies in these circumstances;
9. The Local Authority as holders of the legal duty to notify can proceed with the submission of a notification or decline the decision to submit a notification
10. The GSCP Partners can decide to either proceed with a Rapid Review or communicate under the National Panels guidance which states the following "Should you decide that submission of a rapid review to the Panel is not required in this case can you please confirm in writing to the Panel that there are no concerns regarding known or suspected neglect or abuse in relation to the child".

Note: The National Panel and the GSCP Executive accepts that circumstances will arise where an assessment of an incident may result in a difference of professional opinion, but both consider these to be the exception rather than the rule.

11. Where the joint decision is that the incident does not meet threshold but the partners feel that the incident deserves a possible 'after action reflective discussion' arrangements for a referral to the GSCP Resolution Group should be discussed at this point.

Note: 'Out of County', 'Out of Country' as well as responsibilities regards children placed in Gloucestershire by other local authorities can be found on page 21 and 22.

Rapid Review

When the partnership submits a SIN the National Panel will notify the Partnership of the obligation to conduct a Rapid Review to consider the incident and determine if it may require a Local Safeguarding Practice Review. The GSCP must report on the Rapid Reviews findings back to the National Panel within 15 working days of their notification.

The aim of a Rapid Review is to:

- gather the facts about the case, as far as they can be readily established at the time
- discuss whether there is any immediate action needed to ensure children's safety
- consider the potential for identifying improvements to safeguard and promote the welfare of children
- decide what steps the GSCP should take next, including whether to commission an LCSPR
- submit a report to the National Child Safeguarding Practice Review Panel outlining the above

The GSCP through the QiiP Subgroup will set out the scope of the review including agency involvement. The Business Unit on the direction of the QiiP will:

- Set and communicate a Rapid Review date, usually 7 working days from the National panels Notification
- Appoint a Chair and identify practitioners required to be in attendance.
- Communicate with all agencies seeking a brief submission using the Rapid review Template provided (Appendix 1) Submissions will be expected within 3 working days from request
- Share submissions with the Chair of the Rapid Review and Identified Rapid Review members asking all to consider key lines of enquiry for the review.
- Conduct a Rapid Review providing administrative support

An easy read flowchart of the Rapid Review Process can be found as Appendix 2

Attendance at the Rapid Review by identified agencies is mandatory. The Rapid Review will consider the incident in question with the outcome being either:

- A recommendation to proceed to a Local Child Safeguarding Practice Review where it is considered that the partnership needs to take a further and more detailed look at one or two key aspects of practice
- A decision to not proceed to a Local Child Safeguarding Practice Review as the key aspects of learning have been identified and any further review would be duplication.

The Rapid Review should set out in a written report the discussion, analysis and final decision relating to the incident and submit it for sign off by the QiiP statutory partner's members. Due to the timely nature of reporting to the National Panel Sign off will be achieved through delegated responsibility with the QiiP Chair taking that responsibility with representatives of the three principle safeguarding partners.

Rapid Review reports should summarise the case, set out clearly issues identified and recommendations for learning including potential national recommendations. The report will also consider whether an LCSPR is needed and make recommendations to the QiiP and the National Panel accordingly.

Appendix 1 is the template Rapid Review Report that will be used as the basis of all reports.

Rapid Review Principles

- The Rapid Review should be attended by the most relevant professionals who can confidently discuss their agencies involvement with, and knows, the child or children. As part of the request for information agencies should identify the most appropriate professional in their organisation to attend. It is recommended that front line staff are invited supported by a manger. This should be done on a case by case basis and not be reliant on one individual or group of individuals. The QiiP should not become the default Rapid Review Panel for all cases.

- Rapid Reviews can be independently chaired but this may not always be the best solution. Each Rapid Review should be considered individually to avoid a standardised approach to conducting a review
- Rapid Reviews are a process to determine if an incident requires a LCSPR and they are therefore an opportunity to consider an incident to understand what can be learnt and applied to improve practice.
- In the main Rapid Reviews should be instigated from the submission of a Serious Incident Notification. There may be circumstances where this is not the case or where a Serious Incident Notification is submitted and the GSCP decide not to proceed to a Rapid Review. These must be the exception not the rule.
- Learning from Rapid Reviews must be disseminated and shared across the partnership to improve practice. This requires all representatives to share and promote the sharing of Rapid review findings

National Panel Annual Report 2018/2019
"In the best rapid reviews, there has been thoroughness that has meant there has been no need for a further local safeguarding practice review and those areas have been able to move quickly to implement the learning across their system. These reviews feature: a concise statement of what has happened; the key questions which emerge from an appraisal of the case; a detailed and sufficient analysis which addresses those key lines of enquiry; and clearly related learning with actions to address any weaknesses".

Local Child Safeguarding Practice Reviews

Purpose
To identify, analyse and set out key areas of learning from an incident so that the partnership can address practice issues and improve safeguarding outcomes for children and families.

Process
A range of review options are open to the partnership with the methodology and rationale being set by the QiiP following receipt of a Rapid Review report that recommends proceeding to an LCSPR. The Rapid Review Report should define the area that the Rapid Review felt the partnership should focus on in its recommendation to proceed to a LCSPR and not seek a replay of the Rapid review itself

The QiiP will set out the LCSPR arrangements on a case by case basis and in line with WT2018 so as not to create a single review approach but consider each incident and case on its own merits.

LCSPR's are required to produce and publish a report following the latest Working Together guidance

Partners must ensure that the final report includes:
- a summary of any recommended improvements to be made by persons in the area to safeguard and promote the welfare of children
- an analysis of any systemic or underlying reasons why actions were taken or not in respect of matters covered by the report

Any recommendations should be clear on what is required of the safeguarding partners and relevant agencies collectively and individually, by when, and focussed on improving outcomes for children.

Reviews are about promoting and sharing information about improvements, both within the area and potentially beyond, so safeguarding partners must publish the report, publishing any information about the improvements that should be made following the review that they consider appropriate to publish. The name of the Chair and involved partners, relevant agencies should be included. Published reports or information must be publicly available for at least one year".

Sign Off & Governance of Review Process

Reports and response plans are submitted to the QiiP for editing and QA processes. QiiP members have a responsibility to ensure that the First Draft report and response plan is shared appropriately within their agency and to obtain their own senior management sign off prior to submission to the GSCP Executive.

It is the responsibility of the QiiP subgroup to ensure the report is ready for publication, that the response plan is being actioned and that all agencies have reviewed and signed off the report and response plan and finally that there is a publishing plan in place in which all safeguarding partners agreed on.

All this must be in place prior to submission to the GSCP Executive with a recommendation to Publish.

Publication and imbedding of learning

The GSCP Executive receives final LCSPR Reports, Action Plans and Publication Plans for overview and multi-agency sign off.

The GSCP Business Unit, under direction of the GSCP Executive, coordinates the submission of reports and actions plans. Publishing reports on the GSCP Website no sooner than seven days after submission to the National Panel, Secretary of State and OFSTED.

The GSCP Business Unit will coordinate the publishing of links to the Report, its findings, practice briefings and links to relevant learning material as part of the post review learning multi agency cascade.

The QiiP Subgroup will coordinate the implementation and measuring of impact on all multi agency findings from the Rapid Review/LCSPR process. Reporting to the GSCP Executive via the GSCP Management Group on a quarterly basis.

All agencies are required to ensure that the learning from Rapid Reviews/LCSPRs are cascaded and imbedded in practice using the Section 11, and other, reporting processes to assure the GSCP Executive of compliance and changing practice.

Out of County Incidents

Where an incident occurs out of county and involves a child open to or previously known to Gloucestershire services it is the duty and responsibility of the local safeguarding partnership for the area in which an incident occurred to conduct and manage any statutory reviews; The GSCP and its Business Unit have no authority or responsibility other than to assist the responsible authority when requested to in contacting Gloucestershire Agencies. This includes but is not limited to, Child Death Reviews, Acute Life Threatening Events, and Local Child Safeguarding Practice Reviews (including Rapid Review).

All agencies and organisations are required to respond and comply with requests from out of county safeguarding partnerships to engage fully with their local arrangements when requested to do so.

Occasionally the National Panel will recommend a Joint Review of an incident between safeguarding partnerships where a child or children are known in one or more local authority area. In these circumstances the GSCP will:

- Lead on any incident occurring in Gloucestershire and seek engagement and support from relevant out of county safeguarding partnerships, including shared costs of any review.
- Expect the safeguarding partnership where an incident occurred to lead on any review offering support via the GSCP Business Unit sharing the cost of the review.

Out of Country Incidents

The Children Act 2004 (as amended by the Children and Social Work Act 2017) states where a local authority in England knows or suspects that a child has been abused or neglected, where the child normally resides in Gloucestershire, dies or is seriously harmed outside England the local authority must notify the Child Safeguarding Practice Review Panel.

Gloucestershire boarders Wales, therefore incidents occurring in Wales (or indeed any other country) where a child dies or is seriously harmed must be considered under this procedure as if the incident occurred in Gloucestershire.

Arrangements for the Submission of a SIN must be made in line with this procedure and within the defined timeframes, five working days from being aware of the incident.

The GSCP including the Gloucestershire Child Death Overview Panel will work with the appropriate local authority in which the incident occurred to consider the review arrangements to avoid duplication and may decide to either lead on any review or assist the local authority in which the incident occurred in their own arrangements.

Children Placed in Gloucestershire buy Other Local Authorities (OLA's)

Children placed and living in Gloucestershire by OLA's are not considered to be 'normally resident' in Gloucestershire due to the nature of being on placement, which is not considered a long term residency arrangement.

Therefore any out of county incident occurring to a child placed by an OLA remains the responsibility of the county in which the incident occurred and or the OLA placing a child (where the incident occurs in another country (Wales). The GSCP and its Business Unit have no authority or responsibility for such incidents even though they are living in Gloucestershire at the time of the incident.

Links with other Statutory Review Processes

Child Death Review (CDR) and Acute Life Threatening Event (ALTE) Reviews.

The Child Death review Partners, Gloucestershire Clinical Commissioning Group and Gloucestershire County Council must make arrangements to review all deaths of children normally resident in the local area, and if they consider it appropriate, for any non-resident child who has died in their area. The Child Death Overview Panel (CDOP) oversees the local arrangements under the Child death review: statutory and operational guidance (England) and Working Together through the Child Death Review (CDR) team. The CDR Team are responsible for conducting and coordinating such reviews. The CDR Team comprises of the Named Nurse for Child Death employed through GHC and the Designated Doctor for Child Death employed by the CCG supported by the GSCP Business Unit Statutory Review Coordinator supported by the GSCP Executive Business Manager.

In some cases a Child Death Review or ALTE may identify a serious safeguarding concern that may meet a serious safeguarding incident threshold. In such cases the Designated Doctor for Child Death will refer the case to the GSCP Business Unit to consider under the multi-agency SIN arrangements.

Definitions Used under the Child Death Review Process

- **Unexpected Child Death** - An unexpected death is defined as the death of an infant or child which was not anticipated as a significant possibility, for example, 24 hours before the death; or where there was an unexpected collapse or incident leading to or precipitating the events which lead to the death. – Unexpected child deaths need to be considered regards threshold for a safeguarding review.

Safeguarding reviews do not replace the statutory CDR responsibilities but where possible joint processes will be followed to avoid duplication. It is expected that information will be shared appropriately to facilitate both statutory duties.

- **Early Neonatal & Neonatal Child Death** - **Early Neonatal Death:** when the baby dies within the first week of life (0–6 days) of any cause. **Neonatal Death:** when the baby dies within 28 days of birth of any cause or for the purpose of this process a baby who dies that has not left hospital since birth. Note: Healthcare Safety Investigation Branch, HSIB investigation is conducted separately and in parallel for Early Neonatal Death.
- **Expected Child Death** – A child with a life limiting condition and not expected to survive more than 24 hours.
- **Acute Life Threatening Event (ALTE)** – The unexpected collapse of a child where there is no known antecedent condition that might be expected to cause the collapse at that time, or an incident that may have resulted in a death without intervention. The child may, or may not, die immediately or subsequently from the consequences of the precipitating event or collapse. – ALTE cases may meet the threshold for a safeguarding review. Safeguarding reviews do not replace the statutory CDR responsibilities but where possible joint processes will be followed to avoid duplication. It is expected that information will be shared appropriately to facilitate both statutory duties.

Appendix 1

GSCP Template Rapid Review Report

This report sets out:

1. Family Background
2. Rapid Review Details
3. Report on Case under Review
4. Other Relevant Information
5. Identified Learning
6. Recommendation
7. Themes of Potential National Interest:
8. Decision to Proceed to LCSPR

1. Family Background

Child's Last Name	
Child's Forename	
Child's Middle Name	
Age at time of incident	
DOB	
Gender	
Ethnicity	
Nationality	
Parent's Name	
Parent's DOB	
Relationship to Child	
Parent's Name	
Parent's DOB	
Relationship to Child	
Siblings	

2. Rapid Review

- Meeting date time and venue

- Attendees
  Note: Include Apologies or non-attendance. All agencies will have nominated an attendee when submitting agency information. The nominated attendees should be listed here detailing if they attended or not.

3. Report on Case under Review

- Concise Statement of Case setting out Key Events:
- Key Questions Emerging

- Appraisal of the case
  Note: Detailed analysis and with sufficient detail addressing key lines of enquiry and identified learning. Where Rapid Reviews cannot get to the learning consideration and discussion of LCSPR is needed.

4. Other Relevant Information

- Are there any other siblings or children to consider?

- Was the child on a CP plan at the time of the incident?

- Was the Child on a CP plan at any time prior to the incident?

- Is the case linked to a complex abuse investigation?

- Other Immediate Safeguarding Considerations

- Medical Details

5. Identified Learning:

Learning Identified	Single Agency / Multi Agency	Actions

NOTE: Learning should be clearly related to the analysis of the case and actions identified are SMART achieving the most impact on improved practice.

6. Recommendation:

Note: Does this case need to proceed to CSPR or has the Rapid Review provided a thoroughness that means that the partnership can proceed to focus on the implementation of the learning identified? Detail decision/s and rationale

7. Themes of potential national interest:

8. Decision to Proceed to CSPR Yes / No

- **Methodology Agreed**

- **Scope of Review**

- **Agencies Required to Cooperate**

- **Other Requirements for LCSPR**

Report endorsed by:

Quality and Improvement in Practice Subgroup Chair (CCG)

Date ___________

Gloucestershire Childrens Social Care Representative (Vice Chair)

Date ___________

Gloucestershire Constabulary Rapid Review Lead Officer

Date ___________

Report Submitted to the National Panel:

Date__________

Appendix 2

Rapid Review Process and Timeline

Working Days	Statutory or other Requirement	GSCP Action	Lead
1 to 5	Children Act 2004 & GSCP Local Arrangement	Partners become aware of an incident and convene a SIN discussion under the GSCP Safeguarding Practice Review Process to determine threshold for the submission of a SIN	GSCP QiiP statutory Partner's Leads and GCC CSC SIN Lead/s
1-to 2 from Notification From National Panel of the requirement to undertake a Rapid Review	Working Together statutory guidance sets out arrangements, as introduced by the Children and Social Work Act 2017	**Serious Incident Notification Submitted, Notification received from the National Panel of the requirement to undertake a Rapid Review.** GSCP Business Unit instigates The Rapid Review process. Identification and commissioning of independent Chair Rapid Review Notification and Paperwork submitted to all partners and relevant agencies identified as having engaged with the child or children requesting a brief summary of key events and involvement with the child/family	Statutory Review Coordinator / GSCP Business Manager
3 to 5	GSCP Local Arrangements	All agencies produce and submit a brief summary report of key evets and involvement including setting out key questions to be explored in the Rapid Review Agencies to advise on representation ensuring front line practitioner engagement where practicable and appropriate	All identified agencies
6 to 7	GSCP Local Arrangements	Independent Chair to review submission compiling key event chronology and key lines of enquiry Agency Submissions shared with attendees Attendees advised to consider Key Lines of Enquiry for the Review meeting	Independent Chair GSCP Business Unit All attendees
8th working day	Working Together 2018 statutory guidance	**Convene Rapid Review.** **Core Membership:** GSCP Business Manager and or Statutory Review Coordinator (Minutes) All other members to be determined relating to the incident and agencies involved. Discuss the incident to identify 1. Circumstances and specifics – Undertake analysis of incident 2. Identify partnership or single agency learning 3. Deciding on need for any further LCSPR process 4. Identifying national themes if any	Statutory Review Coordinator GSCP Business Unit to organise meeting and to minute discussion. Led by review Chair

		All decisions need to be clearly justified in concise terms at the time of the decision - Including identification of any immediate or urgent actions for agencies	
Day	**National Requirement**	**GSCP Action**	**Lead**
9 – 13	Working Together 2018 statutory guidance	Rapid Review Report compiled and submitted to the GSCP Business Unit	Review Chair
13 to 14	GSCP Local Arrangements	Statutory Partner QiiP members review and sign off report, Business Manager ensures report meets WT2018 requirements.	CCG Rep Constabulary Rep GCC CSC Rep Business Manager
14 – 15	Working Together 2018 statutory guidance	Submission of Rapid Review report to National Panel by GSCP business unit	Statutory Review Coordinator/GSCP Business Manager