



West Dunbartonshire Guidance for the Adult Protection and Child Protection Committees Undertaking Learning Reviews 2022

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1. INTRODUCTION

This Guidance aligns West Dunbartonshire practice to the National Guidance for Child Protection Committees Undertaking Learning Reviews 2021) and the National Guidance for Adult Protection Committees Undertaking Learning Reviews (2022). It replaces the National Guidance for Child Protection Committees - Conducting a Significant Case Review (2015) and the Interim National Framework for Adult Protection Committees for Conducting a Significant Case Review (2019).

The National Guidance for Child Protection Committees Undertaking Learning Reviews was published on 2nd September 2021¹ and the National Guidance for Adult Protection Committees Undertaking Learning Reviews was publish on 22nd May 2022².

All references to 'Initial Case Review' and 'Significant Case Review' in other current policy and guidance documents will now be understood as referring to a 'Learning Review' as defined by the present Guidance.

This Guidance is primarily intended for members of the Child Protection Committee (CPC) and Adult Protection Committee (APC) within West Dunbartonshire; however, it also has relevance for the Public Protection Chief Officers Group (PPCOG) within West Dunbartonshire. It should also be read and understood by a wide multi-agency audience.

Protecting children and young people is an inter-agency and inter-disciplinary responsibility overseen by the CPC and it is the CPC, on behalf of the Public Chief Officers Group, that decides whether a Learning Review is warranted and for agreeing how the review is conducted.

For Adults, an Adult Support and Protection Learning Review is a means for public bodies and office holders with responsibilities relating to the protection of adults at risk of harm to learn lessons by considering the circumstances where an adult at risk has

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¹ https://www.gov.scot/publications/national-guidance-child-protection-committees-undertaking-learning-reviews/pages/1/

² https://www.gov.scot/publications/adult-support-protection-learning-review-guidance/





died or been significantly harmed. It is carried out by the Adult Protection Committee under its functions of keeping procedures and practices under review, giving information and advice to public bodies and helping or encouraging the improvement of skills and knowledge of employees of public bodies as set out in section 42(1) of the Adult Support and Protection (Scotland) Act 2007³.

The overall purpose of a Learning Review is to bring together agencies, individuals and families in a collective endeavour to learn from what has happened in order to improve and develop systems and practice in the future and thus better protect children and young people. In relation to the CPC, the process is underpinned by the rights of children and young people as set out in the United Nations Convention on the Rights of the Child⁴ (UNCRC).

2. CONTEXT

The Learning Review approach stemmed from Scotland's commitment to strengthen its learning culture. In 2017 Protecting Scotland's Children and Young People: It is Still Everyone's Job – Child Protection Systems Review⁵ highlighted the need to 'move beyond apportioning blame to learning together about what is helping and what is hindering efforts to help children'. The report made three recommendations in this regard, fully adopted by the Scottish Government's Child Protection Improvement Programme, which informed the development of the National Guidance.

The 2019 Protecting Children & Young People - Child Protection Committee and Chief Officer Responsibilities⁶ Guidance states that Chief Officer Groups should be advised by the Chair of the CPC of any cases that should be considered in respect of meeting the criteria for warranting a Review. Once agreed that there is a need to undertake a Review, the CPC should consider and agree how the review is to be undertaken and who should lead the review and ensure that appropriate communication of the case has taken place in respect of key contacts. Once a Review is concluded, all findings and recommendations should be considered by the Chief Officers Group.

³ https://www.legislation.gov.uk/asp/2007/10/contents

⁴ https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-child

⁵ Protecting Scotland's Children and Young People: It is Still Everyone's Job – Child Protection Systems Review

⁶ Protecting Children & Young People - Child Protection Committee and Chief Officer Responsibilities





Definition of a child

For the purpose of this document a child is a person under the age of 18, although there may be exceptions for care leavers who were in receipt of aftercare or continuing care at the time of the incident that led to a Learning Review Notification.

A comprehensive definition is provided in the National Guidance for Child Protection in Scotland⁷.

Definition of an adult at risk of harm

The Act refers to an 'adult' as a person aged 16 or over and Adults at Risk of Harm are defined as those adults who:

- are unable to safeguard their own well-being, property, rights or other interests
- are at risk of harm
- because they are affected by disability, mental disorder, illness or physical or mental infirmity are more vulnerable to being harmed than adults who are not so affected

Within West Dunbartonshire, it has been agreed that for those young people who fall between the age of 16 and 18 years, the Independent Chair will decide whether the Adult or Child Protection Committee will undertake the Learning Review. Where there are legitimate interests and engagement from services for children and adult agreement should be reached as to how each of the committees will be involved and updated on progress of the review. This will require consideration on a case-by-case basis, and the involvement of the Chief Social Work Officer may be helpful in these deliberations.

KEY FEATURES OF LEARNING REVIEWS

The key features of a Learning Review are:

I. Inclusiveness, collective learning and staff engagement

A Learning Review should be multi-agency; bringing practitioners together with the review team in a structured process in order to reflect, increase understanding and identify key learning.

II. Support for staff

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⁷ National guidance for child protection in Scotland 2021 - gov.scot (www.gov.scot)





It is important to acknowledge that participants may enter into this process with some degree of anxiety, specifically where the Learning Review is focussed on an incident where a service user has come to harm. As such support will be made available to all participants both within and out with the review process.

Participants can expect that clearly stated arrangements will be in place offering support independent of the process, enabling their continued capacity to perform in their role out with the parameters of the review. This may include enhanced line management support or access to other more specific supports by agreement.

Support for participants will also be critical and integral to the review process in order that all involved are enabled to participate fully in the process, reflect on their practice, share their knowledge and contribute to the emerging learning effectively. Thus reviewers will work with participants to create a safe learning environment in which information can be shared and discussed and differences resolved constructively, thereby reducing any barriers to effective learning in practice.

III. Systems approach

The Learning Review does not stop at the points when shortcomings in professional practice have been recognised, it moves on to explore the interaction of the individual with the wider context, including cultural and organisational barriers, in order to understand why things developed in the way they did. The focus is on:

- What happened
- How some assessments were made
- Understanding how people saw things at the time; what knowledge was drawn on to make sense of the situation; the resources available and the emotional impact of the work
- Effective practice
- Identification of learning points and how these will be actioned and implemented in future practice and systems

IV. Proportionality and flexibility

The situations under review will inevitably be complex and diverse and this therefore requires a streamlined, proportionate and flexible approach to ensure





effective learning. This flexible approach remains grounded in the underpinning principles and values of Learning Reviews.

V. Timing and Timelines

Long review processes should be avoided. Optimum learning arises not just when the process allows significant events to be identified but also when it is relevant for the current practice context.

Underpinning Principles and Values

Learning Reviews are underpinned by the following core principles and values:

- They promote a culture that supports learning
- Their emphasis is on learning and organisational accountability and not on culpability
- They recognise that a positive shared learning culture is an essential requirement for achieving effective multi-agency practice
- They are objective and transparent
- They are sensitive to the needs and circumstances of children, young people, adults at risk of harm and families
- They ensure that staff are engaged and involved in the process and supported throughout the period of the review
- They recognise the complexities and difficulties in the work to protect children, young people and adults of risk of harm and their families and carers.
- They produce learning which can be disseminated, both at local and national level, so it directly impacts on and positively influences professional practice and organisational systems

Creating the preconditions for learning

Learning Reviews are <u>not</u> investigations. They are an opportunity for in-depth analysis and critical reflection in order to gain greater understanding of inevitably complex situations and to develop strategies to support practice and improve systems across agencies. It is important, therefore, to create and sustain a positive shared learning culture throughout the process of the Review.

Reviewing complex situations can raise anxiety in individuals and organisations. This anxiety can block learning by generating defensiveness, with a consequent inability to review and reflect. In order to create the preconditions for learning it is essential that





individuals who are part of the Review process feel safe⁸ so that they can begin to honestly consider what has happened and engage in appropriate and constructive questioning and challenge. This will then result in the development of ideas and realistic and realisable action plans. Clarifying objectives, setting out purpose and being transparent about expectations, based on a culture of respect and value for all professions and services, will help to minimise defensiveness and manage the inevitable anxiety within organisations, systems and individuals.

Effective leadership is crucial to creating the preconditions for learning. Chief Officers, who are accountable for all the work of the Child Protection Committee, must promote and support national learning and improvement activity in the protection of children as a matter of course, providing leadership and guidance in relation to the need to carry out Learning Reviews.

Criteria for undertaking a Learning Review

The Child Protection Committee will undertake a Learning Review in the following circumstances:

When a child has died or has sustained significant harm or risk of significant harm as defined in the National Guidance for Child Protection in Scotland

and

there is additional learning to be gained from a review being held that may inform improvements in the protection of children and young people

and one or more of the following apply:

- Abuse or neglect is known or suspected to be a factor in the child's death or the sustaining of or risk of significant harm
- The child is on, or has been on, the Child Protection Register (CPR) or a sibling is or was on the CPR or was a care experienced child (i.e. looked after, or receiving aftercare or continuing care from the local authority). This is regardless of whether or not abuse or neglect is known or suspected to be a factor in the child's death or sustaining of significant harm, unless it is absolutely clear to the Child Protection Committee that the child having been on the CPR or being care experienced has no bearing on the case

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⁸ Professional Development Group, University of Nottingham in Charles, M Stevenson, O (1990)
Multidisciplinary is Different University of Nottingham





 The child's death is by suicide, alleged murder, culpable homicide, reckless conduct, or act of violence

Learning Reviews may also be undertaken where effective working has taken place and outstanding positive learning can be gained to improve practice in promoting the protection of children and young people.

These criteria do not preclude a CPC reviewing the death of a child pre-birth.

The Adult Protection Committee will undertake a Learning Review in the following circumstance:

Criteria for undertaking a Learning review An Adult Protection Committee will undertake a Learning review in the following circumstances:

- 1. Where the adult is, or was, subject to adult support and protection processes and the incident or accumulation of incidents gives rise for reasonable cause for concern about how professionals and services worked together to protect the adult from harm, and one or more of the following apply:
 - (i) The adult at risk of harm dies and
 - harm or neglect is known or suspected to be a factor in the adult's death;
 - the death is by suicide or accidental death;
 - the death is by alleged murder, culpable homicide, reckless conduct, or act of violence. or
 - (ii) The adult at risk of harm has not died but is believed to have experienced serious abuse or neglect





- 2. Where the adult who died or sustained serious harm was not subject to adult support and protection processes
 - (i) When the findings of an inquiry or review by another organisation or court proceedings, or a referral from another organisation gives rise to reasonable cause for concern about lack of involvement in relation to the Adult Support and Protection (Scotland) Act 2007 or
 - (ii) The Adult Protection Committee determines there may be learning to be gained through conducting a Learning Review.

Parallel or Other Processes

Learning Reviews are one of the many processes that exist to support continuous improvement. Where a child or young person is significantly harmed or has died and the criteria for a Learning Review have been met there may be parallel processes to consider due to the specific circumstances for that child or young person.

The parallel processes to be considered may include (this is not an exhaustive list):

- Local Authority report on the death of a looked after child
- NHS significant critical incident or significant adverse event reviews
- Drug Related Death Review
- Fatal accident inquiries (FAI)
- Police investigations.
- Report of death to the Procurator Fiscal
- Ongoing criminal proceedings
- Independent investigations by the Police Investigations and Review Commissioner
- Death-in-prison learning audit and review held jointly within two weeks of a death in custody by the Scottish Prison Service and NHS
- Multi-Agency Public Protection Arrangements (MAPPA)
- Mental Welfare Commission Review
- Local Authority Serious Incident Reviews
- Disruption meetings and Carer Review Panels that public and provider agencies hold internally when there is a significant detrimental event in a child's placement (including abusive)
- Sudden Unexplained Deaths in Infants (SUDI)





Suicide Reviews

These processes have distinct purposes, and some are the subject of separate statutory guidance. No process is inherently more important and therefore expected to automatically take precedence, however where there are ongoing criminal proceedings or an FAI, the Crown Office and Procurator Fiscal Service (COPFS) may include conditions that impact on whether a Learning Review can be easily progressed or concluded. To help establish what status a Learning Review should have relative to other formal investigations there should be ongoing dialogue with Police Scotland, COPFS, SCRA or others to determine how far and fast the Learning Review process can proceed in certain cases. Issues to be considered include how to:

- Link processes;
- Avoid witness contamination;
- Avoid duplicate information being collected; and
- Decide whether to postpone a Learning Review if a parallel process is running and wait for the determination of the parallel proceedings.

Where a case is subject to police investigations or court proceedings, these should not inhibit the setting up of a Learning Review nor delay immediate remedial action being taken to improve services. It is important that the purpose of the review process, which is to support professional and organisational learning and to promote improvement in future inter-agency child protection practice, is understood and remains the focus. The COPFS and Police Scotland have a protocol which recognises that criminal proceedings can be managed simultaneously (see CPC Annex 2). This is a National Protocol agreed by COPFS, Police Scotland and Child Protection Committees to provide a framework for the sharing of appropriate information generated through both processes wherever possible.

Parallel processes linked to Adult Learning Reviews are detailed in the APC Annex 7. As is described above in relation to children and young people, for adults there may be criminal investigations and NHS Significant Adverse Event Reviews, that could be running in parallel with a Learning Review and this raises several issues including:

- relationship of the Learning Review with other processes, such as criminal proceedings and Health Board reporting and reviewing frameworks
- securing co-operation from all agencies, including relevant voluntary sector interests in relation to the release and sharing of information
- minimising duplication through the integration and coordination of these processes wherever possible





ensuring a sufficient degree of rigour, transparency and objectivity.

Depending on the case, there could be a number of processes which come into play which are driven by considerations wider than service failure or learning lessons across agencies. These can include disciplinary processes, criminal investigation, report of death to Procurator Fiscal or a Fatal Accident Inquiry. In addition to this, agencies should ensure that the areas for improvement identified and shared learning are directed through the relevant clinical and care, or quality assurance, governance arrangements.

These processes may impact on whether a review can be easily progressed or concluded; criminal investigations always have primacy. To help establish what status a Learning Review should have relative to other formal investigations, on-going dialogue with Police Scotland, COPFS or others to determine how far and fast the Learning Review process can proceed in certain cases must take place. Issues to be considered include:

- how to link processes
- how to avoid witness contamination
- how to avoid duplicate information being collected
- whether to postpone a Learning Review until determination of a parallel proceeding.

There could be cross-cutting issues, for example, gender-based violence, human trafficking, or problematic alcohol and drugs use.

Processes can, and do, run in tandem, and the basic principles to follow are: check if there are other processes going on from the start; ensure good communication with each other; and ensure the relevant information is shared with the right parties. Above and beyond this, the priority is that the adult is, and remains safe, regardless of other ongoing investigations (including criminal investigations).

Within West Dunbartonshire, links will be made with those who may be undertaking a parallel process. Whose responsibility it is to communicate with those leading on parallel processes will be agreed at the Learning Review subgroup, linked to either the APC/CPC. Discussions will also take place at the earliest opportunity regarding how best to proceed, in order to minimise duplication and maximise learning. The Learning Review subgroup Chair/appointed person will discuss the most appropriate review type and sequence with the body responsible for the parallel process.





Regardless of the parallel processes in place, these processes contribute to increasing confidence in public services, providing accountability and a level of assurance about how those services acted in relation to a situation concerning a child or vulnerable adult.

Confidence in the agreed process and a joint commitment to keeping the child/adult and their family at the centre will ensure that a robust and shared learning culture takes place without delay.

National Hub for Reviewing and Learning from the Deaths of Children and Young People

The National Hub for Reviewing and Learning from the Deaths of Children and Young People has been set up by the Scottish Government to ensure that the death of every child in Scotland is subject to a quality review and that there is a consistent approach and coordinated process for all local review activity that is undertaken in relation to learning from the circumstances surrounding the deaths of all children and young people in Scotland. The overarching purpose of the National Hub is to ensure that data generated from these reviews will inform national policy, education and learning and contribute to the prevention of child deaths in the future.

The National Hub, hosted by Healthcare Improvement Scotland and the Care Inspectorate, will ensure reviews are conducted on the deaths of all live born children up to the date of their 18th birthday, or 26th birthday for care leavers who are in receipt of aftercare or continuing care at the time of their death.

When a Health Board or local authority is notified about the death of a child or young person there should be clear governance arrangements and processes in place to determine the appropriate review mechanism. Engagement must take place early in the process with any other organisations involved in the child or young person's care to reach a decision about the most suitable review process. All organisations and agencies involved should work together to undertake one single review wherever this is possible and appropriate. The rationale for deciding which review process should be carried out should be clear, take into consideration any statutory, legal, or national requirements, and be reached in a timely manner. A National Child Death Review and Learning Hub process map can be found at CPC Annex 3.

The National Hub for Reviewing and Learning from the Deaths of Children and Young People guidance sets out the implementation processes for Health Boards and Local Authority areas when responding to, and reviewing, the death of a child or young





person. Whilst organisations can establish their own structure and process for reviewing the deaths of children and young people, they should ensure the local processes align to this. A link to the Guidance 'National Hub for Reviewing and Learning from Deaths of Children and Young People – National Guidance when a Child or Young person dies' can be found at Healthcare Improvement Scotland⁹.

National Hub Core Review Data Set

If a child or young person who was the subject of the Learning Review has died, then the National Hub requires the completion of the Core Review Data Set at the conclusion of the Learning Review Process. The Core Review Data Set is included in the National Hub for Reviewing and Learning from Deaths of Children and Young People – National Guidance. This will be completed by Senior Nurse for Children and Families.

3. INITIATION OF A LEARNING REVIEW: DECISION MAKING PROCESS

Learning Review Process Map

NOTIFICATION form

To be reviewed by the nominated person or sub-group within APC/CPC

Request for and collection of further information:

- 'Request for Information' form.
- Relevant agencies provide <u>brief</u> account of involvement and some very initial reflection.

Consideration of information gathered,

by the nominated person or sub-group within APC/CPC

⁹ National guidance when a child or young person dies: January 2021 (healthcareimprovementscotland.org)





Recommendation <u>not</u> to proceed with consideration of Learning Review:

- Recommendation template;
- Suggested alternative approach for learning.

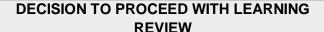
Recommendation to proceed with consideration of Learning Review:

- Recommendation template
- Proposed terms of reference

APC/CPC meet to consider the recommendation



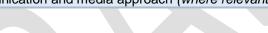
DECISION NOT TO PROCEED WITH LEARNING REVIEW





Recording and communicating the decision:

- 'Learning Review Decision' form
- Informing the Chief Officers Group
- 'Notification Response' form
- Notifying the Care Inspectorate
- Communication and media approach (where relevant).

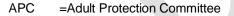


Consider alternative approach for

learning (if the decision is not to undertake a Learning Review)

Learning Review arrangements:

- Lead Reviewer identified and Learning Review Team set up.
- Family Liaison Strategy.
- COPFS /MA meeting re. parallel reviews (where relevant).



CPC = Child Protection Committee

COG = Chief Officers Group

CI = Care Inspectorate

COPFS = Crown Office and Procurator Fiscal Service

LEARNING REVIEW PROCESS

- Collecting and collating further information (including chronologies)
- Review Team meetings
- Liaising with family (as per strategy)
- Involving practitioners and managers
- Considering emerging learning
- Completing the National Child Death Review Dataset (where relevant)





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Learning Review Report for APC/CPC and PPCOG; also sent to CI Action Plan for Dissemination of Learning

The National Guidance states the Adult and Child Protection Committees should have in place mechanisms for deciding whether or not to initiate a Learning Review. The decision-making process should embody the key features of proportionality and timeliness. Within West Dunbartonshire, as defined by the National Guidance, has agreed that any Partner can initiate a Learning Review if they feel the criteria above has been met. This should be done by completing Annex 1.1 for CPC Learning Reviews and Annex 2 for APC Learning Reviews and returning this to either the Child Protection Lead Officer for CPC Learning Reviews or the Adult Protection Lead Officer for APC Learning Reviews as soon as possible.

On receipt of this notification the Lead Officer will request further information from agencies involved with the child/adult and their family or who may support the understanding of the situation (Annex 1.2 for CPC and Annex 3 for APC). The purpose of information gathering at this stage is to decide about whether or not to proceed with a Learning Review with reference to the criteria as specified in the previous section and therefore the data gathered should be only enough to make that decision. It will include a **brief** account of agency involvement prior to the event which triggered the notification and some very initial reflection regarding practice and decision-making within that agency. This information should be returned within 14 days of the information being requested.

After consideration of the gathered data the Learning Review subgroup will then make a recommendation to the APC/CPC as to whether or not to proceed with a Learning Review. The recommendation will contain the following information (Annex 1.3 for CPC – also to be used for APC):

- A brief outline of the case and the basis for referral
- The current circumstances of the child and family and what actions have been taken
- Any other formal proceedings underway including criminal investigations or ongoing criminal proceedings





The subsequent decision as to whether or not to proceed with a Learning Review will be accompanied by (Annex 1.4 for CPC and a Learning Review Notification Response is at Annex 1.5 for CPC – also to be used for APC):

- (If yes) Proposed terms of reference of a Learning Review, as well as a family liaison strategy for ensuring appropriate communication and support. (See section 5 and Annex 4 for CPC – also to be used for APC)
- (If not) Consideration of an alternative approach for learning (see the section on 'If a situation does not meet the criteria for a Learning Review')
- An assessment of the likely communication and media issues, as known at the time

The Chief Officers Group should be informed of the recommendation and of the subsequent decision about whether to proceed with a Learning Review or the reasons for not doing so¹⁰. The Care Inspectorate will also be informed. This will be done via an electronic notification form.

If the decision is to go ahead with a Learning Review then a review team will be established, and a Chair and Reviewer(s) appointed.

Timeframe for the initial decision-making process

The timeframe for this initial decision-making stage will vary depending on the situation being considered. However, timeliness is important, so that any learning arising is relevant to the current practice context. Clear systems and mechanisms for arriving at a decision will facilitate and expedite the process. It is suggested that 28 to 42 days from the receipt of a referral would be an appropriate and realistic timeframe for the completion of this initial process.

More than one Adult or Child Protection Committee is involved

In the case of a potential cross-authority Learning Review within Scotland, the relevant APC/CPC Chairs should meet and agree a mechanism for joint working, including which APC/CPC should take the lead and if required, joint commissioning of the Reviewer and agreement on the composition of the Review Team. It will also be

¹⁰ In line with Scottish Government (2019), <u>Protecting Children & Young People - Child Protection</u> <u>Committee and Chief Officer Responsibilities</u>, section 2.9.





important that clear channels are identified for how information is shared across local authorities. Any disputes (between local authorities) should be escalated to the relevant Public Protection Chief Officers Group (PPCOG) for consideration.

In the case of a potential cross-border Learning Review, the APC/CPC Chair should meet with the relevant Chair of the Safeguarding Children Partnership (in England) or with the Chair of the Regional Safeguarding Children Board in Wales or the Chair of the Safeguarding Board for Northern Ireland to agree a mechanism for joint working.

More than one child

There may be cases where more than one child has died or sustained significant harm as a result of abuse, harm, neglect or exploitation and each child is the subject of the same Review. The review process must consider each child's perspective and experience individually but ensure that learning arising from the children's circumstances is brought together in one Learning Review report at the conclusion of the Review.

The Learning Review and other formal staff processes

If any issues of staff malpractice or competency emerge during the course of a review these should be referred to and managed by the relevant agency's own staff procedures. Learning Reviews are about multi-agency learning in order to improve future practice. They are not investigations or a means of dealing with complaints.

If a situation does not meet the criteria for a Learning Review

There will be some situations where, after careful consideration, it is decided that the criteria for undertaking a Learning Review have not been met. However, the situation may contain some valuable reflective learning for practitioners and services and therefore it is important that the APC/CPC gives consideration to what might be learned and how that learning can be disseminated to the multi-agency workforce.

There are several ways in which this learning can be accessed such as facilitated multi-agency or single agency reflective sessions or other Quality Assurance or evaluation processes. Whatever the approach they are all part of a continuous programme of learning and development. As such the Learning Review subgroup will





ensure that a short and succinct report is completed, identifying key learning and if appropriate, some multi-level strategies for changing, improving, or strengthening practice in the future and for sustaining effective practice. Learning points will also be aligned to the quality indicators set out in the Care Inspectorate - A Quality Framework for Children and Young People in Need of Care and Protection (2019)¹¹. For Adult Services, please refer to the New National Health and Social Care Standards¹², Joint Inspection of Adult Support and Protection Quality Indicator Framework¹³ and Health and Social Care Standards: My Support, My Life¹⁴.

Potential Media Interest

Consideration of potential media interest should be discussed by the APC/CPC and Public Protection Chief Officers Group. When cases are likely to attract high public and media interest, a strategy should be prepared allowing for a range of scenarios. Media statements should make it clear that the purpose of the review is learning and not culpability. The Learning Review subgroup will therefore ensure close links with West Dunbartonshire's Communications Team for support.

When dealing with Learning Reviews which are likely to attract high levels of media attention APC/CPCs and Public Protection Chief Officers Groups should consider the impact on the staff and families involved in the review, advising and supporting them as much as possible. This includes those likely to be approached by the media for statements or who may be put forward as spokespersons. Whilst general media training or coaching is helpful it can be more effective to hold training sessions focussed on the specifics of the review in question.

It is advisable that key local and national Partners, particularly the Scottish Government, are made aware that media enquiries are anticipated, including when the decision is not to proceed with a Learning Review. This may include sharing the

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https://www.careinspectorate.com/images/documents/5865/Quality%20framework%20for%20children%20and%20young%20people%20in%20need%20of%20care%20and%20protection%202019 Revised.pdf

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https://www.careinspectorate.com/images/documents/5548/Adult%20support%20and%20protection%20qua lity%20indicator%20framework.pdf

¹² https://www.gov.scot/publications/new-national-health-social-care-standards/pages/4/

¹⁴ https://www.gov.scot/publications/health-social-care-standards-support-life/





strategy and any pre-prepared statements with them so that they can provide an informed and agreed response.

The email address for informing and liaising with the Scottish Government is:

child_protection@gov.scot

4. UNDERTAKING THE LEARNING REVIEW

A systemic approach

This National Guidance does not prescribe a model for undertaking a Learning Review as it is recognised that APC/CPCs have a variety of review models that work well for them. However, it is important to emphasise that a Learning Review is a collective endeavour and that, whilst the detail of how a review is undertaken may vary, all reviews must adopt a systemic approach. Such an approach goes beyond individual or professional practice to explore underlying systemic factors, the links with organisational factors and the wider contexts.

The central idea is that any professional's performance is a result both of their own skills and knowledge, and of the organisational setting in which they are working. A Learning Review, therefore, must focus on understanding how people saw things at the time, why things happened as they did, what belief systems were operating and how capabilities and capacity were affected by the roles and positions adopted by family members and other professionals, together with the emotional impact of the work and the resources available.

An effective systemic model has the following components:

- It is truly participatory and collective, involving all relevant professionals, managers, agencies, and families.
- All participants in the review contribute to the critical reflection and analysis of the situation under review and the development of strategies to support practice and improve processes and systems across agencies.
- It adopts an analytical and evidence-based approach.
- There is an appreciation that learning is not something 'done' to people but rather something that people themselves do and own.
- It takes learning to a deeper level by examining systems, structures, and cultural and contextual factors.





- It explores the interrelated and interdependent parts of different services and agencies and the impact this has had on the lived experience of the child who is the subject of the review.
- It explores how user/human friendly systems are for children and families, as well as professionals.
- It does not focus solely on what went wrong but also includes an examination and analysis of effective practice.
- Learning does not just come at the end of the review once the report is published, there is a 'thread of learning' throughout the review process. The learning develops with each Review Team meeting and professionals' event, as hypotheses are formulated and tested, and issues identified and explored.
- The learning from a review is disseminated and implemented in practice and in systems at both a local and a national level.

The Review Team

When a decision has been made to proceed to a Learning Review the first step is to set up a Review Team. Within West Dunbartonshire, the Review Team is the Learning Review subgroup; however, it may be appropriate to consider any additional members who need to be included for a particular Learning Review. The Review Team manages the whole process of the review and is a multi-agency group whose members should have a working knowledge of the relevant services involved in supporting children, adults and their families (including child protection and adult services), but, as far as possible, not have direct involvement in the situation under review. Consideration must be given to ensuring a group size that is conducive to learning and joint working. The number and composition of the Review Team will be specific to each case and there may be situations where the initial membership will need to be adjusted after the first meeting of the Review Team, based on a better understanding of the situation under review. Nevertheless, efforts should be made to ensure consistent participation of all members throughout the review and to keep membership changes to a minimum.

It is the Review Team's responsibility to ensure the Learning Review remains proportionate and focussed and is conducted in accordance with the underlying principles and values set out earlier on this Guidance.

The Review Team works together within a culture of collaborative problem solving to review and assess all information available; clarify issues for further exploration and to identify any gaps or deficiencies in the information available to the review. The





Review Team brings to the task the ability to reflect; to analyse and to look at the wider impact for practice and service delivery.

The Review Team consists of the separate roles of:

- The Chair
- Team members
- The Reviewer(s)
- The Administrator

The role of the Chair of the Review Team

The key components of the role of the Review Team Chair are to:

- Consider whether there are parallel processes ongoing i.e. criminal proceedings/FAI. This will involve making enquiries to establish whether there is an ongoing criminal investigation or ongoing criminal proceedings (see Annex 2 for CPC, Annex 7 for APC).
- Coordinate the identification and engagement of the relevant partners and suitable contributors to the Learning Review
- Coordinate the work of the Review Team
- Ensure that a clear and realistic timetable for the review process is set out and is adjusted where and when needed
- Ensure timely requests are made for key documentation relevant to the review from organisations involved in the situation under review and to follow up instances when that information is not provided in a timely manner
- Chair and facilitate meetings of the Review Team
- Contribute to the development of the learning emerging through the review process
- Ensure the review process has a consistent child centred perspective throughout
- Meet with family members alongside the Reviewer as appropriate
- Attend practitioner and manager events alongside the Reviewer
- Provide regular updates to the APC/CPC and PPCOG





The role of the Review Team members

Members of the Review Team have an important role to play in the process and outcome of the Learning Review and therefore, it is important that they manage and prioritise different work demands so that sufficient time is allocated to the review.

The main aspects of the role of Review Team members are to:

- Attend the meetings of the Review team
- Contribute to the collection and collation of information throughout the review
- Identify any gaps or deficiencies in the information available to the Learning Review and seek to remedy this
- Act as an interface between their service or organisation and the Learning Review Team, contributing to all practical aspects of the review that are required from their service or organisation
- Identify those professionals within their service or organisation who will be part of the review
- Help participants to feel informed and supported when they enter the review, as well as throughout and at the end of the review process
- Contribute to the identification of emerging themes and issues
- Participate in the verification, interpretation, and analysis of the information
- Assist in the drafting of the review report by critical and constructive appraisal

The role of the Reviewer

The overarching role of the Reviewer is to facilitate and manage the learning emerging throughout the review process and to take responsibility for the production of the report at the end of this process which brings together all of the learning into a coherent whole.

The essential elements of the Reviewer's role are therefore to:

- Work collaboratively and transparently with the Review Team Chair and members
- Attend the meetings of the Review Team
- Review and assess all information available to develop a full and multifaceted understanding of the case
- Interpret and analyse the workings and shortcomings of complex, multiagency systems





- Establish effective relationships with contributors to the review
- Effectively facilitate group work and manage complex group dynamics
- Facilitate practitioner and manager events so that:
 - Participants understand the purpose of the review as well as the underpinning principles and values of Learning Reviews
 - Trust is established between participants
 - o All participants can voice their views in a safe manner
 - Discussion, debate, probing, and constructive challenge are encouraged
- Use a range of participatory and creative approaches to obtain the views and experiences of children, young people, and their families
- Pull together the learning and write the report, with the assistance of the rest of the Review team

In some circumstances it may be appropriate to have two Reviewers. For instance, if a case is particularly complex or there is more than one child who is the subject of the review, or sometimes as a means of increasing the competence and confidence of someone new to the role of a Reviewer. When there is more than one Reviewer it will be important that they work closely together and agree how tasks will be allocated.

The role of the administrator

To support and coordinate the Learning Review process it is essential that high quality administrative support is in place. The Administrator is an important member of the Review Team and the key aspects of this support role are to:

- Administer meetings and events that are part of the review, including scheduling Review Team meetings, booking venues, managing some financial arrangements, and supporting with other associated practicalities
- Take minutes and notes of Review team meetings and practitioner and manager events
- Support the communications of the Review Team, including collating, distributing and storing documents and information as required

Within West Dunbartonshire, this support will be provided by the Public Protection Assistant.





Skills, attributes, experience, and knowledge

The skills, attributes, experience, and knowledge associated with the various roles within a Review Team are outlined in Annex 5 (CPC, Annex 5 for APC), which is intended to support the local process of appointing and, where suitable, the specific training and coaching arrangements. These will be dependent on the nature of the Review and the requirement of the Adult and Child Protection Committee and Public Protection Chief Officers Group.

Enabling factors within the wider context

A supportive Public Chief Officers Group is an essential enabling factor in ensuring that Learning Reviews are effective and fulfil their purpose. This means the Public Chief Officers Group taking ownership of and a constructive interest in the review process, findings and learning with strategic level commitment to implement the actions and learning stemming from the review.

There needs to be sufficient budget in place to resource Learning Reviews, for example if an Independent Reviewer is needed or for coaching and training staff in Learning Review methodology, as well as to support wider learning opportunities across areas. Staff time must be made available to the Learning Review process and recognition that Review Team members may need to devote multiple days to the review over and above their day-to-day work responsibilities.

Terms of reference

Terms of reference are a guiding statement which define the scope of the Learning Review. Terms of reference should reflect the rationale for undertaking a review and be relevant and specific to the situation under review. Based on the information known at the time, proposed terms of reference will have been drawn up at the point a recommendation is made to the Chair of the APC/CPC to proceed with a Learning Review. It should be noted that terms of reference are a living document and, once the review is underway, may need to be amended as further information is collated by the Review Team. The APC/CPC should be informed of and in agreement with any changes to the Terms of Reference.

The final terms of reference will be included in the Learning Review report at the completion of the Review.





Collecting and collating further information

The preparation of single agency chronologies is an important first step in the collection and collation of further information. The decision about how far back to go in terms of the timeframe preceding the incident will, to a certain extent, be dependent on the situation under review. However, in the interests of proportionality, timing, and timeliness the guiding principle must be that chronologies cover as short a timeline as possible. In most instances two to three years preceding the incident should be sufficient. If agencies and services have been involved with a child, adult and their family for many years, then a brief summary of that earlier involvement should be prepared.

Chronologies might not necessarily conclude at the point of the precipitating incident. Sometimes the responses of agencies in the immediate aftermath will provide useful learning and should be part of the Learning Review.

Once single agency chronologies have been compiled, they will be merged, thus providing the Review Team with an overview of the situation from which issues can be identified and questions developed in order to begin to explore what happened in the situation under review. Information on systems, structures, and cultural and contextual factors will also be explored in order to enhance the overview of the situation.

As the review progresses gaps in information will emerge and it is the responsibility of Review Team members to facilitate the gathering of any additional information or access to other pertinent documents. This will ensure that the Reviewer and the Review Team have sufficient information to conduct the review.

Managing emerging issues and challenges during the Review

There may be instances, when, during a Learning Review, an issue arises that may challenge or confuse or add further complexity to the review. If this should happen it is important that the Terms of Reference are revisited, potentially leading to pausing the review process in order that the Review Team consider sources of advice and an appropriate strategy for moving forward. If it is likely that an issue or challenge will delay the review reaching its conclusion then the APC/CPC and the PPCOG must be informed.





Engaging the family in the Review process

A Learning Review is a collective endeavour to bring together agencies, individuals, and families to learn from what has happened in order to better protect children and young people in the future. As the family are, therefore, integral to Learning Reviews, the Review Team must consider how to involve them in the process in a meaningful and sensitive way by developing a Family Liaison Strategy at Annex 4 (CPC, also to be used for APC).

The purpose of engaging with the family is to explore their perspective and to elicit their opinions about the practitioners and services who were involved in their lives. This will include what they found helpful or unhelpful and their suggestions for how services to children and families could be improved. Their thoughts, opinions and feelings contribute to the overall learning of the review.

Careful consideration should be given as to who constitutes the family group. This will differ from review to review but may include:

- Parents
- Step parents
- Carers
- Siblings
- Grandparents
- Aunts and uncles
- The child/young person
- Other significant family members, including partners or spouses
- Close family friends

The family should be informed as soon as possible that a Learning Review is being undertaken and the purpose of that review should be clearly stated. Inviting them to take part in the review must be done sensitively. If there are professionals still involved with the family then they may be involved as appropriate in explaining to families the purpose of the review and ascertaining their wishes as to if, how and when they want to be involved.

If family members wish to participate in the Learning Review, then a decision will be made as to who, from the Review Team, should meet with them and where. Usually this would be the Reviewer accompanied by either the Review Team Chair or a Review Team member. Where and how to meet will be dependent on the wishes of the family; it may be at the family home or at a neutral venue or on-line. It is also important to





note that it may not be appropriate to meet all family members at the same time. There may have to be more than one meeting.

It is helpful if meetings with the family can be arranged before any practitioner events or managers' events. This means that the family views can be taken into those forums for reflection and discussion.

At the end of the review process arrangements should be made to feedback to the family the conclusion of the review, the learning contained within the report and any strategies to improve practice and systems in the future. Again, this must be approached in a sensitive manner as the family may not agree with the findings of the Review. The family should also be asked how they found the process of the review itself and their feedback should inform the conduct of future Learning Reviews.

The feedback may have a number of functions for the family. It may provide validation or reassurance, but it may also cause distress or revive painful memories. In some circumstances support from professionals may need to be available to family members.

Families and others involved in Learning Reviews may well be suffering from trauma. There is a commitment to ensuring that Scotland has a workforce that is fully aware of the impact of trauma, and is equipped to respond appropriately to people who have experienced trauma at any age. Information on this can be found at Scottish Government: Adverse Childhood Experiences - Trauma Informed Workforce¹⁵.

Scotland was one of the first countries in the world to develop a robust Knowledge and Skills Framework for Psychological Trauma¹⁶. This framework lays out the essential core knowledge and skills needed by all tiers of the Scottish workforce to ensure that the needs of children and adults who are affected by trauma are recognised, understood and responded to in a way which recognises individual strengths, acknowledges rights and ensures timely access to effective care, support and interventions for those who need it.

A National Trauma Training¹⁷ Programme has been established to implement this knowledge and skills framework and to support all sectors of the workforce to upskill

¹⁵ Trauma-informed workforce and services - Adverse Childhood Experiences (ACEs) and Trauma - gov.scot (www.gov.scot)

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¹⁶ nationaltraumatrainingframework.pdf (transformingpsychologicaltrauma.scot)

¹⁷ Trauma – national trauma training programme | NHS Education (scot.nhs.uk)





staff in trauma informed practice, as well as to embed and sustain this model of working. The programme of work is being led by NHS Education for Scotland (NES) and informed by people with lived experience, to create and deliver quality training resources.

Involving practitioners, first line managers and strategic managers

Whilst this guidance does not prescribe a particular model for undertaking a Learning Review, all reviews must adopt a systemic and proportionate approach. Such an approach should be participatory and collective and, as well as engaging with families, should involve all relevant staff. This will include those practitioners and first-line managers who were involved in the situation under review as well as strategic managers, who, though not directly involved in a review situation, are responsible for the development of processes and structures to facilitate the delivery of services to children and their families.

Bringing together practitioners and first line managers in a group ensures that their voice directly contributes to the review and has two distinct purposes:

- Firstly, it enables them to describe what they did and why; to reflect on and analyse
 assessments and decision-making at the time and to identify what could have been
 done differently but also, what prevented them from doing this. It also enables the
 group to recognise effective practice and what worked well and why.
- Secondly, it generates immediate learning, at both an individual and at a group level that can be taken back into practice.

For strategic managers meeting as a group is an opportunity to understand the learning from a particular situation in order to consider the implications from both a single agency and a multiagency perspective.

Annex 6 (both APC and CPC) looks at how to facilitate and shape events for practitioners and first line managers and strategic managers.

Review Team Meetings

Regular meetings of the Review Team should be scheduled throughout the course of the Learning Review. The overall purpose of these meetings is to review the progress of the review, identify the emerging learning, highlight issues and questions for further exploration, set out the next steps and allocate tasks.





The focus of each Review Team meeting will differ depending on the stage in the review process. For instance, in the early stages collating information, identifying any significant gaps in that information, and clarifying which practitioners and managers should be involved in the review and how they will be supported to participate effectively will be on the agenda. As the review progresses the Review Team meetings will consider the learning emerging from contact with family members and from the practitioner and manager events. In the latter stages of the Learning Review the focus will be on the construction of the report.

All information processed by the Review Team must be kept secure, particularly given its sensitivity, and should be relevant to and necessary for the Review, rather than excessive. This information will be retained in perpetuity.

The Report

The purpose of a Learning Review report is to identify key learning points and how and why that learning has emerged throughout the review process. Reports should be clear, succinct, and as anonymous as possible. This will simplify any process of redaction of Personal Data prior to circulation for learning purposes or wider publication and ensure that the redacted report is still meaningful. When this is not possible, detailing Personal Data in particular sections of the report, rather than including with more general content, is recommended.

Where a living individual can be identified from the report or even from the report and other information held, this will be Personal Data and so data protection principles, including a data subject's right of access, will apply. Personal Data includes opinions and indications of intentions. A Learning Review, by its very nature, will contain professional opinions, but it is important that these are recorded as such and distinguished from fact.

Whilst it is the responsibility of the Reviewer to pull together the learning and draft the report, this should be done alongside the Review Team whose role is to scrutinise, challenge appropriately and ensure that the report represents all the learning that has been generated by the Review process.

The report content should cover (Annex 1.6 for CPC, Annex 4 for APC):

- A brief description of how the review was conducted
- A brief outline of the circumstances that led to the Learning Review





- The practice and organisational learning that has been identified and the evidence substantiating this learning
- Examples of effective practice in the situation under review and the reason why it was effective
- Suggested strategies for improving practice and systems. It must be noted that
 in some situations the Review Team may conclude that practice and processes
 have not failed or been inappropriate and, therefore, at this point no changes
 are required.

It is recommended that suggested strategies for improving practice and systems should be CLEAR¹⁸. This means that:

- The Case for change: the Review Team should clearly identify the issues that give rise to the need for change, outlining the likely consequences should no change occur. Any proposed change should be set within the context of current policy or that which is known to be in preparation.
- Learning orientated: any suggested strategies should highlight key lessons for practice identified by the review process and should promote the transfer of learning.
- **Evidence based**: proposed strategies for improving systems and practice should draw on evidence of any shortcomings in policy or practice revealed by the review and only be made if evidence exists that their implementation will effectively address the shortcomings identified in the review report.
- **Assign responsibility**: each strategy should identify the discipline or organisation with responsibility for implementation, recognising that some will require a collaborative response.
- **Review**: any strategies recommended by the review report should be amenable to review. This can be done by specifying desired outcomes and timelines and any additional resources required to achieve them

The Learning Review report will be presented to the APC/CPC and the PPCOG for consideration and sign off. It is recommended that the Reviewer and the Chair of the Review Team take responsibility for presenting the report.

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¹⁸ Buckley H, O'Nolan C (2014) *Child Death Reviews: Developing CLEAR Recommendations* in Child Abuse Review Vol 23





Publishing the Report

The Public Protection Chief Officers Group, informed by a recommendation in this regard from the Adult/Child Protection Committee, will decide if and when to publish the report. In making this decision issues of confidentiality and data protection principles must be considered. The family should also be consulted, and their views considered and given due weight in arriving at a decision. Any publication must be suitably anonymised but also clearly reflect the learning emerging from the review and the evidence for any proposed changes. Where a decision not to publish the report is reached, the exceptional circumstances underpinning that decision will be noted in the minutes of the Public Protection Chief Officers Group meeting. If a report is not published, then the learning should be extracted from the report and be published separately.

Even if a decision is reached not to pro-actively publish the report, there is always a possibility, particularly in high profile cases, that a Freedom of Information (FOI) request may be received. In such cases the relevant public authority will be obliged to disclose information on request, unless one of the fairly narrow exemptions apply, particularly where there is a public interest in doing so. Although there is an exemption for Personal Data when disclosure of which would breach the data protection principles, it may be difficult to justify withholding the report in its entirety and it may need to be issued under redaction of Personal Data.

Timescale for the Learning Review

If the learning identified throughout the review process is to be relevant and helpful to the development and improvement of adult/child protection practice and processes it is important that the review is completed as soon as possible. Once a decision has been made to undertake a Learning Review, the process should be completed within a timeframe of six to nine months, thus avoiding drift.

However, in some situations there may be some avoidable delay at any stage, for instance because of parallel processes. The Chair of the Review Team should communicate the reasons for any delay back to the APC/CPC, with a revised timescale. Lengthy delays should be avoided because of the impact on both staff and families involved.





5. DISSEMINATING AND IMPLEMENTING THE LEARNINFROM THE REVIEW

The dissemination and implementation of learning from a Learning Review has several components which are:

- The implementation of suggested strategies, specified in the report, for improving practice and systems
- Dissemination of learning at a local level
- Dissemination of learning at a national level

Implementation of suggested strategies

The final section of the report will often but not always contain suggested strategies for improving practice and systems, which identify the case for change; are learning orientated; evidence based; and assign responsibility. The APC/CPC must then ensure that a succinct action plan is drawn up to support the implementation of these strategies. The action plan will clarify who will do what and within what timescale.

The Public Chief Officers Group will consider the Action Plan, as well as any resource issues that are relevant for the production and progress of the Action Plan.

Once the action plan is agreed at the PPCOG, it is expected the Learning Review subgroup will assume ownership of the action plan and update the APC/CPC on a quarterly basis of the progress of the action plan. It is the responsibility of the Learning Review subgroup Chair/appointed person to provide this update and advise the APC/CPC of any drift or challenges in progressing the action plan. If required, this should be escalated to the PPCOG.

Dissemination of learning at a local level

The purpose of dissemination at a local level is twofold:

- Firstly, to clarify what the learning is and what led to that learning so that it is understood by practitioners, managers and organisations
- Secondly, to explore how that learning can be embedded in practice and systems





There are a variety of approaches and models that can be used to disseminate learning at a local level. These may include multi-agency reflective sessions, seminars, learning summaries and briefings. To ensure dissemination of learning is sensitively tailored to meet the needs and learning styles of different individuals and groups, a variety of modes and approaches should be used. It is essential that dissemination takes place in a timely manner, is targeted at the right audience and allows space for consideration of the implications for practice and systems and identifies what needs to happen to ensure the learning is applied.

Dissemination of learning at a national level

The purpose of disseminating learning at a national level is to look at recommendations and suggested strategies that are outside the remit of an individual APC/CPC but require action; share learning across the APC/CPC areas; identify overarching themes and consider if issues need further exploration, or if they should underpin or inform the development of national policy.

Dissemination of learning at a national level is facilitated by the publication of annual overview reports by the Care Inspectorate and by regular meetings of the Learning Review Liaison Group. This group, compromising representatives from the Scottish Government, the Care Inspectorate and CPCScotland, has been established to provide a forum to discuss thematic findings from Learning Reviews that have national implications for policy and practice development.

Dissemination of learning at a national level can also be facilitated by the online Learning Review Knowledge Hub (CPC). This online forum enables members to participate, contribute and share information, knowledge and best practice relating to the Learning Review process, practice and learning. Membership of the Learning Review Knowledge Hub is restricted to those who have a specific role, remit and focus on case review processes, research, policy and learning.





6. Appendices Document



