West Dunbartonshire

Adult Protection and Child Protection Committees Guidance and Protocol for Undertaking Learning Reviews

2025

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CONTENTS

1. INTRODUCTION

This Guidance aligns West Dunbartonshire practice to the National Guidance for Child Protection Committees Undertaking Learning Reviews (2024) and the National Guidance for Adult Protection Committees Undertaking Learning Reviews (2022).

The National Guidance for Child Protection Committees Undertaking Learning Reviews was updated in 2024[1] and the National Guidance for Adult Protection Committees Undertaking Learning Reviews was published in May 2022[2].

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.

Similarly, for adults, Adult Support and Protection Learning Reviews, protecting adults who are vulnerable and at risk of harm is an interagency and multi-disciplinary responsibility overseen by the APC and it is the APC , on behalf of the PPCOG, that decides whether a Learning Review is warranted and for agreeing how the review is to be conducted.

The overall purpose of a Learning Review (both CPC and APC) is to bring together agencies, individuals and families in a collective endeavour to learn from what has happened 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 Child[3] (UNCRC).

Similarly, Learning Reviews in relation to adults are based on a human rights approach as enshrined in the European Convention on Human Rights. The human rights approach is based around the following elements- empowerment of everyone to understand and claim their rights; and the ability and accountability of all public, private and voluntary bodies to ensure human rights are fulfilled in practice. All three of the key pieces of legislation relating to Adult Support and Protection – Adults with Incapacity (Scotland) Act 2000; Mental Health (Care and Treatment) (Scotland) Act; and Adult Support and Protection (Scotland) Act 2007 directly reference human rights principles such as participation, least restrictive intervention and non-discrimination.

[1] National guidance for child protection committees undertaking learning reviews - gov.scot

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

[3] https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-child

2. CONTEXT

The Learning Review approach stems 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 Review[4] 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 Responsibilities[5] 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, 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.

Similarly, the Adult Support and Protection (Scotland) Act 2007 Guidance For Adult Protection Committees (2022) highlights, while not referenced in the Act, it is now accepted practice across all APCs that learning reviews are commissioned by APCs across Scotland.

The purpose of such reviews is to gain a multi-agency understanding of the circumstances of a particular case and to identify what can be learnt to best inform future policy, practice and procedure.

In May 2022, the Scottish Government published National Guidance for Adult Support and Protection Committees Undertaking Learning Reviews. This guidance document provides an update to the previously published Adult protection significant case reviews: interim framework (November 2019). The Learning Review guidance, now much aligned to the equivalent guidance for learning reviews undertaken by Child Protection Committees, places the responsibility for commissioning and overseeing such reviews with Adult Protection Committees, on behalf of the Chief Officer's Group. It confirms that APCs are responsible for agreeing recommendations within case reviews and for overseeing any improvement plans that may follow. These matters should be reported to the local Chief Officer Group for approval and once approved, reports of case reviews that meet the criteria laid out in the guidance should be submitted to the Care Inspectorate (including any case review or reflective learning review that is referred to by a different name but meets the criteria for a learning review).

Definition of a child

For the purpose of this document, a child is a person under the age of 18 years old, 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.

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

[5] Protecting Children & Young People - Child Protection Committee and Chief Officer Responsibilities

A comprehensive definition is provided in the National Guidance for Child Protection in Scotland[6].

Definition of an adult at risk of harm

The Act refers to an 'adult' as a person aged 16 years 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 Chief Social Work Officer should be involved in these deliberations.

3. 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 to reflect, increase understanding and identify key learning.

II. Support for staff

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. This should be considered and agreed by the Review Team set up to progress the review.

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, Lead Reviewers

[6] National guidance for child protection in Scotland 2021 - gov.scot (www.gov.scot)

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 within 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 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.

VI. 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

VII. Creating the preconditions for learning

Learning Reviews are **not** 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 safe[7] 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. It is the role of PPCOG to promote and support national learning and improvement activity in the protection of children and adults at risk as a matter of course, providing leadership and guidance in relation to the need to carry out Learning Reviews.

[7] Professional Development Group, University of Nottingham in Charles, M Stevenson, O (1990) *Multidisciplinary is Different* University of Nottingham

Child Protection criteria for undertaking a Learning Review

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

When a child 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 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 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
- the child's sustaining of or risk of significant harm is caused by attempted suicide, alleged attempted murder, reckless conduct, or act of violence
- the child is being managed under Care and Risk Management (CARM) processes and causes harm to another person or themselves.

When a child has died 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, 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
- the child is being managed under Care and Risk Management Processes

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

Please note, following the establishment of the National Hub for Reviewing and Learning from the deaths of Children and Young People, all child deaths should be reviewed. A range of review processes are currently in place when a child or young person dies. Therefore, early discussion between child/public protection leads, NHS Board and local authority implementation leads for child death reviews, and relevant senior officers from the local authority/Health and Social Care Partnership (HSCP), should take place to consider and agree the most appropriate review process.

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 has 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 -

- 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.

It should also be noted, some of the above processes are currently under review at a National level and it is important to consider this locally once complete.

Issues to be considered include how to -

- Link processes;
- Avoid witness contamination;
- Avoid duplicate information being collected;
- 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 and adult protection practices, 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 and should be completed prior to commencing a Child Protection Learning Review, where there are ongoing criminal proceedings. This allows for agreement in terms of what can or cannot be progressed in relation to the Learning Review. The Child Protection Lead Officer is responsible for completing the Annex 2.1 (Learning Review Notification To Crown Office & Procurator Fiscal Service) and sending to Police colleagues, who will then liaise with the COPFS to request permission to commence or the parameters of the Learning Review.

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;
- ensure the relevant information is shared with the right parties.

Above and beyond this, the priority is that the child or 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 initial consideration meeting by Ault and Child Protection Learning Review subcommittee. Discussions will also take place at the earliest opportunity regarding how best to proceed, in order to minimise duplication and maximise learning. The responsible 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 Scotland[8].

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.

4. INITIATION OF A LEARNING REVIEW AND DECISION MAKING PROCESS

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, any Partner can initiate a Learning Review if they feel the criteria above has been met. Initially the referring Partner should discuss the potential referral with the Chief Social Work Officer and Independent Chair.

Once it has been agreed that a notification should be raised, the initiating Partner should complete Annex 1.1 for CPC Learning Reviews and Annex 2 for APC Learning Reviews and return 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 whoever may support the understanding of the situation (Annex 1.2 for CPC and Annex 3 for APC). This will be requested from the CPC/APC member related to the Service who is involved with the child/adult, who will oversee the timely completion of the document. In addition to any Health Departments involved with the child or adult, the NHS Public Protection Service will also be included in the email requesting information (ggc.cpadmin@nhs.scot).

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

The purpose of information gathering at this stage is to decide 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.

Information provided 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.

Partners should also provide their chronology of events in relation to the family. Where there is no chronology of events available or where this is handwritten, the following template should be completed to ensure key events are provided for the compiling of the multi-agency chronology. Chronology Template can be found under additional appendices Annex 3.

This information should be returned to the relevant Lead Officer within **14 calendar days** of the information being requested.

At the same time as information being requested, the Lead Officer, with support from the Public Protection Assistant, will organise an initial consideration meeting, which will take place within **28 calendar days** of the notification being received. This meeting will take place with representatives from across Partners and will be Chaired by the Chief Social Work Officer.

Prior to the initial consideration taking place, the Public Protection Assistant, with guidance from the Lead Officer, will share the Learning Review notification, Partner returns (Annex 1.2 for CPC and Annex 3 for APC) and single agency chronologies to allow for preparation in advance of the meeting taking place.

After consideration of the gathered data the initial consideration meeting 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) and will be completed and presented to the CPC/APC by the Lead Officer:

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

To minimise delay in making this decision, if the CPC/APC **is not** due to take place within an appropriate timeframe, the annex 1.3 should be provided to the Independent Chair for consideration. The Independent Chair will make a decision and the annex 1.3 will be presented to the next CPC/APC for information.

PPCOG will also be notified of the decision to progress with a Learning Review and the rationale for this.

Following this decision, the Lead Officer will complete annex 1.3, Learning Review Decision and annex 1.4, Learning Review notification response (annex 1.4 to be returned to the person raising the notification). Please note, these steps are not included in the APC National Guidance, however West Dunbartonshire have chosen to follow the same steps, therefore the Adult

Protection Lead Officer will also follow this process and complete CPC paperwork, annex 1.3 and 1.4 to ensure consistency of approach.

The Care Inspectorate will also be informed by the appropriate Lead Officer. For the Child Protection Lead Officer, they should do so by completing the following form Learning Review Notifications - Children's. For the Adult Protection Lead Officer, they should do so by completing the following form Learning Review Notifications - Adults. Further information can be found at the following link Care Inspectorate - LR Notifications

If the decision is to go ahead with a Learning Review, then a review team will be established, a Chair will be appointed, and the responsible Lead Officer will draft Terms of Reference for the review group. Example Terms of Reference can be found under additional appendices Annex 1.

Timeframe for the initial decision-making process

The timeframe for this initial decision-making stage will vary depending on the situation being considered. However, timelines are 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. The National Guidance suggests 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. Within West Dunbartonshire, it has been agreed that the initial consideration meeting should take place 28 calendar days from the notification being received to allow the decision to be made within 42 calendar days.

More than one Adult or Child Protection Committee is involved

In the case of a potential cross-authority Learning Review within Scotland, the relevant CPC/APC Chairs and Chief Social Work Officers should meet and agree a mechanism for joint working, including which CPC/APC 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 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 CPC/APC 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 subcommittee 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)[9]. For Adult Services, please refer to the New National Health and Social Care Standards[10], Joint Inspection of Adult Support and Protection Quality Indicator Framework[11] and Health and Social Care Standards: My Support, My Life[12].

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. An example media strategy can be found at CPC Annex 8. Media statements should make it clear that the purpose of the review is learning and not culpability. The Review Group Chair 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

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

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

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

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

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 and should be considered, in some situations, training sessions focussed on the specifics of the review in question may be more appropriate.

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 strategy and any pre-prepared statements with them so that they can provide an informed and agreed response, therefore the Review Group should consider how this should be done.

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

child_protection@gov.scot

5. 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 CPC/APCs have a variety of review models that work well for them. However, it does highlight the importance of a Learning Review being 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/adult who is the subject of the review.
- It explores how user/human friendly systems are for children/adults 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.

Consideration should be given to the approach used when appointing a Lead Reviewer, to ensure there is a clear agreement to the expectations.

West Dunbartonshire have agreed a preference in the use of the Learning Together approach, however, highlight any approach should be proportionate and subject to agreement by the Independent Chair in conjunction with the Chief Social Work Officer.

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 subcommittee; however, it may be appropriate to consider any additional members who need to be included for a particular Learning Review eg if there has been involvement from a particular service who does not usually sit on the Learning Review subcommittee.

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. In addition, Review Team members must ensure they attend and are prepared for each review team meeting.

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

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 (to be agreed at the start of the review)
- Child or Adult Protection Lead Officer (depending on whether it is a child or adult protection learning review
- Social Work Representative
- Health Representative
- Education Representative (children's only)
- Police Scotland Representative
- Housing Representative
- Review Team members
- The Reviewer(s)
- The Administrator – Public Protection Assistant

In order to maximise attendance at meeting, the review team meetings will be agreed and placed in diaries for the duration of the review following the initial meeting.

The timelines example can be found under additional appendices Annex 2 and should be used at the start of the process. –

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/adult 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 prioritising 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 multi-faceted understanding of the case
- Interpret and analyse the workings and shortcomings of complex, multi-agency 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
    - 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, adults 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.

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.

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.

Enabling factors within the wider context

National Guidance states, 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. The approach to be undertaken for the learning review will be detailed within the Terms of Reference and will be agreed by the Committee and the review team. 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 CPC/APC to proceed with a Learning Review. These will be drafted by the relevant Lead Officer and will be signed off by the relevant Committee.

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 CPC/APC 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.

Example Terms of Reference can be found under additional appendices Annex 1.

Collecting and collating further information (chronologies)

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.

Single agency chronologies will be requested at the point of the initial information gathering. As noted above, this should be provided either on Partners electronic chronology format, of where there is no chronology or where this is written and not typed, this should be provided on the multi-agency chronology template (Chronology Template can be found under additional appendices Annex 3)

Once single agency chronologies have been compiled, they will be merged, by the relevant Lead Officer, supported by the Public Protection Assistant, and will be shared in advance of the initial consideration meeting, 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 CPC/APC 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, young people and adults 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 (for 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/adults 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/adult
- 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 Workforce[13].

Scotland was one of the first countries in the world to develop a robust Knowledge and Skills Framework for Psychological Trauma[14]. 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 Training[15] Programme has been established to implement this knowledge and skills framework and to support all sectors of the workforce to upskill 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.

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

[14] nationaltraumatrainingframework.pdf (transformingpsychologicaltrauma.scot)

[15] Trauma – national trauma training programme | NHS Education (scot.nhs.uk)

Involving practitioners, first line managers and strategic managers

As highlighted earlier, all learning reviews must adopt a systemic and proportionate approach and should therefore be participatory, 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/adults 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.

As stated earlier in this guidance, review team meetings will be agreed at the first meeting and placed in diaries to ensure maximum attendance. It is important that review team members prioritise these meetings.

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 1.5 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 **CLEAR**[16]. 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.

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

- **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 CPC/APC and the PPCOG for consideration and sign off. The Reviewer and the Chair of the Review Team take responsibility for presenting the report.

In West Dunbartonshire, an executive summary is always requested from the Lead Reviewer.

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 in an executive summary report.

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.

In any case, West Dunbartonshire have agreed to publish an executive summary on to the adult or child protection website, with a link available should further information be required.

Timescale for the Learning Review

To ensure the learning identified throughout the review process is 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 unavoidable 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.

6. DISSEMINATING AND IMPLEMENTING LEARNING FROM 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 CPC/APC 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. This action plan will be drafted within the review team meeting and presented to the CPC/APC. Once agreed at the Committee, the Public Protection 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 subcommittee will assume ownership of the action plan and update the CPC/APC on a quarterly basis of the progress of the action plan (update to be provided by the relevant Lead Officer). The CPC/APC should be notified of any drift or challenges in progressing the action plan and 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 models 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.

Once the review has concluded, the review team should agree the method for disseminating learning at a local level and this should be undertaken in a multi-agency fashion.

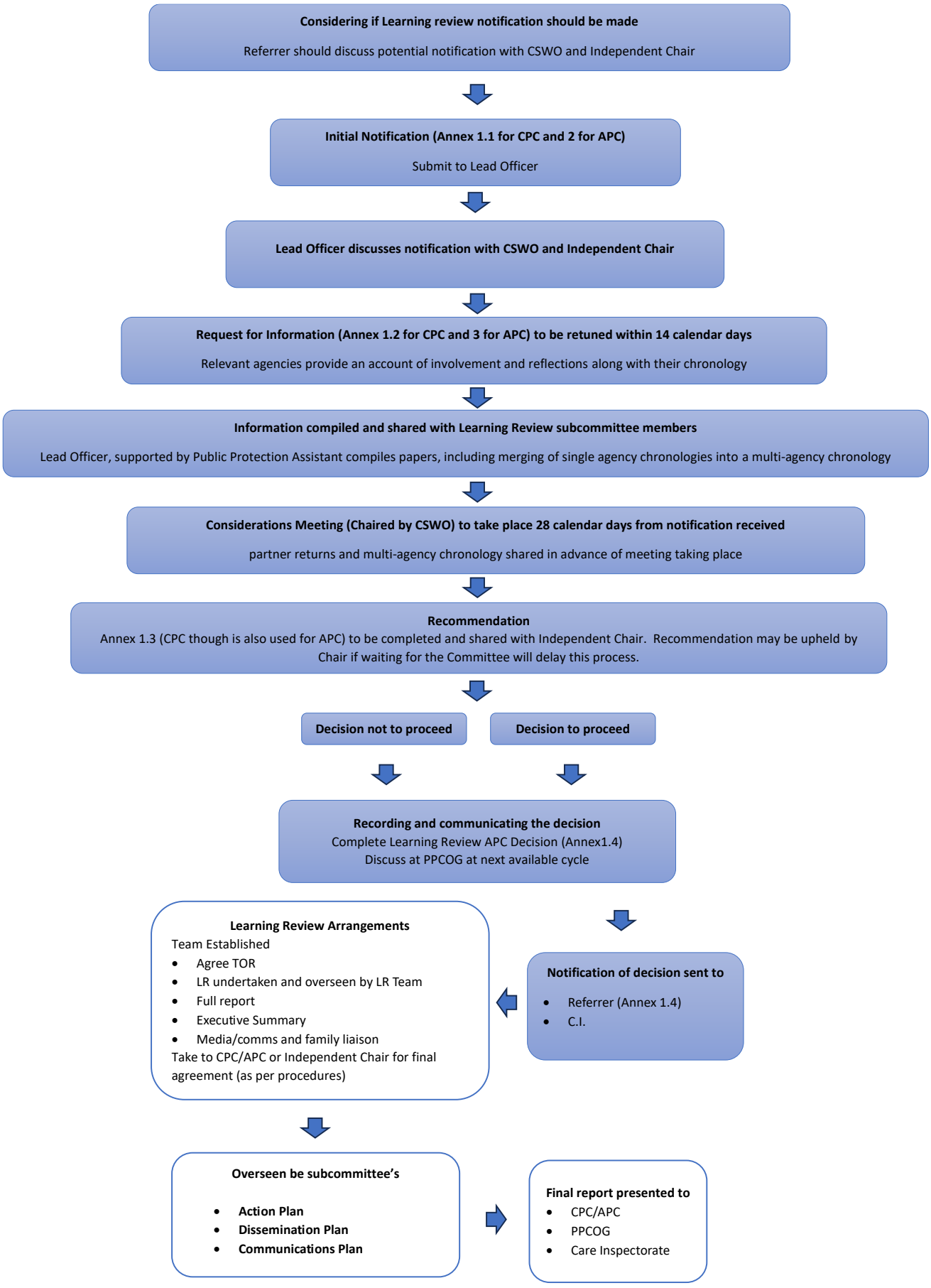
Dissemination of learning at a national level

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 CPC/APC but require action; share learning across the CPC/APC 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.

7. Learning Review process - Child & Adult Support and Protection



8. Appendices – Child Protection Committee Appendices

Annex 1.1 – Learning Review Notification Template:

[*TO BE SPECIFIED*] CHILD PROTECTION COMMITTEE

OFFICIAL – SENSITIVE- PERSONAL

LEARNING REVIEW NOTIFICATION

Request from:	
Contact details:	
Agency:	
Date completed:	

Any member of the Child Protection Committee, agency or practitioner can ask for a case to be considered by [*to be specified*] Child Protection Committee for a Learning Review if they consider it meets the following criteria:

Criteria:

***When a child has sustained significant harm or risk of significant harm as defined in the* National Guidance for Child Protection in Scotland 2021 (updated2023)**

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 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 looked after has no bearing on the case
- the child's sustaining of or risk of significant harm is by attempted suicide, reckless conduct, or act of violence
- the child is being managed under Care and Risk Management (CARM) processes and causes harm to another person or themselves.

When a child has died

and there is additional learning to be gained from a review being held that will lead to 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
- 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, 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
- the child is being managed under Care and Risk Management Processes
- the child's death is by suicide, alleged murder, culpable homicide, reckless conduct, or act of violence

Please be reminded that, following the establishment of the National Hub for Reviewing and Learning from the deaths of Children and Young People, all child deaths should be reviewed.

A range of review processes are currently in place when a child or young person dies therefore early discussion between child/public protection leads, NHS Board and local authority implementation leads for child death reviews, and relevant senior officers from the local authority/HSCP, will be important to consider and agree the most appropriate review process.

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.

This criteria does not preclude a CPC reviewing the death of a child pre-birth.

Where the referring agency or individual considers that a case meets the criteria above, they should complete and forward this Learning Review Notification form (Annex 1.1) to the Child Protection Committee at [*insert email*].

(The Referrer can discuss the referral with the Chair and/or the Learning Review nominated person within the CPC [*insert contact details*]).

The decision about whether a Learning Review will be undertaken will be made by the Child Protection Committee after information from services/agencies/individuals who are involved with the child has been submitted and considered using the Learning Review Request for Information form (Annex 1.2). The request for information to other services/agencies/ individuals will be by e-mail. The referrer will receive a Notification Response form (Annex 1.4).

INFORMATION FOR CONSIDERATION OF LEARNING REVIEW

Child's details	
Child's Name/Identifier:	
Child's date of birth:	
Child's date of death (if applicable):	
Child's home address:	
Child's current residence:	
Child's gender:	
Child's current legal status:	
Education establishment details:	
Please include key additional factors such as disability, ethnicity, religion:	
Parents/carers' details	
Names and DOB of child's parents/carers:	
Address if different to child's:	
Child Protection Register	
Is the child's name currently on the Child Protection Register?	

Are any siblings currently on the Child Protection Register?	
Has the child's name previously been on the Child Protection Register? If yes, provide details, including dates.	
Have any siblings previously been on the Child Protection Register? If yes, provide details, including dates.	
Looked After Child	
Has the child been looked after by, or received aftercare /continuing care from local authority? If yes, please give details, including dates.	
Have any siblings been looked after by, or received aftercare or continuing care from the local authority? If yes, please give details, including dates.	

In case of more than one child for whom a Learning Review should be considered, please repeat or amend the relevant rows in the table above, making sure to present the information in a clear manner, with adequate differentiation (e.g. using 'parents of Child 1' if they differ from the 'parents of Child 2')

Criteria for Learning Review	
What grounds within criteria do you consider to apply for a Learning Review?	
Immediate and general concerns	
Are there any immediate concerns? If yes: • What are the immediate concerns and have these been passed to the relevant agency for consideration/action? • What action has been taken?	

Are there any general concerns identified during this process of notification? If yes: • What are the general concerns and have these been passed to the relevant agency for consideration/action? • What action has been taken?	
Parallel processes	
Are you aware of any parallel processes for any other type of review being undertaken for this case? If yes, please give details:	
Are you aware of any criminal procedures being undertaken in connection with this case? If yes, please give details:	

Date of significant incident:
Summary of the case:

Name of service/agency/individuals involved with the child(ren) and/or family, including Named Person and Lead Professional			
Service:	Role with the child/ the family:	Practitioner name and title:	Contact details:

The recommendation is that this notification will be responded to within 28 to 42 days, with the outcome of the CPC's consideration of whether or not to proceed with a Learning Review.

Annex 1.2 – Request for Information Template:

[*TO BE SPECIFIED*] CHILD PROTECTION COMMITTEE

OFFICIAL – SENSITIVE- PERSONAL

REQUEST FOR INFORMATION

TO CONDUCT A LEARNING REVIEW

• You have been identified to participate in a Learning Review and are asked to complete this request for information • This requires to be completed **within 14 calendar days** and sent electronically to [*insert email address*] • This report is required to contain information outlining your agency/service contact/interaction with the child and/or family whose details are below. • Please 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. If you have historical information please give a brief summary of the themes and issues you have identified in the background history section.	
Learning Review identifier:	[to be specified]
Date of the request for information:	[to be specified]

Child's Name and Identifier number:	[to be specified]*
Date of birth:	[to be specified]*
Date of death (if applicable):	[to be specified]*
Date of significant incident:	[to be specified]*
Gender:	[to be specified]*

**If more than one child for whom the Learning Review is considered, repeat the second column.*

Please provide the following information

Details	
Names of child's parents/carers and dates of birth :	
Names of siblings and dates of birth:	
Child's home address:	
Child's current address, if different from above:	
Education establishment details:	

If more than one child for whom the Learning Review is considered, please amend or repeat the table above

Summary of involvement with the child(ren) and/or family:
Background history:

Key practice issues:

Please provide information on:

- recognition and assessment of risk and need in relation to the child(ren)/family;
- information sharing in this case;
- strategies and actions to minimise harm;
- timely and effective action taken;
- multi-agency responses;
- evidence of planning and reviewing;
- quality of record keeping;
- appropriate use of legal measures;
- evidence of child-centred practice;
- any good practice identified;
- any areas identified for practice improvement.

Parallel processes	
Are you aware of any current or planned reviews being undertake for this case? If yes, please give details:	
Are you aware of any criminal proceedings associated with this case? If yes, please give details:	

Report completed by:

Name:	
Title:	
Agency:	
Email address:	
Date:	

Annex 1.3 – Learning Review Recommendation and Decision Template: Recommendation

[*TO BE SPECIFIED*] CHILD PROTECTION COMMITTEE

OFFICIAL – SENSITIVE- PERSONAL

LEARNING REVIEW RECOMMENDATION AND DECISION

Child(ren)'s name(s) and date(s) of birth:	
Learning Review identifier:	

Notification from:	
Name:	
Agency:	
Date of notification:	

Basis for referral:
Agencies that provided information during the information gathering stage:
A brief outline of the case:

Current circumstances of the child and family (including actions taken):
Details about other formal and/or parallel processes:
Summary of key practice issues from single agency information (Annex1.2)

Recommendation After consideration of the notification and the information submitted from relevant agencies, the nominated person/sub-group within the CPC:	
	recommends a Learning Review to be undertaken.
	does <u>not</u> recommend a Learning Review to be undertaken.

A brief rationale for the recommendation *(overall views on the information gathered and the criteria)***:**

Recommendation completed by:

Name:	
Title:	
Email address:	
Date :	

Annex 1.3 – Learning Review Recommendation and Decision Template: Decision

[*TO BE SPECIFIED*] CHILD PROTECTION COMMITTEE

OFFICIAL – SENSITIVE- PERSONAL

For completion after the Child Protection Committee decision

Child(ren)'s name and date of birth:	
Learning Review identifier:	

Section 1: **The Decision**	
	After consideration of the information submitted from relevant agencies, CPC have considered the request for undertaking a Learning Review and have **decided that this does reach the criteria for a Learning Review**. *See Section 2.A.*
	After consideration of the information submitted from relevant agencies, CPC have considered the request for undertaking a Learning Review and have **decided that this does <u>not</u> reach the criteria for a Learning Review**. *See Section 2.B.*
A brief rationale for the decision *(short comment on the recommendation made by the nominated person/sub-group within the CPC, the information considered and criteria)***:**	

Section 2: Next steps	
2.A:To be completed if the decision is to proceed with a Learning Review	Initial considerations regarding: • Learning Review Team set up; • Terms of reference and the time-period under review; • Family liaison approach;
2.B: To be completed if the decision is <u>not</u> to undertake a Learning Review	Reason for not proceeding with a Learning Review:
	Initial considerations regarding an alternative approach for learning (e.g. facilitated multi-agency or single agency reflective sessions, file audits etc.):

Section 3: Further considerations
Communication and media approach (where relevant):
Other parallel reviews or processes (where relevant):

Notification to Child Protection Committee (date and details):

Notification to Chief Officers Group (date and details):

Completed by:

Name:	
Title:	
Email address:	
Date :	

Annex 1.4 – Learning Review Notification Response Template:

[*TO BE SPECIFIED*] CHILD PROTECTION COMMITTEE

OFFICIAL – SENSITIVE- PERSONAL

LEARNING REVIEW

NOTIFICATION RESPONSE

Request from:	[to be specified]
Contact details:	[to be specified]
Referring agency:	[to be specified]
Date of notification:	[to be specified]
Child's name and date of birth:	[to be specified]
Learning Review identifier :	[to be specified]

Thank you for the notification for consideration of a Learning Review. The CPC has considered the information submitted and have determined that:	
	This reaches the criteria and the CPC decided to proceed with a Learning Review.
	This does not reach the criteria for a Learning Review, however it may be that an alternative approach for learning may be undertaken. [include more details, if available]

Completed by:

Name:	
Title:	
Date:	
Email address:	

Annex 1.5 - Learning Review Draft Report Template:

[TO BE SPECIFIED] Child Protection Committee

Learning Review Report

Re: *insert Learning Review identifier*

Introduction
To include: • Age of the child • The precipitating incident • The criteria for a Learning Review

The Process of the Review
To include: • The constitution of the Review Team including the Chair and the Reviewer(s) • How many times the Team met • The length of the review process (and the initial notification date) • A summary of the terms of reference and the time-period under review • The Family Liaison Strategy: how were family members involved in the review? Which family members participated? When were they seen? How were they kept informed of the progress of the review? How were their views represented throughout the review? • When the practitioner/first line manager event was held; how many attended and from what agencies and the shape of the event • When the strategic manager event was held; how many attended and the shape of the event

The Circumstances that Led to the Learning Review
To include: • Family composition • A brief account of the main events in the family history • What involvement the child/family had with professionals and services

Practice and Organisational Learning
Identify and analyse each area of learning emerging from the review with supporting evidence from the relevant circumstances to substantiate that learning

Effective Practice
List areas of effective practice identified by the review and explain what made them effective

Suggested Strategies for Improving Practice and Systems

• Any suggested strategies must be CLEAR i.e.
  ○ Set out the need for change and the likely consequences should no change occur
  ○ Be learning orientated
  ○ Be evidence based
  ○ Assign responsibility – who should do what
  ○ Be amenable to review
• In some situations, the review may conclude that practice and processes have not failed or been inappropriate and, therefore, at this point, no changes are required

Signed and dated by:

Reviewer(s):	
Review Team Chair:	
Date:	

Annex 2:

Crown Office and Procurator Fiscal Service (COPFS) Protocol

National Protocol for the Police Service of Scotland, the Crown Office and Procurator Fiscal Service, and Child Protection Committees on Significant Case Reviews

Parties

The parties to this protocol document are Child Protection Committees (CPCs), the Crown Office and Procurator Fiscal Service (COPFS) and the Police Service of Scotland.

Aim

The aim of this protocol is to provide a framework between the parties for conducting Learning Reviews (LRs) when criminal prosecutions, Fatal Accident Inquiries (FAIs) or investigations with a view to such proceedings are running in parallel and for the sharing and exchange of relevant information generated by each process.

Principles

The parties to this protocol recognise that criminal proceedings, FAIs and LRs are important processes which should each be carried out as expeditiously as possible, and should not adversely affect the pogress of the other unless it is necessary in the interests of justice.

All processes are crucial to ensuring the safety and wellbeing of children and young people. The parties recognise that a significant consideration in any decision should be the welfare of children and young people

Learning Review

A LR examines the circumstances and context of a child being harmed or killed, to evaluate the nature and quality of professional contact, if any, with the child, to identify any system failures which may impact on other children, and to learn from the incident, any specific lessons which will strengthen child protection systems, locally and nationally.

A LR is not an enquiry into why any child or young person died, was harmed or to establish who may be culpable. These are matters for criminal investigation and for employer disciplinary procedures as appropriate. It is further acknowledged that agencies may additionally have their own internal/statutory review procedures to investigate serious incidents and mechanisms for reflective practice eviews, which take place independently of any LR or criminal investigation.

LRs are commissioned by local CPCs. Protecting children and young people is an inter-agency and inter-disciplinary responsibility. While social work children's services usually lead on the discharge of local authorities' legal responsibilities in respect of safeguarding

children, any agency (including voluntary sector organisations) or profession may be the initiator of the LR process.

LRs will sometimes be undertaken in circumstances where there is no concurrent criminal investigation or FAI. Similarly, some cases of criminal investigation involving harm to children or young people will not be subject to a LR. Good relationships and liaison arrangements between CPCs, COPFS and Police Scotland will ensure that parallel processes are pre-planned and that changes in the status of a case (e.g. where early in an LR the need arises to refer matters for a criminal investigation) are readily shared.

Learning Reviews and the work of Police Scotland and COPFS

The paramount consideration in any decision or arrangement in respect of LRs taking place alongside other investigations is the need to protect children and young people from harm. In many instances this will be achieved by the successful prosecution of those who pose a threat to children in conjunction with securing improvements in systems which exist to prevent children being exposed to harm.

n the event of a child fatality or a case of serious harm which may be subject to a LR, it is essential for the CPC, Police Scotland and COPFS to confirm the likely processes of review and investigation to which the case is likely to be subjected (e.g. LR, criminal investigation, FAI, LAC Review by Care Inspectorate, Health and Safety investigation, Fire Brigade investigation).

At the earliest possible opportunity where it is identified that a LR may be appropriate, the Chair of the CPC or designated member should contact Police Scotland to confirm:

- whether a death report or criminal case has been reported to COPFS; or
- that there is evidence of a crime having been committed although no report has been submitted to COPFS.

Where a report has been submitted, a Procurator Fiscal (PF) reference number should be ascertained.

W here a criminal case or death report has been reported to COPFS, the Chair of the CPC or designated member should, in conjunction with the local policing Detective Superintendent or the Senior Investigating Officer, complete the LR Notification Form Annex 2.1), setting out the focus of the review, the witnesses who will be contacted (if any) and the timescales for the work.

The LR Notification Form should be sent to the Single Point of Contact (SPOC) within COPFS and copied to the local policing Detective Superintendent. The SPOC within COPFS will ensure that a relevant member of staff is tasked with considering the LR Notification Form and contacting the CPC and the local policing Detective Superintendent to arrange a meeting and/or confirm the steps that the CPC can take. Where appropriate, the Senior Investigating Officer will attend.

In circumstances where a case **has not been reported** to COPFS and a police investigation is ongoing, the Chair of the CPC or designated member should complete the LR Notification Form, setting out the focus of the review, the witnesses who will be contacted (if any) and the timescales for the work.

The LR Notification Form should be sent to the local policing Detective Superintendent who along with the Senior Investigating Officer, will prepare a report for COPFS on the ongoing police investigation highlighting its progress, the ongoing investigative strategy, remaining lines of inquiry and an assessment on the likelihood of a report being submitted to COPFS.

The LR Notification Form should then be sent to the SPOC within COPFS **along with** the report on the investigation prepared by the police. The SPOC within COPFS will ensure that a relevant member of staff is tasked with considering the LR Notification Form and contacting the CPC and the local policing Detective Superintendent to arrange a meeting and/or confirm the steps that the CPC can take. Where appropriate, the Senior Investigating Officer will attend.

Consideration will be given in this discussion to arrangements which allow review of systems critical to the welfare of children and young people to get underway in the context of the need to secure and preserve the integrity of best evidence within criminal and other investigations.

Timescales for a Learning Review

It is desirable that the LR should be undertaken as speedily as feasible in order to identify and redress any individual or systemic factors which may put children or young people at risk. CPC's are required to agree timescales for when reports should be produced in light of the circumstances and context of that particular case.

The timing of different processes will be determined by the particular circumstances of individual cases. It should not be necessary to postpone the initiation of a LR until the conclusion of criminal proceedings or FAI but care must be taken that the LR does not prejudice or put in jeopardy either of these proceedings. Therefore in some instances, a LR process may have to be adjourned after an initial review of critical systems until the conclusion of aspects of the criminal or other investigations or alternatively it may be possible to take information from a limited number of witnesses at first

Criminal cases and FAI's can take a long time to resolve and there may be some circumstances where the CPC, in carrying out its duties to conduct the LR, considers it would not be appropriate to wait to gather all possible learning about how best to safeguard children and young people. If, prior to charge or conclusion of a trial or FAI, those engaged in the LR wish to undertake interviews with people who are either witnesses, suspects or who have been charged with a criminal offence or potential witnesses in a FAI, **this should be agreed beforehand with Police Scotland and COPFS.**

Where there is an FAI, or potential for one, and where no criminal proceedings are anticipated, the conclusions of the LR may assist the decision making and such interviews should be encouraged.

Where there are criminal proceedings anticipated or ongoing and COPFS are giving consideration as to whether witnesses can be interviewed as part of the LR process, the following are some of the factors which may be taken in to account:

- the risk around the rehearsal of evidence in advance of trial,
- the vulnerability of witnesses,
- the risk of any confusion about the two processes and
- the impact of information being in the public domain.

Disclosure/Freedom of Information

If agreed by Police Scotland and COPFS, a LR will usually involve the reviewer interviewing members of staff of the elevant authorities who have had engagement with the child or young person, as well as people who may be considered as having a significant part in the life of thechild or young person. The material generated from this activity, including interview notes is likely to contain information which is of relevance to any potential criminal proceedings or FAI.

Police Scotland has a duty to reveal the existence of relevant information to COPFS and all such information must be made available to the Reporting Officer/SIO as soon as possible for consideration. To allow Police Scotland to fulfil this duty, in these circumstances close collaboration between the Lead Reviewer and the SIO will be required. Revelation to the prosecutor does not mean automatic disclosure to the defence. COPFS will assess whether the information is material and thus whether it should be disclosed and how it should be disclosed to the defence. It should further be noted that the law is not settled in relation to Freedom of Information status of LR reports and the material from which they are compiled. A presumption of exemption currently exists, but this has not been tested.

Interview of parent, carer or significant family members

It is good practice that parents, carers and significant family members are interviewed or otherwise engaged during the LR process to seek any learning from them. The CPC, COPFS and, where appropriate, the police officer leading the investigation, or their representative, must discuss the timing and scope of such interviews or other engagement. While there may be no need to delay LR interviews pending the outcome of criminal proceedings or FAI, a balance must be achieved between the need to capture relevant data and learning in order to protect children and the investigation of a death or prosecution of a criminal case in the public interest.

The best timing of such interviews will differ depending on the circumstances and features of the case and as such arrangements should be made on a case-by-case basis.

Persons conducting LR interviews must be conversant with rules of evidence and competent in the management of investigative processes running in tandem with criminal investigations.

Interview or individual suspected or accused of a crime

Where suspicion has crystallised on a person for a crime, permission must be sought from COPFS before any contact is made with that person as part of any LR process. This would apply if the person has been charged and either released, released on police bail, bailed by the court or has been remanded in custody. It will also apply if the person has not been charged but remains a suspect, including any period where a suspect is released on Investigative Liberation.

If there is any doubt as to whether or not a person remains a suspect in any given case, the matter should be raised with Police Scotland and COPFS.

If permission is given by COPFS, the individual's legal representative must also be informed that the individual is to be interviewed. It should at all times be stressed to legal representatives that their client's participation in the LR process is voluntary, that no adverse inference will be drawn from a refusal to participate and that any information provided for the purpose of the LR may be disclosed in criminal or related proceedings.

Interview of member of staff from relevant authority or other professional witnesses

It is good practice that members of staff from the relevant authority or other professional witnesses are interviewed or otherwise engaged during the LR process to seek learning from them. In all cases where COPFS is approached by a CPC to speak to members of staff from the relevant authority or other professional witnesses, there is a presumption that this will be facilitated unless speaking to the witness is likely to prejudice a criminal prosecution or a deaths investigation. In assessing this, COPFS will consider factors such as the nature of the case and the importance of the evidence being given by that witness in the context of the case.

Duty to keep circumstances under review

Investigations are dynamic. It is incumbent on both PS and COPFS to keep the circumstances of any investigation under review and where it is apparent that there has been a change in circumstances, which may lead to the conclusion that a previous decision regarding interviewing of witnesses is no longer appropriate, that the matter is revisited. This may include the rescinding of previous agreement given.

Publication of the findings of a Significant Case Review

In circumstances where there is an ongoing criminal investigation, prosecution or death investigation, the CPC must seek permission from COPFS before publishing learning from a LR. Publication may need to be delayed if it is likely to prejudice an ongoing criminal investigation, prosecution or death investigation.

Conclusion

It should be possible, in many circumstances, to manage LR's and criminal proceedings/FAIs simultaneously, without one jeopardising the other. In their own way, all

processes are important to protect and promote the safety and wellbeing of children and young people, which should always remain the primary consideration.

The learning obtained from a LR is largely dependent on the willingness of individual professionals and family members to engage in the process. They need to have confidence that any information they give will be treated with respect, and they should be made aware if it could be used for any purpose other than that for which it was intended.

Annex 2.1:

Annex 2.1 – Learning Review Notification To Crown Office & Procurator Fiscal Service

Where a criminal case or death report has been submitted to COPFS and a Learning Review is to be conducted, the Chair of the Child Protection Committee or designated member should, in conjunction with the local policing Detective Superintendent or the Senior Investigating Officer, complete this Notification Form and submit it to the Single Point of Contact (SPOC) within the Crown Office and Procurator Fiscal Service (COPFS) copying in the local policing Detective Superintendent.

In circumstances where a case has not been reported to COPFS, the Chair of the Child Protection Committee or designated member should complete this Notification Form and send it to the local policing Detective Superintendent who will arrange for a report to be prepared for COPFS. Once prepared, this Notification Form along with the report should be submitted to the SPOC within COPFS.

*This report should only be submitted once authority has been given by the Chair of the CPC after a LR has been agreed but before it has commenced.

**All email communications must be made from a secure email address i.e. .Gov.Uk/NHS.net or PNN.Police.uk and sent to the agreed copfs.gov.uk address.

Stage 1: Learning Review Notification

1. DETAILS OF CASE UNDER REVIEW	
Child's Name:	
Child's Address:	
Names of those with parental responsibility and their relationship to the child.	
Date of Incident:	
Name and contact details of Reviewer:	
Police Scotland Crime Reference Number:	
Name and contact details of Senior Officer in charge of investigation:	
Crown Office Procurator Fiscal Reference Number	(Where a case has been submitted to COPFS, this form should not be submitted without the PF reference number.)
Confirmation that the case has been reported to COPFS	Y/N – If no, confirm that the Notification Form has been sent to the local policing Detective Superintendent and the report on the investigation prepared by Police Scotland is available.
2. SUMMARY OF CASE UNDER REVIEW	
(Provide information regarding the circumstances of the incident and information as to why a Learning Review is being conducted.)	
3. FORMAT OF THE REVIEW PROCESS	
(As a minimum, this should include: the intended structure of the review i.e. paper/file read only, group discussions, one to one conversations or a mixture of both; the focus of the review; the witnesses who will be contacted and the purpose of the contact with those witnesses.)	

4. DETAILS OF PERSONS WHO WILL BE SPOKEN TO DURING THE REVIEW PROCESS	
NAME	**EMPLOYED BY OR ADDRESS IF NOT EMPLOYEE**
5. INTENDED TIMESCALES	
(Please specify the intended start date together with an estimated completion date. If there are any timescales for contacting proposed witnesses, please include this information.)	
6. ANY OTHER RELEVANT INFORMATION/CONCERNS	
7. DETAILS OF CPC CHAIR OR OTHER AUTHORISED CONTACT	
Name:	
Telephone number:	
Email address:	
(All email communications must be made from a secure email address i.e. .Gov.Uk/NHS.net or PNN.Police.uk and sent to the agreed copfs.gov.uk address.)	
Date signed:	Signature:

(to be submitted to the Chair of the CPC)

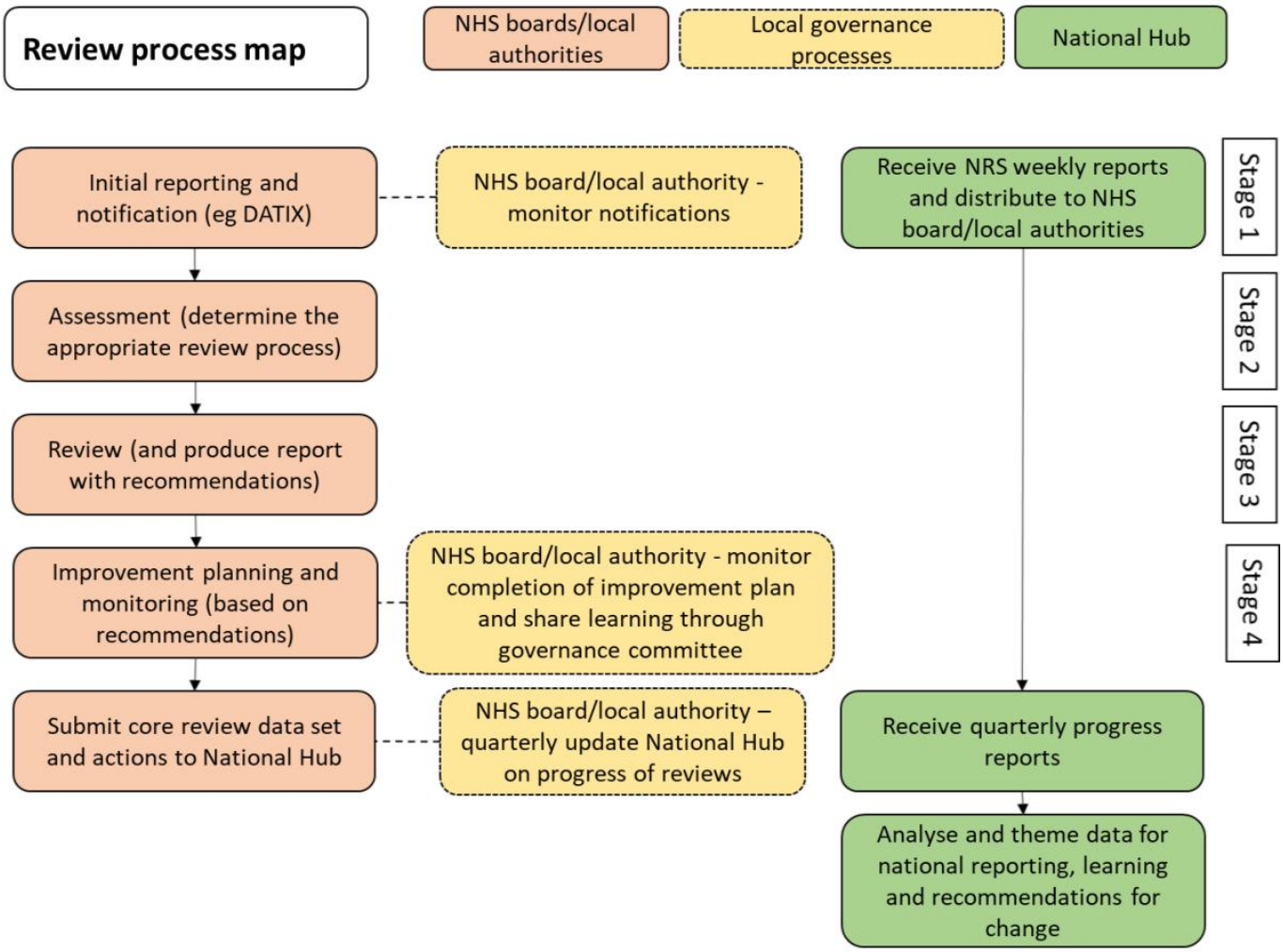
Stage 2: COPFS response

(The response should be intimated to the person submitting the request within 28 days).

8. DETAILS OF ANY FURTHER INFORMATION REQUESTED FROM CPC	
9. COMMENTS ON PERSONS WHO WILL BE SPOKEN TO DURING THE REVIEW PROCESS	
NAME	
10. DECISION FOLLOWING NOTIFICATION OF LEARNING REVIEW	
1. No objections to LR proceeding.	Provide summary of reasons for decision.
2. LR can proceed but additional conditions are set.	Provide summary of reasons for the decision and clearly set out any additional considerations/constraints.
3. LR cannot proceed	Provide information about the decision. If the case is particularly sensitive and there are reasons why we are unable to explain our decision, advise the CPC accordingly.
Date signed:	Signature:

Annex 3:

National Child Death Review and Learning Hub Process Map



Annex 4:

Family Liaison Strategy

An important function of the Review Team is the formation of a Family Liaison Strategy that ensures that families are included in any review process that is being undertaken in a planned and structured way.

The strategy should include:

- Identification of Review Team members who are responsible for informing the family of the review, this would usually be the Chair of the Review group, however it may be another professional who is involved with the family and is considered to be the most appropriate person.

- Identifying who the family is and who should be invited to contribute their views. This could include:

  Parents

  Step parents

  Carers

  Siblings

  Grandparents

  Aunts and uncles

  The child/young person

  Other significant family members or close family friends

  It is important to take into account the possible dynamics of a family's structure to ensure that the appropriate family members are contacted. This is particularly important in situations where families may be split in some way.

- Informing the family that a Review is to be undertaken will include explaining the purpose of the Review, the process of the Review and the request to have their views taken into account by the Reviewer and the Review Panel. It is good practice to provide the family with the available information leaflet that includes contact numbers of the Review Team members who will be in communication with them. (A format for an information leaflet for families can be found in the Supporting Resources provided by Scottish Government)
- Consideration of any particular cultural or lifestyle considerations, religious beliefs, or any communication requirements in terms of language or disability.

- Consideration of sensitivities due to experience of bereavement due to the death of a child, significant abuse that a child may have experienced or that the child or children may no longer be in parental care.
- The planning for meeting of parent/carer or guardian with the Reviewer and Review Group Chair to invite contribution of their views, should be arranged for a mutually convenient time and venue. The planning for the venue should take into consideration safety issues.
- Updating the family on completion of the review and sharing the findings when it is possible to do so.
- If the review is paused, stopped or delayed the family must be informed of this.
- Consideration should be given to the discussion being documented, with the family's consent.

In some cases, where there is an ongoing criminal investigation a Police Family Liaison Officer may have been appointed. If a Learning Review is to take place in such a situation, then the Police Family Liaison Officer should be invited to meet with the Review Team, before any contact with the family, to help plan and support the Learning Review Family Liaison Strategy.

Annex 5:

Learning Review Team – Attributes, Skills, Experience and Knowledge

Supplementary Guidance for Child Protection Committees

Table of Contents

1. Introduction

Context

This Supplementary Guidance is primarily for use by members of Child Protection Committees and sits alongside the National Guidance for Child Protection Committees: Undertaking Learning Reviews, which details the different roles within a Learning Review Team:

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

The Child Protection Systems Review considered challenges around the skills and competencies of reviewers and recommended that:

> *"A set of National Standards should be developed setting out the skills and competences required of those reviewers (…)"* (Recommendation 9)

This recommendation was accepted by the Scottish Government in March 2017 as part of the broader Child Protection Improvement Programme and has informed the development of this Supplementary Guidance.

The Purpose of the Supplementary Guidance

This Supplementary Guidance is intended to support the local processes of appointing and, where suitable, training and coaching Chairs, Team Members, Reviewers and Administrators for Learning Reviews. It supports Child Protection Committees and Chief Officers Groups by enabling:

- Multi-agency partnership to better understand the attributes, skills and areas of knowledge of those who form a Learning Review Team, which may be required to effectively undertake Learning Reviews;
- Learning Review Teams to better understand the attributes, skills and areas of knowledge they may need to hold and/or develop.

The attributes, skills and areas of knowledge outlined are applicable across different review methodologies and approaches.

This document aims to provide guidance to support Child Protection Committees and Chief Officers Groups and is not intended to be seen as a list of mandatory requirements. It is acknowledged that Reviews will differ and therefore requirements of Learning Review Teams will vary in different circumstances.

The process for selecting a Learning Review Team will be dependent on local arrangements, circumstances of the Review and the requirements of the Child Protection Committees and Chief Officers Groups.

Structure of the Supplementary Guidance

The profile of Learning Review Team has been organised under three main headings:

- **Attributes** – the personal qualities that may be required by Learning Review Teams (Section 2).
- **Skills** – the abilities and expertise that may be required by Learning Review Teams (Section 3).
- **Experience and knowledge** – the professional and practice experience and knowledge that may be required by Learning Review Teams (see Section 4).

2. Attributes

This section sets out the personal qualities or attributes that may be required by those who are part of a Learning Review Team. These are supported by:

- examples of descriptors for each set of attributes, illustrating what a person with those attributes may say or do;
- an indication of whether the attributes are of particular relevance to specific roles within a Learning Review Team – Chair, Team Member, Reviewer or Administrator.

This has been set out to support local decision-making and professional judgement. The specific attributes required, as well as their descriptors, will be dependent upon the nature of the Learning Review and the requirement of the Child Protection Committee.

ATTRIBUTES	EXAMPLES OF DESCRIPTORS:	APPLICABLE TO:
Honest, fair, objective and open minded	• Is non-judgemental of individuals' and organisations' involvement in the case, with the focus on understanding the learning that can be taken from the case as a whole; • Supports contributors to be open, honest and non-protective in presenting and discussing their own organisation's involvement with the case; • Avoids hindsight bias so that reflections on policies, procedures, actions and experiences are at the time of the incident, and do not reflect on what is now known.	**Everyone**
Empathetic and calm manner	• Is sensitive to and empathetic of contributors' emotions, noting that contributors can be confused, angry, emotionally fragile, worried and/or in need of support; • Remains mindful that, in a Review, some contributors might feel more 'under the spotlight' than others and, hence, supports their participation in a safe manner; • Brings a calm manner, reassurance and open approach to communication, paying attention to the 'power of words'; • Identifies and makes contributors aware of wellbeing and counselling services that are available to them; • Maintains the confidentiality of the evidence throughout.	**Everyone**

ATTRIBUTES	EXAMPLES OF DESCRIPTORS:	APPLICABLE TO:
Respectful and collaborative	• Is open to learning and recognise that no single individual will know everything about the case. Establishing a full picture of the situation requires trusting, listening to and learning from the information and views of all contributors; • Respects and values all contributors.	**Everyone**
Methodical, rigorous	• Is systematic in requesting, collating and checking information required to build full case picture.	**Everyone**
Attention to detail	• Cross-checks information across different sources for building the full case picture; • Identifies gaps or deficiencies in the information available to the Review.	**Everyone**
Flexible	• Makes and/or supports adjustments throughout the Learning Review to ensure that the purpose of the Review and the underpinning principles and values are followed.	**Everyone**

3. Skills

This section sets out the skills and abilities that may be required by those who are part of a Learning Review Team. These are supported by:

- examples of descriptors for each set of skills/abilities, illustrating what a person with those skills/abilities may say or do;
- an indication of whether the skills/abilities are of particular relevance to specific roles within a Learning Review Team – Chair, Team Member, Reviewer or Administrator.

This has been set out to support local decision-making and professional judgement. The specific skills and abilities required, as well as their descriptors, will be dependent upon the nature of the Learning Review and the requirement of the Child Protection Committee.

SKILLS / ABILITIES:	EXAMPLES OF DESCRIPTORS:	APPLICABLE TO:
Leadership skills	• Leads planning, delivery and completion of the Learning Review; • Coordinates the identification and engagement of the relevant partners and suitable contributors to the Learning Review (e.g. professionals who have the appropriate knowledge, skills and attributes, senior managers, participants who can contribute and/or benefit from being involved in the Learning Review); • Coordinates the distribution of roles and responsibilities of Learning Review partners and contributors, where this has been agreed by CPC; • Coordinates the drafting of the Terms of Reference and/or agreed ways of working for the Learning Review process, where this has been agreed by CPC.	• **Chair**

SKILLS / ABILITIES:	EXAMPLES OF DESCRIPTORS:	APPLICABLE TO:
	• Ensures that the underpinning principles and values governing Learning Reviews in Scotland are followed throughout the Review (e.g. is guided by the underpinning principles and values in using an appropriate degree of flexibility and ensuring that the Review remains proportionate, inclusive and collective, with a systems approach and focused on learning; reiterates the underpinning principles and values at various times during the Review process, assertively bringing them to the forefront, where needed).	• **Chair** • **Reviewer**
Planning and organisational skills	• Ensures that a clear and realistic timetable for the Learning Review process is set out and makes suitable adjustments, where needed (e.g. amending the Review timetable to allow additional information to be provided); • Ensures timely requests made for key documentation relevant to the Review from organisations involved (e.g. practitioner case notes, organisational policies, procedures etc.) and follows up with organisations where information is not provided;	• **Chair**
	• Ensures timely circulation of key documentation in advance of Review meetings; • Manages and prioritises different work demands so that sufficient time is allocated to the Review.	• **Everyone**
Facilitation and interpersonal skills	• Helps contributors to enter the Review process feeling informed and supported (e.g. provides adequate information, including about the supports available; remains open for further clarifications etc.); • Helps family members feel supported and maintains a relationship with them, while managing the boundaries and responsibilities of this task (particularly relevant for those liaising with the family); • Works well in a group setting.	• **Everyone**
	• Discusses and debates with others in an objective, non-judgemental and transparent manner, demonstrating that they have no 'hidden agenda' (e.g. openly shares their own thoughts and understanding of the case, tests key ideas with the Review Team).	• **Chair** • **Team Member** • **Reviewer**

SKILLS / ABILITIES:	EXAMPLES OF DESCRIPTORS:	APPLICABLE TO:
	• Establishes effective relationships with participants, noting that they will come with differing levels of status, expertise, experience and education; • Effectively facilitates group work and manages complex group dynamics (is able to assess, react and change). • Facilitates 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; - All participants can voice their views in a safe manner; - Discussion, debate, probing and constructive challenge are encouraged; - Meetings remain focused on the core purpose of the Review; • By establishing their independence from any operational management responsibilities or decision making in relation to the case under review, asks challenging but constructive questions; • Puts participants at ease and encourages them to openly and honestly express their views and reflect on their involvement in the case; • Uses a range of participatory and creative approaches to obtain the views and experiences of children, young people and parents/ carers and practitioners in a safe manner.	• **Reviewer**
	• Effectively chairs and facilitates Review meetings (is able to assess, react and change)	• **Chair**
Active and reflective listening skills	• Shows interest in and empathy with the views expressed by others. Is respectful of the views expressed by others; • Seeks to understand the idea expressed by the other person, then relays the idea back, to confirm that it has been understood correctly; • Remembers what others said and builds on their contributions.	• **Everyone**

SKILLS / ABILITIES:	EXAMPLES OF DESCRIPTORS:	APPLICABLE TO:
Analytical skills	• Reviews and assesses all information available (events/consultations/meetings minutes, practitioner case notes, organisational policies, procedures etc.) to develop a full and multi-faceted understanding of the case; • Identifies gaps or deficiencies in the information available to the Learning Review; • Is able to undertake own research, where there is a knowledge gap; Learning Review Team are not expected to know everything, but they are expected to know where to seek and how to review evidence; • Verifies information presented through cross-checking of information against other sources, in order to understand the multiple lenses of the case (e.g. whether facts and explanations provided are aligning and complementing one another, addresses contradictory perspectives etc.); • Interprets and analyses the workings and shortcomings of complex, multi-agency systems (e.g. taking into account policies and procedures, resources, staffing levels etc.); • Elicits and analyses information from a learning and child-centred perspective, looking at the wider impacts for practice and service delivery (e.g. going beyond the identified challenges and understanding what had caused them, the systems' implications and needed improvements); • Makes sound judgements based on the information collected and analysed during the Learning Review, through logical thinking and a culture of collaborative problem solving.	• **Reviewer** • **Team Member** • **Chair**
Communication skills (written and oral)	• Is able to communicate with multiple audiences (e.g. children, young people, families, practitioners, senior managers and Chief Officers Group, as appropriate) about the Review purpose, process, timetable and outcomes, in a clear and accessible manner. This may require: – Adopting different communication methods with specific groupings; – Providing updates throughout the Review process.	• **Reviewer** • **Chair**
	• Conveys complex issues in a concise, well-structured and accessible manner, using plain English wherever possible, so that multiple audiences (the family, practitioners, senior managers, elected members and the public) can understand the findings and learnings. The clarity is required in both written and verbal communication. The objective should be to draft the report so that it can be published; • Uses a neutral tone in the report, with a focus on learning, not blaming; • Balances the importance of providing detailed (but confidential) insight to the case with the learning that can be taken from it; • Focuses on communicating key points of learning from the case.	• **Reviewer**

SKILLS / ABILITIES:	EXAMPLES OF DESCRIPTORS:	APPLICABLE TO:
	• Recognises and responds to non-verbal signs from others (e.g. body language, tone of voice etc.); • Adapts and changes their communication styles where appropriate (for example, from a sensitive and listening style to a more assertive and challenging style where appropriate – where trust is achieved and probing and constructive challenge can be used).	• **Everyone**

4. Experience and knowledge

This section sets out the professional and practice experience and knowledge that may be required by those who are part of a Learning Review Team. These are supported by:

- examples of descriptors illustrating what a person who has that area of experience and knowledge may say or do;
- an indication of whether the area of experience and knowledge is of particular relevance to specific roles within a Learning Review Team – Chair, Team Member, Reviewer or Administrator.

This has been set out to support local decision-making and professional judgement. The specific experience and knowledge required, as well as their descriptors, will be dependent upon the nature of the Learning Review and the requirement of the Child Protection Committee.

EXPERIENCE AND KNOWLEDGE :	EXAMPLES OF DESCRIPTORS:	APPLICABLE TO:
Systems insight	• Understands and can interrogate the workings of the whole system around the child/family, including relevant single-agency and multi-agency procedures; • Understands how organisations and systems influence and impact on how individuals operate; • Knows where, and from whom, to get specific information and expertise in order to build a comprehensive understanding of the system; • Has a good understanding of the differences in the terminology used by various agencies.	• **Reviewer** • **Chair** • **Team Member**
Review methodologies	• Is knowledgeable and understands methodologies and approaches for undertaking Reviews.	• **Reviewer**
Adult learning and group facilitation	• Has experience of facilitating active engagement within a group setting; • Understands group processes and dynamics and has experience of helping people to explore, reflect and learn; • Understands how to build on what participants and contributors have experienced and learnt in the past.	• **Reviewer**

EXPERIENCE AND KNOWLEDGE :	EXAMPLES OF DESCRIPTORS:	APPLICABLE TO:
Child Protection system(s) experience	• Has recent experience and understanding of child protection practice, processes and procedures in Scotland, including the *National Guidance for Child Protection Committees: Undertaking Learning Reviews* (Scottish Government, 2020) and specific legal processes and requirements; • Has experience and understanding of child protection organisational arrangements – both multi-agency working arrangements and internal organisational structures; • Has experience and understanding of the complexity of communication, collaboration and cooperation within multi-agency child protection practice and policy	• **Reviewer** • **Chair**
Child development theory knowledge	• Has up to date knowledge of child developmental theory and research.	• **Reviewer**
Related services knowledge	• Understands the role, practice and impact of services connected to child protection, e.g. social work, health, education, adult services, criminal justice, addictions or domestic violence.	• **Reviewer** • **Team Member** • **Chair**
Legal and policy systems knowledge	• Understands relevant legislation and policy within the Scottish context; • Differentiates between Learning Review remit and task as opposed to criminal or negligence proceedings; • Understands roles, responsibilities and governance of Learning Review processes as set out in national and local guidance; • Considers rules of evidence and is able to manage the Learning Review process where criminal proceedings also taking place using the *Crown Office and Procurator Fiscal Service (COPFS) Protocol* (Annex 2 of the *National Guidance for Child Protection Committees: Undertaking Learning Reviews*).	• **Chair** • **Reviewer** • **Team Member**
Report writing	• Has experience of writing comprehensive reports in a concise, well-structured and accessible manner, allowing the findings and learnings to be understood by multiple audiences.	• **Reviewer**

Annex 6:

Facilitating and Shaping Practitioner and First-Line Manager Events and Strategic Manager Events

Learning Reviews are a collective endeavour to learn from what has happened in order to improve systems and practice in the future and thus better protect children and young people. Bringing together practitioners and their first line managers in a facilitated event is an opportunity for them to reflect on practice and also to ensure that their voice directly contributes to the review. A sensitively facilitated event can also generate immediate learning at both an individual and a group level; learning which can be applied directly to current practice. For strategic managers, meeting together in a facilitated 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.

However, reviewing complex situations where a child or young person has been harmed or been at risk of significant harm can raise anxiety in organisations and individuals. This anxiety can block learning by generating defensiveness, with a consequent inability to review and reflect, or to acknowledge the need for change and development in processes and practice. It is essential, therefore, that careful consideration is given to the shape and structure of group events and that they are well facilitated.

Careful preparation is essential if the events for practitioners and their first line managers and events for strategic managers are to be effective and make a meaningful contribution to the Learning Review. Preparation includes identifying participants so that the relevant people attend, selecting an appropriate venue, and thinking about the duration of the event.

At this preparation stage all participants need clarity about the purpose of the group session and a sense of how it will be conducted. They also need a framework to help them prepare and for participants and first line managers this will consist of asking them to revisit their involvement with the situation under review and to think about the assessments they completed, the decisions they made, the actions they took and their interaction with other professionals and services. They should also be asked to identify areas of effective practice and areas where, in retrospect, they realise that something could have been done better.

Review Team members have an important part to play in preparing participants and should be the link with those staff from their service area or organisation to ensure they are well briefed and understand the purpose. Review Team members should also be prepared to answer any queries prior to the event.

Group sessions may vary in duration depending on the situation under review, but for practitioners and first line managers it is advisable to set aside a full day. Sessions for strategic managers can usually be completed in half a day.

The venue, as well as the structure of the day, must facilitate the process and so needs to be comfortable and fit for purpose. The layout of the room is an important factor and it is

helpful if participants are able to see one another in order that they can develop a conversation together. Rooms laid out in boardroom style or horseshoes or circles should assist this, together with space to move in and out of small groups and sub-sets if required. If the event is to be held for the duration of a day then it is preferable to provide lunch. This will help participants to continue thinking together in a less formal way and avoid disruption to the process.

The discussions at this group event do need to be captured as they will directly contribute to the overall learning and to the review report. A note taker should be identified before the events and this will usually be the Review Team Administrator. It should be noted that what they will produce are not formal minutes, but working notes to assist the Reviewer(s) and the Review Team in identifying key learning and recommended actions.

Practitioner/first line manager events and strategic manager require the facilitators to work in the moment with the material generated by the group and cannot be rigidly structured. However, in order that they have some coherency and provide a framework in which participants can work productively they do need some shape with carefully crafted beginnings, middles, and endings.

However well-prepared participants are there will still be some apprehension as they gather for the group session and so a careful introduction is essential. This should cover:

- Introductions to everyone in the room and why they are there
- Reiteration of purpose and process
- An acknowledgement of the apprehensions and anxiety within the room
- Setting out working principles for the sessions
- A brief overview of the situation under review

For practitioner and first line manager events the next stage is the exploration of their involvement in the situation under review. This is best done chronologically and, as the story unfolds, it will be important to remind participants to differentiate between their thoughts and actions at the time, and the wisdom of hindsight afforded by a retrospective reflection. In other words, it is about exploring the question ‘why did we do that then?’ and following this up with the question ‘could we have done it differently and what would have helped us to do so?’

As the discussions and thinking develops within the group, the Reviewer(s) should ensure that the following areas are covered:

- Were the risks in the situation identified and understood?
- How were family members engaged with?
- What were the family’s views at the time and what are they now?
- How did the professionals work together?
- What went well? This is about identifying effective practice and what facilitated that practice.
- What could have been done better and why did it not happen at the time?

To help participants make sense of the emerging issues and learning it is essential that the Reviewer(s) pause from time to time to summarise the discussion.

How the practitioner/first line manager event is brought to a close is important if it is to have some ongoing value and therefore, should not be rushed. This final session of the day should include:

- A summary of the key learning
- An outline of the next steps
- An opportunity for participants to think about their personal learning from the day and how to take it forward
- Checking out how participants feel about the process they have been through

The events for strategic managers also need a careful and thorough introduction similar to the one for practitioner events. However, they will need more input on the circumstances leading to the review so that they have material to work with for the rest of the session. The session will then cover the following areas:

- Small group work to think about:
    - Challenges and missed opportunities in this situation
    - What worked well and why?

Followed by careful feedback to identify themes and issues

- Feedback from the practitioners and frontline managers event, with an opportunity for discussion
- Input on the views of the family, again with an opportunity for discussion
- Discussion on 'what needs to change' to think about:
    - What changes have already been made?
    - What else can be done?
- Summary and agreement on the emerging recommendations/future actions
- Setting out next steps in terms of the process of the Learning Review

For the Reviewer(s) these group events will bring to the fore their facilitation skills. This includes managing the group dynamic but also working sensitively with the individuals within the group. It is about creating an atmosphere of safety and trust, which encourages participants to openly and honestly express their views and reflect on their involvement in the situation. It is about opening up discussion, allowing people to consider and debate but also knowing when to intervene and lead from the front so that the event does not lose its focus.

Annex 7:

National Guidance for Child Protection Committees Undertaking Learning Reviews: Resources

Contents

Learning Review – Information for Families and Carers

Insert relevant CPC logo

Protecting children and young people is the responsibility of several different organisations such as Social Work, Health, Education, Police and others who support children and families.

In each local authority area, there is a Child Protection Committee which is made up of a group of people who work for these organisations. Child Protection Committees make sure organisations and the local community work together to plan, carry out and improve the way the child protection process works.

What is a Learning Review?

When is it needed?

When a child dies or is seriously harmed, or when or when a child was at risk of death or serious harm, the local Child Protection Committee must decide whether or not to look further into what happened.

Why does the Child Protection Committee do this?

To understand if there are any lessons to learn about the support offered to you and your family. The Committee looks at how people have worked together to support you and your family: for example, social workers, GPs, teachers, health visitors, police etc. This is called a 'Learning Review.'

What happens during a Learning Review?

A person called a Reviewer will speak to family members, professionals and other people who know/knew your child/ren to learn more about what happened and to suggest how to make things better in the future.

The Reviewer will be helped by a small group of people from other organisations. This group is called the 'Review Team'. Both the Reviewer and the Review Team will get information from all the organisations that have worked with you and your family. This will mean sharing information and records that they have about your child/ren and family. This information will only be shared with the Review Team and will remain confidential.

Support for You

1. A member of the Review Team will contact you and be your link person. He or she will offer support and communicate with you during the review. This person is able to let you know what to expect, how the process is going and answer any questions you may have.
2. You can also have other people to support you during this Learning Review process such as a friend, family member, support worker or advocacy service.

3 Some families who have gone through the same Learning Review process have told us the kind of information that helped them. Here are some of their questions and typical answers. Please remember that each situation is different but some of these **questions and answers** might help you.

Can someone discuss this leaflet with me as I find it easier to talk with someone?

Yes, of course that is a great idea. We want to help you.

A member of the review team will be in contact with you so that this can take place.

Can someone write down key information that I need for the next stage so I do not forget it or get confused?

Your link person will think that's a great idea to have notes if that will help you – perhaps they might even suggest a small notebook is handy where all your information can be kept together. The note taker could be a friend, family member supporting you, an advocate or another member of the review team. This will be your choice.

What does the Review do that is different to the other services already involved?

The Review is different. It is looking at the actions and responses from all the services involved and so that these services can learn how to improve their practice

How can the Learning Review help me and my family?

It will give you an opportunity to tell what happened from your point of view and how that felt.

How do I know what is happening or what is going to happen next?

The member of the review team that is helping you will keep you updated so you know what is happening.

Who are the people involved?

The member of the review team who is helping you will help you find out about the different jobs and tasks that people have in the Review.

What information from me will the Reviewer and Review Team use?

This is a good question. It may be that they do not use all the information that you share with them. The Reviewer or Chair will plan with you how they will use your information. You can ask about who will be able to see this.

How will I hear about what the Review decides?

Speak to the member of the review team who is supporting you to find out how you will hear about the learning and outcomes of the Review. They can provide more information.

What if there is media interest? How do I handle media interest?

Sometimes, there may be newspaper or media interest in the outcome of a Review. The person supporting you can help you with any arrangements for dealing with this situation if this happens. The important thing is to take it a day at a time.

How long will the Learning Review take?

It usually takes six to nine months from the start of Learning Review to the final report. Sometimes it can take much longer and the person supporting you will speak to you about this if this happens.

Contact us

We understand this is a very difficult time for you and your family.

We hope that this leaflet has helped you and your family to understand more about the Learning Review. Of course, each child / family is different and you may have other questions you would like to ask us or you may want to talk further about the Review. If there is anything else you would like to discuss this please contact us as follows:

Insert relevant contact details…….

…….

…….

Thank you

The ideas from families were taken from research, if you would like to learn more about this please see the reference below.

Morris, K., Brandon, M. and Tudor, P. (2012) A Study of Family Involvement in Case Reviews: Messages for Policy and Practice BASPCAN

Example of a Learning Review Process

(covers the stages between the first meeting of the Review Team and the beginning of dissemination)

First Review Team meeting

Practicalities including discussing the principles and ways of working, clarifying roles and functions; identifying Practitioner Event participants and Senior Manager event participants and their preparation;

Sense making of the situation;

First pass at issues and questions to explore;

Arrangements for collating further information (if gaps identified);

Set dates and venues for Review Team Meetings, and Practitioner & Senior Manager events;

Verifying that the Care Inspectorate was notified of the decision to proceed to a Learning Review.

Second Review Team meeting

Confirming tasks done

Checking on the implementation of the Family Liaison Strategy;

Checking on the preparation for the Practitioner & Senior Manager events (confirmations; information and support for practitioners attending)

Further exploration of the emerging issues and reflections.

Engaging with family members

(according to the Family Liaison Strategy)

Practitioner event

Jointly discussing the story of involvement, identifying and analysing significant events;

Identifying learning;

Identifying effective practice;

Thinking about possible strategies for improving practice and systems, including possible recommendations.

⬇

Post practitioner event

Writing up learning points and circulate to participants to check for accuracy/agreement

⬇

Senior Managers event

Discussing the outline of the situation, the challenges and what worked well and why, the changes needed and the strategies for improvement, together with the emerging recommendations.

⬇

Draft report

⬇

Third Review Team meeting

Discussion of draft report

⬇

Fourth Review Team meeting

(**NB:** a 4th meeting might not be necessary. If things are straightforward there is a possibility all of this can be done at the third panel meeting);

Finalising report;

Outline action plan.

⬇

Feedback to family

⬇

Presentation/dissemination to CPC and COG;

CPC submit completed report to the Care Inspectorate

XXXXXX Child Protection Committee

Learning Review

Child A

Insert date report was completed

The purpose of this exemplar is to illustrate what a completed Learning Review report might look like. It is a work of fiction but based on a number of real scenarios.

This review is set in a pre-COVID-19 world.

1. Introduction

1.1. On 03/10/2020 the father of Child A, called an ambulance to the home address because Child A was not breathing. Father was caring for Child A, his mother and sibling were out. Child A was taken to hospital where he was pronounced dead on arrival. The results of the subsequent post-mortem showed Child A had suffered several injuries which were considered to be non-accidental. Child A was 5 months old when he died.

1.2. Since his birth the family of Child A had been receiving intensive support from Health and Social Work Services. Both Child A and his older sister were on the Child Protection Register under the category of neglect.

1.3. A Learning Review Notification[17] was submitted to *xxxxx* Child Protection Committee and, after requesting further information[18] the decision was made to undertake a Learning Review as this situation did meet the criteria, specifically:

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

1.4. The time frame for the review was from the birth of his older sibling until the death of Child A, a period of some 17 months. However, the Review Team also had access to some historical information relating to mother's childhood.

2. The process of the Review

[17] Scottish Government (2021) National Guidance for Child Protection Committees: Undertaking Learning Reviews Annex 1.1

[18] Scottish Government (2021) National Guidance for Child Protection Committees: Undertaking Learning Reviews Annex 1.2

2.1. In accordance with the guidance[19] this Learning Review adopted a systemic approach. Such an approach goes beyond individual or professional practice to explore underlying systemic elements, the links with organisational factors and the wider context. A key feature of this approach is to bring together agencies and practitioners in a collective endeavour to reflect and learn from what has happened in order to improve practice for the future. The focus is on accountability not culpability, on learning and not blame.

2.2. A Case Review Team was convened to steer the process. It was chaired by the Lead Nurse, Child Protection and made up of representatives from:

- Health Services
- Social Work Services
- Police Scotland

The Review Team and the review process were supported by an Administrator.

2.3. The Review Team began the learning process by identifying significant issues and clarifying the questions and areas to explore. They also identified the participants to be invited to the practitioner/first-line manager event and the Senior Manager event, briefed them on the process, helped them with preparation and supported them throughout. Participants were asked to reflect on their involvement with Child A and his family thinking specifically about:

- Assessments
- Decision making
- Actions
- Interactions with other professionals and services
- Areas of effective practice
- Areas where there could have been some improvements

2.4. The Practitioner Learning Event was held on (insert date) from 9.30 until 4.00 and was facilitated by the Reviewer. There were 14 participants from:

- Paediatrics
- Midwifery
- Health Visiting
- GP Surgery
- Social Work
- Police Scotland

The Review Team Chair was also in attendance and the Review Team Administrator took notes of the session to aid the compilation of this report.

2.5. Each participant described their involvement with the family, highlighting the actions they took and the reasons underpinning them as well as their assessments of the situation at the time. This was done as chronologically as possible. After each input there was an opportunity to ask clarifying questions,

[19] Scottish Government (2021) National Guidance for Child Protection Committees: Undertaking Learning Reviews

engage in discussion and begin to identify key issues and learning points. Once everyone had contributed they moved into small groups for further reflection on the emerging learning and to think about some possible actions and recommendations.

2.6. The following day there was a Learning Event for Senior Managers to bring a strategic perspective to the Review. This was a half-day session and was attended by representatives from:

- Children and Family Services including Children's Services Managers, Chief Social Work Officer and Lead Service Manager
- GP Clinical Lead
- Paediatrics
- Director of Nursing, Midwifery and Allied Health Professionals

As with the Practitioner Event, the Review Team Chair also attended and again the Administrator took notes of the session to aid the compilation of this report.

2.7. Participants reflected on Child A's situation, identified emerging themes; looked at what worked well and why; explored challenges and missed opportunities and considered any changes that were needed as a result of the learning from this review.

2.8. During the course of this review the Reviewer and Review Team chair also met with Child A's parents to ascertain their views.

3. The circumstances that lead to the Learning Review

Family composition

Relationship	Date of Birth	Ethnicity
Child A	01/05/2020	White Scottish
Sibling Child B	02/06/2019	White Scottish
Mother	10/10/2000	White Scottish
Father	15/07/1998	White Scottish
Maternal Grandfather	26/03/1975	White Scottish
Maternal Uncle	04/09/1995	White Scottish

Background

3.1. At the time of Child Bs birth the family were living with maternal grandfather and maternal uncle. There were no concerns about the care of Child B.

3.2. There was some historical information available about mother. As a child she lived with her father and 2 older brothers, her mother having left when she was 2. At the age of 8 her name was placed on the Child Protection Register under the category of neglect.

3.3. During her pregnancy with Child A mother attended all ante-natal appointments and there were no concerns until March 2020 when poor home conditions were highlighted. At this point the family had moved into their own home.

3.4. Child A was born on 01/05/2020. Throughout his short life there were concerns about his health, his weight loss and the conditions within the home and he had four admissions to hospital. The first, at 12 days old, was instigated by the Health Visitor who, on her Primary Birth visit, observed that he was unwell, had lost weight, was suffering from oral thrush and had what looked like flea bites on his legs, (the family had a pet dog). Child A was diagnosed with gastroenteritis and treated and discharged. Two days later he was brought to the emergency department by mother's cousin who was babysitting and who reported he was vomiting after feeds. Child A was admitted to the ward.

3.5. In the meantime the Health Visitor had made a child protection referral and an IRD took place on 14/05/2021. It was agreed that when Child A was ready for discharge it should be with his parents but to the maternal grandfather's home so that their house could be thoroughly cleaned. For the next few weeks things seemed to improve and Child A was feeding well and gaining weight.

3.6. At a Child Protection Case Conference on 07/06/2020 Child A's name was placed on the Child Protection Register under the category of neglect. The Child Protection Plan included the involvement of a Family Support Worker.

3.7. On 12/06/2021 Child A was admitted to hospital for a third time because of coughing episodes resulting in vomiting. (Both parents were heavy smokers.) Mother was reluctant to remain at the hospital and so Child A was discharged 3 days later with open access to the ward if needed.

3.8. For the next 3 months the Social Worker, Health Visitor and Family Support Worker provided intensive support to the family and there were regular Core Group Meetings which one or both parents attended. Home conditions remained a concern, there were some improvements, but they tended to be short-lived.

3.9. On 05/08/2020 Child A was brought to the Hospital Emergency Department by mother who was concerned that he might have epilepsy as she had observed his eyes rolling and he was not responding. He was discharged later that day.

3.10. Child A's health seemed to improve after this but concerns then centred on Father's mental health. He described feeling depressed being anxious about money and having suicidal thoughts. He was prescribed anti-depressants.

3.11. A Review Child Protection Case Conference was held on 06/09/2020 and registration continued under the category of neglect.

3.12. On 03/10/2020 Child A died.

4. Practice and Organisation Learning

4.1. Some families are able to parent a first child to an acceptable standard but struggle when they have a second child:

In this situation no concerns were noted with regard to the parenting of the older sibling. However, the family were living with maternal grandfather and maternal uncle for the first few months of Child B's life. By the time Child A was born they were in their own home and therefore any support they had previously had with managing a home and caring for a baby was reduced. Furthermore, they then had two Children under 2 years of age. When exploring concerns and assessing risk to a child professionals need to be mindful of the impact of changes in circumstances and the increasing complexity in parenting more than one child.

4.2. The importance of describing and clarifying conditions within a home in order to assess the impact of environment on babies and young children and whether or not it is acceptable:

In this situation home conditions were sometimes described as cluttered, sometimes as acceptable and at other times as unacceptable, with rapid deterioration being noted. It is also important, when working with families living in areas of deprivation that professionals do not become inured to this and therefore work with different thresholds of 'good enough'. The use of Neglect Tools can help to prevent such cultural relativism.

4.3. For assessment and planning to be meaningful and robust it needs to be a multi-agency activity, using a range of tools to collect, collate and analyse information, to formulate effective interventive plans and to measure change:

There were a lot of concerns about Child A and a lot of information about the family, but it was not always brought together. For instance, hospital staff had some pertinent information about parenting capacity having observed both mother and father interacting with Child A. If this had been shared at the time it would have helped to build a more holistic picture of what was happening.

The use of assessment tools such as The Graded Care Profile[20] would have greatly helped to measure the quality of care and identify what needed to change and how that change might be realised. The use of chronologies would have also helped to build an understanding of the situation over time and to identify patterns of concern.

4.4. The impact of adverse childhood experiences and parental mental health on parenting capacity:

In this situation mother had herself been a neglected child and father had some mental health problems. It is important for professionals to gain an understanding

[20] The Graded Care Profile was created by Paediatricians Drs Poinay and Srivastave and was developed to help professionals measure the quality of care being given to children where there are concerns they may be being neglected.

of how these issues might impact on parenting capacity and the lived experiences of children in order to provide resources to build, increase and improve parenting ability.

4.5. In recording it is important that professionals distinguish between what they have directly observed and what has been reported to them:

Here there were examples of parental reporting of Baby M feeding well when to the professionals he appeared pale and listless and was losing weight.

4.6. Some families may have the potential to change but lack the motivation to do so:

There were some improvements in home conditions and parenting when the parents were strongly urged to make changes by the professionals involved. These improvements were usually observed on **planned** visits by the Health Visitor or the Social Worker or the Family Support Worker. However, opportunistic visits by professionals revealed that this progress was not sustained and often conditions had deteriorated.

The professionals involved felt increasingly 'stuck' as the situation did not improve. This raises the question of what interventions are effective in situations of neglect and how can parents be motivated to make those changes.

4.7. The importance of distinguishing between a family's attendance at meetings and their engagement with the change process:

The parents gave the appearance of complying with child protection plans and processes. They attended Child Protection Case Conferences and Core Group meetings where the concerns of professionals were clearly expressed and minuted. However, they were either unable to take them on board or did not see the point of making sustained changes.

5. Effective practice

5.1. In this situation there were many examples of good communication and inter-agency working including:

5.1.1. Liaison and information sharing between Midwifery and the Health Visiting service was good and resulted in a timely referral to Children's Social Work Services.

5.1.2. The Social Worker, Family Support Worker and Health Visitor worked very collaboratively. They co-ordinated their visits, shared information, ensured there was a mixture of planned and opportunistic contacts with the family and gave consistent messages about the need for change and the nature of the change required. They worked hard to try to improve the situation and to protect Child A.

6. Suggested strategies for improving practice and systems

6.1. It is suggested that the CPC set up a development programme on the theme of neglect focussing on:

- Assessment tools including Graded Care Profiles and the use of chronologies
- The assessment of parenting capacity and the impact of adverse childhood experiences and mental health issues
- Identifying interventive strategies for effecting positive change

6.2. In this situation the professionals worked hard to support and help this family, but improvements were minimal and short-lived. It is suggested, therefore, that, in addition to supervision within their own team/agency, professionals have access to joint, facilitated cross-service reflective sessions to review situations that seem 'stuck' and to think about how to change and move things on in order to protect children.

6.3. A review of the template for Child Protection Plans to build in:

- Overarching aims
- Specific objectives
- Clarification of indicators of genuine progress
- Realistic timescales

6.4. Ensure Acute Services are aware of child protection concerns and Child Protection Plans through:

- Attendance at IRD meetings and Child Protection Case conferences as appropriate
- Access to the Child Protection Register
- Ensuring they are in 'communication loop'

Signed and dated by:

Reviewer(s):	
Review Team Chair:	
Date:	

Example Learning Review Action Plan Template

Strategies for improving practice and systems

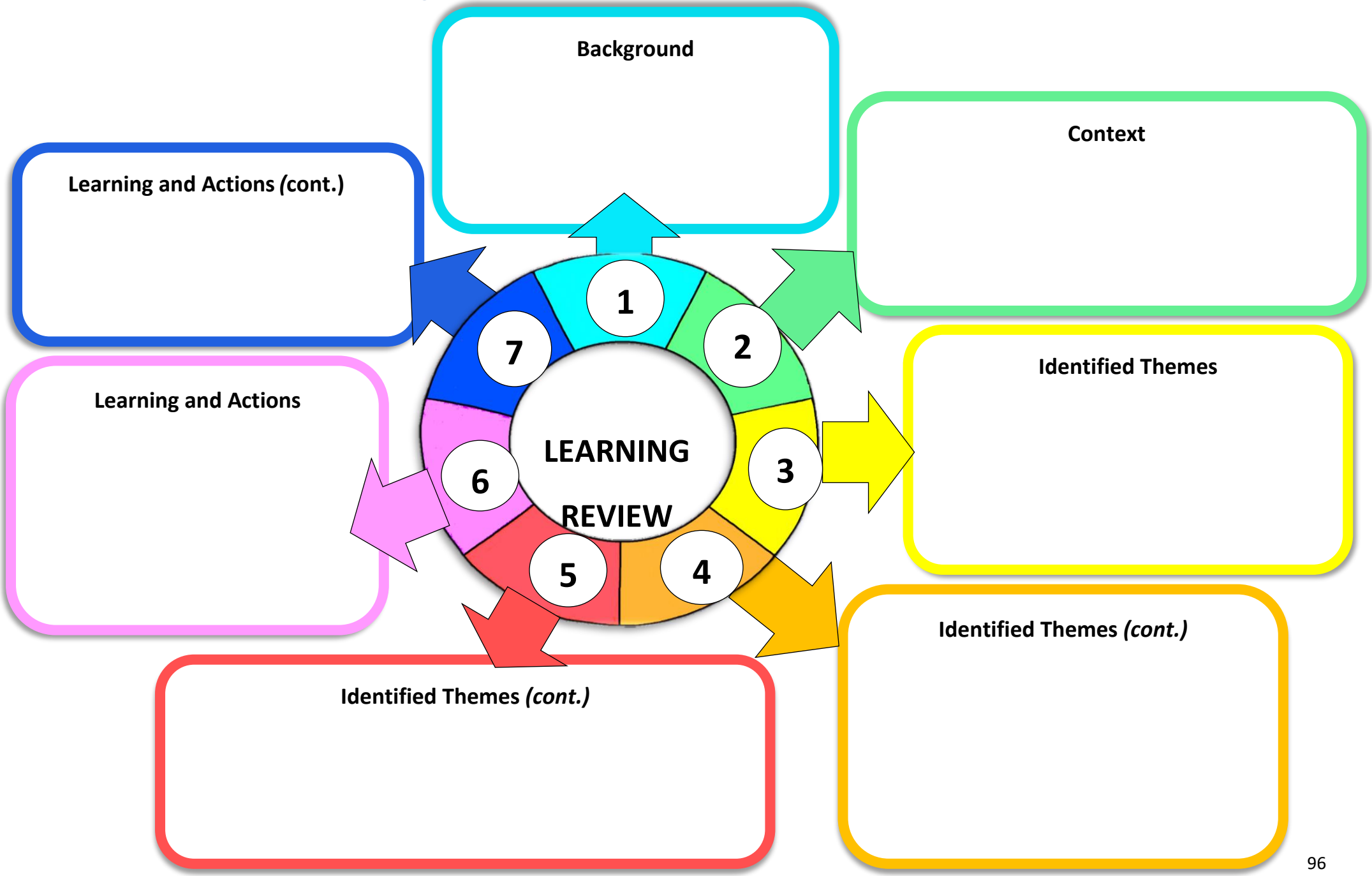
Strategy 1:				
Action **(how we intend to do it)**	**Timescale**	**Responsible lead**	**Performance measure** **(how well are we doing?)**	**Analysis of performance** **(are we making a difference?)**

Strategy 2:				
Action **(how we intend to do it)**	**Timescale**	**Responsible lead**	**Performance measure** **(how well are we doing?)**	**Analysis of performance** **(are we making a difference?)**

Strategy 3:				
Action **(how we intend to do it)**	**Timescale**	**Responsible lead**	**Performance measure** **(how well are we doing?)**	**Analysis of performance** **(are we making a difference?)**

Strategy 4:				
Action **(how we intend to do it)**	**Timescale**	**Responsible lead**	**Performance measure** **(how well are we doing?)**	**Analysis of performance** **(are we making a difference?)**

Example Seven Minute Briefing Template



Driving The Change: Improvement and Implementation Resources

The change process that starts during a Learning Review cannot stop once an action plan has been agreed, or the findings disseminated. The end of a Learning Review should also mark a shift of focus towards how to best drive the required change.

Various approaches, such as those informed by the Model for Improvement or implementation science, could prove valuable in guiding the process of embedding learning and driving the change identified through a Learning Review. More information on these approaches can be found by exploring the resources below.

Improvement methodology resources

The Model for Improvement is a tool that could be used for **accelerating improvement** of outcomes and processes. The model moves through four stages to identify aims, establish measures, create change ideas and test changes using the 'Plan-Do-Study-Act' cycle.

- Institute for Healthcare Improvement (IHI), How to improve;
- West of England Academic Health Science Network (AHSN), Quality Improvement (QI) tools;
- Social Care Institute for Excellence SCIE, Quality improvement in health and social care (free e-learning course);
- Associates in Process Improvement (API), Reading Lists (relevant literature on improving quality).

Specific to Scotland:

- Children and Young People Improvement Collaborative (CYPIC);
- Health Care Improvement Scotland, I-Hub;
- NHS Education for Scotland, Quality Improvement Zone (QI Zone);
- Education Scotland, National Improvement Hub;
- Scottish Government, Model for Improvement;
- Improvement Service (IS);
- Care Inspectorate, the HUB;
- Centre for Excellence for Children's Care and Protection CELCIS, Quality Improvement programme: Permanence and Care Excellence (PACE).

Implementation science resources

Implementation science is focused on addressing the gap between evidence, policy and practice. 'Active Implementation' is one of the theories of implementation and provides a set of six frameworks that can be used to guide **complex systems change**.

- Active Implementation Research Network(AIRN);
- National Implementation Research Network;
- Global Implementation Society (GIS);

- UK Implementation Society (UK-IS).

Specific to Scotland:

- NHS Education for Scotland, Early Intervention Framework: provides a database of evidence-based prevention and early intervention approaches designed to improve the mental health and wellbeing of children and young people; the implementation science underpins the development of the tool;
- Education Scotland, National Improvement Hub;
- Centre for Excellence for Children's Care and Protection CELCIS, Active Implementation: making a meaningful difference.

Example Media Communications Plan

Prepared on behalf of the …… CPC/Chief Officers Group Date last updated: …….

Title	**Learning Review – X**
Lead	Chief Officers Group Y
Initial preparation date	DD/MM/YY
Lead partners and key stakeholders	• A Council • An NHS board • A CPC • Police Scotland • SCRA • Scottish Government • Care Inspectorate • The Crown Office • CPCScotland
Main communications contacts	• Council • NHS • Police Scotland • Scottish Government • Care Inspectorate

	• Crown Office • CPCScotland
Context	Brief Description of the subject matter of the Learning Review together with key points.
Aims	• To reassure the local community • To provide a coordinated response to questions and concerns raised internally across all agencies and externally with the public • To deliver accurate information about the case, including roles and responsibilities and action taken • To ensure that public confidence in the member agencies is appropriately supported • To deliver a human and compassionate message about the tragic incident
Communications outcomes	• Balanced media reporting of the facts and key messages • Ensure internal audiences including elected members and members of health boards are aware of the facts and key messages and the actions that are being taken within their own organisation, as appropriate • Reporting of any action that has been taken or will be taken, as appropriate • Tone of compassion, openness, transparency and willingness to learn if there are improvements to be made
Target audiences	• Direct family • Social work, Justice SW Service and NHS, Police Scotland (local) • Local Elected Members and NHS Board Members • Local communities • Scottish Government • Media • Other partner stakeholders as appropriate

Other stakeholders	• Local MSPs and MPs • Care Inspectorate and Healthcare Improvement Scotland • The professions and public sector workers • General public • Social Work Scotland • CPCScotland
Potential risks	• Lack of coordination • Inconsistent messages from partners • Third-party media statements • Lack of understanding/awareness of roles and responsibilities • Off-the record briefing • Media presentation of child protection issues – wider media agenda • Appearance of defensiveness • Public expectation of action by responsible organisations – call for people to step down
Strategy	• Be compassionate, open, available and responsive - even if there is little new information that can be shared • Hold information back by exception and only where there is precedent and/or a publicly justifiable reason to do so. Note - the reason will need to stand up legally and for example if information is requested under 'Freedom of Information' • Acknowledge any mistakes genuinely and upfront - explain circumstances consistently and clearly – confirm what action will be taken – why, by whom and when and what difference that will make • Front the review through a single spokesperson but ensure partner agencies have what they need to respond to specific questions and on a timely basis

	• Set the communication strategy – including the tone of response - through the CPC/COG Group and deliver through the communication leads in each partner agency • Agree timetable and channels for release of information. Key findings of the Review to be published online and agreed statement through a release to media. Social media to be monitored by communications leads and co-ordinated responses agreed as appropriate through council communications. Deal with interviews on request • Agree responsibilities for briefing target groups in advance of publication • Coordinate initial media enquiries through an agreed lead agency but route responses through communications leads in individual partner agencies.

Communications action plan

Requirements	Deadline	Audience	Action	Responsibility
Timetable agreed		CPC COG Partner agency leads	• Communication strategy/action plan agreed by COG	Lead Agency Communications (co-ordination)
Report and/or executive summary		CPC COG Partner agency leads	• Full report and or Executive Summary agreed and signed off	COG
Key messages		CPC COG Partner agency leads	• Key messages from the report developed and agreed by COG	Lead Agency Communications (co-ordination)
Spokespeople		CPC COG Partner agency leads	• Lead spokesperson for the review agreed by COG following media training feedback	COG
Public Statements		CPC	• Press statement and publication arrangements finalised and agreed • Questions and Answers – on process etc.	Lead Agency Communications to draft and

Requirements	Deadline	Audience	Action	Responsibility
		COG Partner agency leads	• Background notes for Editors	agree through Communications leads
Day of publication – internal briefings		Direct staff Family Foster Carers Administration Group Leaders/Conveners All members MSPs MPs Other stakeholders as appropriate	• Face-to-face briefing on key messages including findings, action and responsibilities, how to handle questions and timetable ahead • Provide link to report online • Provide copy of agreed media statement being issued	CPC to upload report to Child Protection website and provide link to Communications leads Relevant services to carry out appropriate staff briefings Family liaison contact to meet with family.

Requirements	Deadline	Audience	Action	Responsibility
				Communications leads to ensure their own appropriate stakeholders are provided with information
Day of publication - media		Media Public	• Report online • Intranet • Media statement • Partner websites • Social Media monitored • Interviews on request? • Media monitoring	Lead Agency Communications and Communications leads
Post publication		CPC COG Partner agency leads	• Evaluation of media coverage • Report back to COG	Lead Agency Communications

Media response

Issues highlighted by the Learning Review:

Key media messages:

Potential media questions:

- Why is the Learning Review not being published in full?
- Why is the Learning Review not being published?
- Services are failing children. Are children safe in in this area? Is the system broken?
- Surely it has to be recognised that there is catastrophic service failure. Who is responsible? Why is no one losing their job over this?
- This Learning Review highlights recurring themes highlighted in previous reviews. Why are you not learning from past reviews?
- Staff don't appear to understand the processes and procedures they need to do their jobs properly. Is there an issue in terms of lack of training/resources? Or have staff been negligent?
- Will this ever happen again?

Draft press statement

Date: tbc

Key findings of the Review

Independent Chair of XXXXX Child Protection Committee commented:

Link to summary report online

Notes to Editors

9. Appendices – Adult Support & Protection Appendices

Annex 2

Adult Support and Protection Learning Review Notification

Request from:	
Contact details:	
Agency:	
Date completed:	

Any agency with an interest in an adult's wellbeing or safety can raise a concern about a case which it is believed may meet the criteria for a Learning Review and submit a notification to the APC using the Learning Review notification form.

This notification will be acknowledged and then responded to with the outcome of the Adult Protection Committee's consideration of whether or not to proceed to a Learning Review.

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 ofviolence 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.

Adult's details	
Name:	
Date of birth:	
Date of death:	
Home address &/or current residence:	
Gender:	
Next of Kin/carers address if different:	
Any other Local Authorities involved:	
Is/was the adult subject of any statutory powers at time of concerns arising in relation to Adult Support and Protection, Adults with Incapacity or the Mental Health (Care & Treatment) Act?	
Contact details for any Guardian or Power of Attorney, if known	
Criteria for Learning Review	
What grounds within the criteria do you consider apply for a Learning Review in this case?	
Immediate and general concerns	
Are there any immediate concerns? If yes: • What are the immediate concerns and have these been passed to the relevant agency for consideration/ action? • What action has been taken?	
Are there any general concerns identified during this process of notification? If yes: • What are the immediate concerns and have these been passed to the relevant agency for consideration/action?	

• What action has been taken?	
Summary of the case:	
Are other reviews, criminal investigations or other statutory proceedings underway? If so, please give details.	
Name of service/agency/individuals involved with the adult, with contact details	

Annex 3

Request for Information to Allow Consideration to be Given to the need for an Adult Protection Learning Review

This request for information follows a referral for consideration to be given to the need for a Learning Review in relation to the adult named below.

- Please respond within 2 weeks, returning the completed form to xxxx
- Please provide a brief account of your agency's contact with the adult named below, and provide your reflections on the key practice issues listed.

Enter name & return address of person initiating the request for information

Enter date of request

Name of adult	
Date of birth	
Date of death (if applicable)	
Adult's address	

Brief details of the immediate precipitating factors leading to the referral for consideration of a Learning Review
…to be completed by the person initiating this request for information…

Summary of involvement with the adult:
Background history:

Key practice issues: Please provide information on: • Recognition and assessment of Risk and need in relation to the adult • Information sharing in this case • Strategies and actions to minimise harm • Timely and effective action taken • Multi-agency responses • Evidence of planning and reviewing • Quality of record keeping • Appropriate use of legal measures • Any good practice identified • Any areas identified for practice improvement

Parallel processes	
Are you aware of any current or planned reviews being undertaken for this case? If yes, please give details.	
Are you aware of any criminal proceedings associated with this case? If yes, please give details.	

Report completed by:	
Name:	
Title:	
Agency:	
Email address:	
Date:	

Annex 4

Exemplar Learning Review Report

Core Data – Adult	
Adult's Identifier	
Age of adult	
Gender	
Sexual Orientation	
Disability	
Health needs (including mental health and /or learning difficulties	
Education	
Living circumstances prior to incident	
Position in family/ number of siblings	
Ethnicity	
Religion	
Nature of injury/cause of death	
Legal status of adult	
Agencies/Services involved	
Family/carer factors (if applicable)	
Age	
Mental health issues	
Disability	
Health needs (including mental healthand/or learning difficulties)	

Substance use (if applicable)	
Convictions (if applicable)	
Problems in childhood (if applicable)	

Domestic abuse (if applicable)	
Add antisocial behaviour (if applicable)	
Ethnicity	
Religion	
Marital/relationship status e.g. co-habitation	
Living circumstances	
Agencies/Services involved	
Environmental Factors	
Financial problems	
Housing	
Support from extended family/ community	

Introduction

This includes a brief synopsis the circumstances that led to the review.

The review process

This includes the approach taken to the review, the engagement with the Review Team, details of reviews of records and the compilation of any chronologies, details of any individual meetings with practitioners and managers and of group meetings with practitioners and managers. Details of the involvement of the adult and any family members and carers should also be provided.

The facts

This includes the family background and circumstances, and agencyinvolvement. A succinct chronology or timeline of significant events may also be included if it is essential to an understanding of how learning points were identified.

Details of all significant others in the adult's life should also be included.

Analysis

This section critically assesses the key circumstances of the case, the interventions offered, and decisions made. For example, were the family and adult's circumstances sufficiently assessed, were the responses appropriate, were key decisions justifiable, was the relevant information sought or considered, and were there early, effective and appropriate interventions.

Key issues will be identified and the reader should be assisted to understand the 'why' of what happened in the overall context of, for example, organisational culture, training, policies and resources

Practice and organisational learning

This section highlights the key learning points from the review.

This can helpfully be done by laying out key issues or expectations relevant to the case and then commenting on how these were dealt with in the particular case. For example:

Practitioners should operate in a clear policy and strategic context and should be supported by guidance, procedures and processes that promote positive practice

- In this situation policy, procedures and guidance relating to the assessment of capacity was not readily accessible to front line workers and was not consistently understood across agencies

For assessment and care planning to be meaningful and robust it needs to be a multi-agency activity, using a range of tools to collect, collate and analyse information, to formulate effective protection plans and to measure change

- In this situation some agencies felt they were excluded from some planning meetings where they felt that they would have been able to contribute to a broader understanding of the adult's circumstances and to the development of protection plans

Effective practice

This section allows for the identification of good practice as evidenced by the review'

Suggested strategies for improving practice and systems

This section contains recommendations for the Adult Protection Committee to consider

Appendices

These will include, if not already within the body of the report

- Review Team membership
- Terms of reference for the review
- Files accessed/relevant documents
- People interviewed (identified anonymously through their professional role or relationship to the adult)

Annex 5

Person Specification for Lead Reviewer/s

Chairing

- Consider practice experience required for person chairing review – this may differ depending on the particular circumstances of the case
- Responsible for ensuring the required skills and experiences of the review team are made available
- Role of body/person setting terms of reference and providing progress reports
- No preconceived views of the case/outcome
- Quality – ability to set out ground rules

Knowledge base

- Should have an in-depth knowledge of protecting adults

Analytical skills

- Those chairing/leading reviews must have the ability to interpret and analyse complex multi-agency processes and information.
- Identify what sounding boards the group may have
- Identify where to seek knowledge specific area/profession
- Logical thinking ability to map out review process
- Need to understand the context in which services are delivered.

Person qualities

- Those conducting reviews require to be open minded, fair, a good listener and a logical thinker.
- Experience of practice at various levels across an organisation
- A blend of confidence and humility (to be prepared to learn)
- Need to understand professional backgrounds of those involved and be a multi-agency team player

Skills for undertaking the review

- Approachable
- Need to have awareness of adult support and protection
- Risk Assessment/Management
- Ability to challenge constructively
- Open mindedness/fairness
- Good listener
- Fair person

Annex 6

Facilitating and shaping practitioner and first line manager events and strategic manager events

Learning Reviews are a collective endeavour to learn from what has happened in order to improve systems and practise in the future and thus better protect adults at risk of harm. Bringing together practitioners and their first line managers in a facilitated event is an opportunity for them to reflect on practice and also to ensure that their voice directly contributes to the review. A sensitively facilitated event can also generate immediate learning at both an individual and a group level; learning which can be applied directly to current practice. For strategic managers, meeting together in a facilitated 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 multi-agency perspective.

However, reviewing complex situations where an adult has been harmed or been at risk of harm can raise anxiety in organisations and individuals. This anxiety can block learning by generating defensiveness, with a consequent inability to review and reflect, or to acknowledge the need for change and development in processes and practice. It is essential, therefore, that careful consideration is given to the shape and structure of group events and that they are well facilitated.

Careful preparation is essential if the events for practitioners and their first line managers and events for strategic managers are to be effective and make a meaningful contribution to the Learning Review. Preparation includes identifying participants so that the relevant people attend, selecting an appropriate venue, and thinking about the duration of the event.

At this preparation stage all participants need clarity about the purpose of the group session and a sense of how it will be conducted. They also need a framework to help them prepare and for participants and their first line managers, this will consist of asking them to revisit their involvement with the situation under review and to think about the assessments they completed, the decisions they made, the actions they took and their interaction with other professionals and services. They should also be asked to identify areas of effective practice and areas where, in retrospect, they realise that something could have been done better.

Review Team members have an important part to play in preparing participants and should be the link with those staff from their service area or organisation to ensure that they are well briefed and understand the purpose. Review Team members should also be prepared to answer any queries prior to the event.

Group sessions may vary in duration depending on the situation under review, but for practitioners and first line managers it is advisable to set aside a full day. Sessions for strategic managers can usually be completed in half a day.

The venue, as well as the structure of the day, must facilitate the process and so needs to be comfortable and fit for purpose. The layout of the room is an important factor and it is helpful if participants are able to see another in order that they can develop a conversation together. Rooms laid out in boardroom style or horseshoes or circles should assist this, together with space to move in and out of small groups and sub-sets if required. If the event

is to be held for the duration of a day, then it is preferable to provide lunch. This will help participants to continue thinking together in a less formal way and avoid disruption to the process.

The discussions at this group event do need to be captured as they will directly contribute to the overall learning and to the review report. A note taker should be identified before the events and this will usually be the Review Team Administrator. It should be noted that what they will produce are not formal minutes, but working notes to assist the Reviewer(s) and the Review Team in identifying key learning and recommended actions.

Practitioner/first line manager events and strategic manager events require the facilitators to work in the moment with the material generated by the group and cannot be rigidly structured. However, in order that they have some coherency and provide a framework in which participants can work productively they need some shape with carefully crafted beginnings, middles and endings.

However well-prepared participants are there will still be some apprehension as they gather for the group session and so a careful introduction is essential. This should cover:

- introductions to everyone in the room and why they are there
- reiteration of purpose and process
- an acknowledgement of the apprehensions and anxiety within the room
- setting out working principles for the sessions
- a brief overview of the situation under review

For practitioner and first line manager events the next stage is the exploration of their involvement in the situation under review. This is best done chronologically and, as the story unfolds, it will be important to remind participants to differentiate between their thoughts and actions at the time, and the wisdom of hindsight afforded by a retrospective reflection. In other words, it is about exploring the question ‘why did we do that then?’ and following this up with the question ‘could we have done it differently and what would have helped us to do so?’

As the discussions and thinking develops within the group, the Reviewer(s) should ensure that the following areas are covered:

- were the risks in the situation identified and understood?
- how were the family members engaged with?
- How did the professionals work together?
- What went well? This is about identifying effective practice and what facilitated that practice
- What could have been done better and why did it not happen at the time?

To help participants make sense of the emerging issues and learning it is essential that the Reviewer(s) pause from time to time to summarise the discussion.

How the practitioner/first line manager event is brought to a close is important if it is to have some ongoing value and should not be rushed. This final session of the day should include:

- A summary of the key learning
- An outline of the next steps

- An opportunity for participants to think about their personal learning from the day and how to take it forward
- Checking out how participants feel about the process they have been through

The events for strategic managers also need a careful and thorough introduction similar to the one for practitioner events. However, they will need to input on the circumstances leading to the review so that they have material to work with for the rest of the session. The session will then cover:

Small group work to think about:

- Challenges and missed opportunities in this situation
- What worked well and why?

Followed by careful feedback to identify themes and issues, feedback from the practitioners and frontline managers event, with an opportunity for discussion;

- Input on the views of the family, again with an opportunity for discussion
- Discussion on 'what needs to change' to think about:
    - what changes have already been made?
    - what else can be done?
- Summary and agreement on the emerging recommendations/future actions
- Setting out next steps in terms of the process of the Learning Review

For the reviewer(s) these group events will bring to the fore their facilitation skills. This includes managing the group dynamic but also working sensitively with the individuals within the group. It is about creating an atmosphere of safety and trust, which encourages participants to openly and honestly express their views and reflect on their involvement in the situation. It is about opening up discussion, allowing people to consider and debate but also knowing when to intervene and lead from the front so that the event does not lose its focus.

Annex 7

Inter-related investigations, reviews and other processes

Processes, which may need to be considered in addition to a Learning Review include:

Adverse Events (Significant Adverse Events NHS)

In collaboration with NHS boards, Healthcare Improvement Scotland has led the development of the National Framework: **Learning from Adverse events through Reporting and Review: A National Framework for Scotland (Third edition 2018).**

As per the mental Welfare Commission report *recommendation Left alone – the end of life support and treatment of Mr. JL (July 2014)*, processes should make reference to this document.

An adverse event is defined as an event that could have caused (a near miss), or did result in, harm to people or groups of people. The National Framework describes 3 categories of reviews for significant adverse events and a senior manager or Director is assigned to ensure the review is undertaken at the appropriate level.

Category I: Events that may have contributed to or resulted in permanent harm, for example death, intervention required to sustain life, severe financial loss (£>1m), ongoing national adverse publicity

Category II: Events that may have contributed to or resulted in temporary harm, for example initial or prolonged treatment, intervention or monitoring required, temporary loss of service, significant financial loss, adverse local publicity

Category III: Events that had the potential to cause harm but i) an error did not result, ii) an error did not reach the person iii) an error reached the person but did not result in harm (near misses).

The management of adverse events should incorporate the following six stages

1. Risk assessment and prevention
2. Identification and immediate actions following an adverse event, including consideration of duty of candour
3. Initial reporting and notification
4. Assessment and categorisation, including consideration of duty of candour
5. Review and analysis
6. Improvement planning and monitoring

The report outlining the findings, conclusions and recommendations from the review should be presented through local NHS management structures. The third edition of the framework was produced following the implementation of the statutory organisational Duty of Candour legislation in Scotland on 1 April 2018.

Criminal Investigations (CI)

Within Scotland the core functions and jurisdiction of the police are specified by the Police

and Fire Reform (Scotland) Act 2012. This includes a duty to protect life and property. The police are an independent investigative and reporting agency to the Crown Office and Procurator Fiscal Service (COPFS). The police have a duty to investigate both crimes/offences and also any sudden and unexplained deaths.

Crimes and offences

The paramount consideration in any decision or arrangement in respect of learning reviews taking place alongside other investigations is the need to protect adults from harm. In some instances this will be achieved by the successful prosecution of those who pose a threat to adults, in conjunction with securing improvements in systems that exist to prevent adults being exposed to harm.

Should the police receive information, by whatever means, that a crime or offence has been committed, they are duty-bound to investigate that occurrence. Principally the role of the police is to establish the following:

a) Whether or not a crime or offence has been committed;
b) Whether there is sufficient evidence to support a criminal charge;
c) Whether there is sufficient evidence to justify the detention and/or arrest of the alleged offender; and thereafter to
d) Submit a report to the Procurator Fiscal

Where allegations of physical, sexual and emotional abuse are made involving adults, the police consider, in collaboration with other agencies the following before initiating the investigation. Reports of Adults at Risk of Harm being received under the Adult Support and Protection (Scotland) Act 2007 include physical harm, conduct which causes psychological harm (e.g. by causing fear, alarm or distress, unlawful conduct (e.g. Theft) or conduct which causes self-harm:

- The immediate safety and wellbeing of the adult at risk
- The need for medical attention, immediate or otherwise
- The opportunity of access to the victim and to other adults by the alleged perpetrator
- The relationship of the alleged offender to the victim
- The proximity in time over which the alleged abuse has occurred
- The need to remove the adult or other adult from the home to a place of safety, although this will only take place after discussion between the supervisor on duty in both the police and the relevant Social Work Departments
- The need to obtain and preserve evidence

After consideration of the above, which should ascertain the risks and needs of the adult, the investigation, will begin. In many such cases a Senior Investigation Officer (SIO) will be appointed to oversee the investigation.

In matters where a serious crime or offence has been committed, the investigation will usually be conducted by specially trained officers of the Criminal Investigation Department.

The evidence of the crime or offence will be gathered in a variety of ways such as the obtaining of statements from witnesses who have knowledge of the events under investigation, the gathering of forensic evidence such as DNA, fingerprints, hairs, fibres,

etc. and the interviewing of those person(s) suspected of being responsible.

Upon conclusion of the investigation the police will prepare a report of the circumstances and this will be submitted to the Procurator Fiscal. Decisions will also be made as to whether the accused should remain in police custody pending his/her appearance in court, whether they should be released on an undertaking which may specify certain restrictions/provisions or whether they should be released pending report and summons.

In the event of an adult fatality or a case of serious harm which may be subject to a learning review, it is essential for the APC, Police Scotland and COPFS to confirm the likely processes of review and investigation to which the case is likely to be subjected (e.g. learning review, criminal investigation,
Fatal Accident Inquiry (FAI), Health and Safety investigation, Scottish Fire and Rescue Service investigation).

At the earliest possible opportunity, where it is identified that a learning review may be appropriate, the Convenor of the APC or designated member should contact Police Scotland to confirm:

- Whether a death report or criminal case has been reported to COPFS; or
- That there is evidence of a crime having been committed although no report has been submitted to COPFS

Consideration should be given to arrangements that allow reviews of systems critical to the welfare of adults to get underway, in the context of the need to secure and preserve the integrity of best evidence within criminal and other investigations.

If agreed by Police Scotland and COPFS, a learning review may involve the reviewer interviewing members of staff of the relevant authorities who may have had engagement with the adult, as well as people who may be considered as having a significant part in the life of the adult. The material generated from this activity, including interview notes, is likely to contain information which is of relevance to any potential criminal proceedings or FAI.

Police Scotland has a duty to reveal the existence of relevant information to COPFS and all such information must be made available to the Reporting Officer/SIO as soon as possible for consideration. To allow Police Scotland to fulfil this duty, in these circumstances close collaboration between the Lead Reviewer and the SIO will be required.

The timing of different processes will be determined by the particular circumstances of individual cases. It should not be necessary to postpone the initiation of a learning review until the conclusion of criminal proceedings or FAI but care must be taken that the learning review does not prejudice or put in jeopardy either of these proceedings. Therefore, in some instances, a learning review process may have to be adjourned after an initial review of critical systems until the conclusion of aspects of the criminal or other investigations. Alternatively, it may be possible to take information from a limited number of witnesses at first.

Criminal cases and FAIs can take a long time to resolve and there may be some circumstances where the APC, in carrying out its duties to conduct the learning review, considers it would not be appropriate to wait to gather all possible learning about how best

to safeguard adults. If, prior to charge or conclusion of a trial or FAI, those engaged in the learning review wish to undertake interviews with people who are either witnesses, suspects or who have been charged with a criminal offence or potential witnesses in a FAI, this should be agreed beforehand with Police Scotland and COPFS.

Where there is an FAI, or potential for one, and where no criminal proceedings are anticipated, the conclusions of the learning review may assist the decision-making and such interviews should be encouraged.

Where there are criminal proceedings anticipated or ongoing and COPFS are giving consideration as to whether witnesses can be interviewed as part of the learning review process, the following are some of the factors which may be taken into account:

- The risk around the rehearsal of evidence in advance of trial
- The vulnerability of witnesses
- The risk of any confusion about two processes
- The impact of information being in the public domain

It is good practice that carers and significant family members are interviewed or otherwise engaged during the learning review process to seek any learning from them. The APC, COPFS and, where appropriate, the police officer leading the investigation, or their representative, must discuss the timing and scope of such interviews or other engagement. While there may be no need to delay learning review interviews pending the outcome of criminal proceedings or FAI, a balance must be achieved between the need to capture relevant data and learning in order to protect adults and the investigation of a death or prosecution of a criminal case in the public interest.

The best timing of such interviews will differ depending on the circumstances and features of the case and as such arrangements should be made on a case-by-case basis.

Persons conducting learning review interviews must be conversant with rules of evidence and competent in the management of investigative processes running in tandem with criminal investigations.

In circumstances where there is an ongoing criminal investigation, prosecution or death investigation, the APC must seek permission from COPFS before publishing learning from a learning review.
Publication may need to be delayed if it is likely to prejudice an ongoing criminal investigation, prosecution or death investigation.

Fatal Accident Inquiry

A Fatal Accident Inquiry is a court hearing which publically makes inquiries into the circumstances of a death. It will be presided over by a sheriff and will usually be held in the sheriff court. If the death occurred as a result of an accident while the deceased was in the course of employment or where the person who died was at the time of death in legal custody, for example in prison or police custody, an FAI is mandatory. The Lord Advocate has discretion to instruct an FAI in other cases where it appears to be in the public interest that an Inquiry should be held into the circumstances of the death.

The purpose of a Fatal Accident Inquiry is to ascertain the circumstances surrounding the

death and to identify any issues of public concern or safety and to prevent further deaths or injuries. The Procurator Fiscal has responsibility for calling witnesses and leading evidence at an FAI, although other interested parties may also be represented and question witnesses.

At the end of a Fatal Accident Inquiry, a Sheriff will make a determination. The determination will set out:

- Where and when the death occurred
- The cause of death
- Any precautions whereby the death might have been avoided
- Any defect in systems which caused or contributed to the death
- Any other facts which are relevant to the circumstances of the death

The court has no power to make any findings as to fault or to apportion blame between individuals. The Sheriff has the power to make recommendations as to steps which ought to be taken to prevent a death occurring in similar circumstances in future. While there is no compulsion on any person or organisation to take such steps it would be unusual for such a recommendation to be disregarded.

MAPPA Significant Case Review

The fundamental purpose of MAPPA is public protection and managing the risk of serious harm posed by certain groups of offenders. It Is understood that the responsible authorities and their partners involved in the management of offenders cannot eliminate risk – they can only do their best to minimise that risk.

It is recognised that, on occasions, offenders managed under the MAPPA will commit, or attempt to commit, further serious crimes and, when this happens, the MAPPA processes must be examined to, firstly, ensure that the actions or processes employed by the responsible authorities are not flawed and, secondly, where it has been identified that practice could have been strengthened, plans are put in place promptly to do so.

There are five stages to a MAPPA Significant Case Review:

1. Identification and notification of relevant cases
2. Information gathering
3. Decision to proceed, or not to a Significant Case Review
4. Significant Case Review process
5. Report and publication

The criteria for undertaking a Significant Case Review in MAPPA is:

- When an offender managed under MAPPA at any level, is charged with an offence that has resulted in the death or serious harm to another person, or an offence listed in schedule 3 of the Sexual Offences Act 2003;
- Significant concern has been raised about professional and/or service involvement, or lack of involvement, in respect of the management of an offender under MAPPA at any level;
- Where it appears that a registered sex offender being managed under MAPPA is killed or seriously injured as a direct result of his/her status as a

registered sex offender;
- Where an offender currently being managed under MAPPA has died or been seriously injured in circumstances likely to generate significant public concern.

Offences Obstruction

Section 49 of the Adult Support and Protection (Scotland) Act 2007 provides that it is an offence to prevent or obstruct any person from doing anything they are authorised or entitled to do under the act. It is also an offence to refuse, without reasonable excuse, to comply with a request to provide information made under section 10 (examination of records etc.). However, if the adult at risk prevents or obstructs a person, or refuses to comply with a request to provide access to any records, then the adult will not have committed an offence.

A person found guilty of these offences is liable on summary conviction to:

- A fine not exceeding level 3 on the standard scale; and/or
- Imprisonment for a term not exceeding 3 months.

Offences by corporate bodies etc.

Where it is proven that an offence under Part 1 of the Act was committed with the consent or connivance of, or was attributable to any neglect on the part of a "relevant person", or a person purporting to act in that capacity, that person as well as the body corporate, partnership or unincorporated association is also guilty of an offence. A "relevant person" for the purposes of this section means:

- A director, manager, secretary or other similar officer of a body corporate such as limited company, a plc, or a company established by a charter or by Act if Parliament;
- A member, where the affairs of the body are managed by its members;
- An officer or member of the council;
- A partner in a Scottish Partnership; or
- A person who is concerned in the management or control of an unincorporated association other than a Scottish Partnership.

An unincorporated association is the most common form of organisation within the independent and third sector in Scotland. It is a contractual relationship between the individual members of the organisation, all of whom have agreed or "contracted" to come together for a particular charitable purpose, unlike an incorporated body the association has no existence or personality separate from its individual members.

Post Mortem Examination

The Procurator Fiscal will instruct a Post Mortem Examination for all suspicious deaths; all deaths which remain unexplained after initial investigation; and in a number of other situations where there are concerns about the circumstances or cause of death.

Serious Incident Review

A serious incident is defined as an incident involving: -

‘Harmful behaviour, of a violent or sexual nature, which is life ‘threatening and/or traumatic and from which recovery, whether physical or psychological, may reasonably be expected to be difficult or impossible.’ (Framework for Risk Assessment Management and Evaluation: FRAME)

And includes:

- An offender on statutory supervision or licence is charged with and/or recalled to custody on suspicion of an offence that has resulted in the death or serious harm of another person.
- The incident, or accumulation of incidents, gives rise to significant concerns about professional and/or service involvement or lack of involvement.
- An offender on supervision has died or been seriously injured in circumstances likely to generate significant public concern.

The purpose of a serious incident review is to ensure that local authorities and partner agencies identify areas for development and areas of good practice.

Following a serious incident, the Care Inspectorate must be notified of such within 5 working days. The Care Inspectorate will forward to Scottish Government Criminal Justice division. The local authority is then required to undertake a review of the serious incident and submit this to the Care Inspectorate within 3 months of the notification. The review can be completed in two ways: firstly, and initial analysis review is completed – this may be enough with the local authority concluding no further detailed review is required or; secondly following an initial analysis review a more comprehensive review is required.

The Care Inspectorate will then provide a written response to the review and the case will then either be closed or additional information sought.

Sudden and Unexplained Deaths

All sudden and unexplained deaths must be reported to the Procurator Fiscal. The death is usually reported by a doctor (either a General Practitioner (GP) or a hospital doctor), by the police or a local Registrar of Births, Deaths and Marriages. Whether or not the cause of death is known, if a doctor is of the view that a death is not known or is not clear to a doctor, this is described as an “unexplained death”.

Once a person’s death is reported to the Procurator Fiscal, it is for the Procurator Fiscal to decide what further action, if any, will be taken. The Procurator Fiscal may decide that further investigation is required which may include, but is not limited to, the instruction of a post mortem examination to determine the cause of death and/or instructing the police to carry out further enquiries and provide a report.

While some death investigations may conclude once a cause of death is known, others may require further detailed and sometimes lengthy investigation, for example, those involving complex technical and medical issues which may require the instruction of independent experts to provide an opinion. At the conclusion of the Procurator Fiscal’s investigation, it may be necessary for a Fatal Accident Inquiry (FAI) to be held.

Once a death has been reported to the Procurator Fiscal, the Procurator Fiscal has legal responsibility for the body, usually until a death certificate is issued by a doctor and given

to the nearest relative. The Procurator Fiscal will usually surrender legal responsibility for the body once the nearest relative has the death certificate.

In a small number of cases, it may be necessary for the Procurator Fiscal to retain responsibility for the body for a longer period of time to allow for further investigations to be carried out into the circumstances. This happened with only a very small number of deaths, most likely where the death is thought to be suspicious. If this is necessary, nearest relatives will be advised by the Police or the Procurator Fiscal.

Suspicious Deaths

Where there are circumstances surrounding the death which suggest that criminal conduct may have caused or contributed towards the death, this is described as a "suspicious death". The Procurator Fiscal will instruct the Police to investigate the circumstances and consider whether criminal charges should be brought which may lead to a prosecution. All deaths where the circumstances are thought to be suspicious must be reported to the Procurator Fiscal.

In circumstances where the death is considered to be potentially suspicious, the Procurator Fiscal may direct that a two Doctor post mortem examination be carried out for corroboration purposes of the finding. This would be an essential element in the chain of evidence, particularly where criminal investigations and/or proceedings were to be instigated later.

Normally, a Senior Investigating Officer (SIO) will be appointed to investigate suspicious deaths and specially trained officers would carry out these investigations. These investigations may well identify criminality and also those who may be responsible and in these circumstances the police would follow their well-established investigative procedures. Good practice would always suggest that a Family Liaison Officer acts as the single point of contact between them and the police.

Public bodies with responsibility for scrutiny and improvement support include:

Care Inspectorate

The role of the Care Inspectorate is to regulate and inspect care, social work and child and adult protection services so that:

- Vulnerable people are safe
- The quality of these services improves
- People know the standards they have a right to expect

The Care Inspectorate reports publicly on the quality of these services across Scotland. The Care Inspectorate has a duty to support improvement in care and social work services and promulgate good practice. The Care Inspectorate is strongly committed to supporting strategic partnerships such as adult protection committees in their continuous improvement by proving support and feedback locally and by identifying and reporting on wider themes and learning which could improve practice nationally.

The Health and Safety Executive

The Health and Safety Executive ("HSE") is a statutory body established under section 10 of the Health and Safety at Work Act 1974. The Health and Safety Executive's main statutory duties are to:

- Propose and set necessary standards for health and safety performance, including submitting proposals to the relevant SoS for health and safety regulations and codes of practice;
- Secure compliance with these standards, including making appropriate arrangements for enforcement;
- Make such arrangements as it considers appropriate for the carrying out of research and the publication of the results of research and encouraging research by others;
- Make such arrangements as it considered appropriate for the provision of an information and advisory service, ensuring relevant groups are kept informed of and adequately advised on matters related to health and safety; and
- Provide Ministers on request with information and expert advice

Local authorities also have a role in enforcing health and safety legislation in some privately-owned care homes. The HSE and Scottish local authorities have signed an agreement with the Care Inspectorate. The agreement has been developed to assist staff by:

- Promoting co-ordination of investigations, where appropriate, into incidents that have resulted in service user deaths or serious injuries, which could have been prevented
- Encouraging appropriate information to be shared in a timely manger
- Establishing and maintaining liaison arrangements

The Care Inspectorate agreement document can be found on the Health and Safety Executive website.

Healthcare Improvement Scotland

Healthcare Improvement Scotland ("HIS") is an organisation with many parts and one purpose – better quality health and social care for everyone in Scotland. They have five key priorities. These are areas where they believe they can make the most impact and where they focus efforts and resources.

- Enabling people to make informed decisions about their care and treatment
- Helping health and social care organisations to redesign and continuously improve services
- Provide evidence and share knowledge that enables people to get the best out of the services they use and helps services improve
- Provide quality assurance that gives people confidence in the services and supports providers to improve.
- Making the best use of resources, we aim to ensure every pound invested in our work adds value to the care people receive

HIS provides public assurance about the quality and safety of healthcare through the

scrutiny of NHS hospitals and services, and independent healthcare services. HIS reports and published findings on performance and demonstrates accountability of these services to the people who use them. HIS also supports health and social care services to continuously improve and redesign services alongside the provision of evidence and sharing of knowledge. This makes a positive impact on the healthcare outcomes for patients, their families and the public, and feeds the improvement cycle by providing further evidence for improvement.

Mental Welfare Commission for Scotland

Investigations by the Mental Welfare Commission for Scotland focus on one person, but have lessons for many organisations. The Commission carries out investigations into deficiencies in an individual's care and treatment, particularly when it believes there are similar issues in other people's care and where lessons can be learned for services throughout Scotland. Their work is specific to individuals with mental ill health, learning disability, and related conditions. (See section 11 Mental Health Care and Treatment (Scotland) Act 2003).

The Mental Welfare Commission should be notified of significant events that meet particular criteria. It is difficult to be prescriptive, as each and every circumstance will be different. The criteria can be found on the Mental Welfare Commission website.

In the Scottish Government review of arrangements for investigating the deaths of patients being treated for mental disorder report (December 2018) Action 1 is:

The Scottish Government will ask the Mental Welfare Commission for Scotland to develop a system for investigating all deaths of patients who, at the time of death, were subject to an order under either the Mental Health (Care and Treatment) (Scotland) Act 2003 or Part VI of the Criminal Procedure (Scotland) Act 1995 (whether in hospital or in the community, including those who has their detention suspended).

This process should take account of the effectiveness of any investigations carried out by other agencies and should reflect the range of powers the Commission has to inspect medical records, carry out investigations, and hold inquiries (as set out in sections 11-12 and 16 of the 2003 Act). The design and testing of the new system should involve, and be informed by the views of carers, families and staff with direct experience of existing systems. It should include appropriate elements of public scrutiny and should involve staff, families and carers. The new system should have clear timescales for investigation, reporting and publication.

The commission is working to develop this system of reviews and further information and guidance will be issued to all stakeholders at an appropriate stage.

The Office of the Public Guardian

The Office of the Public Guardian (Scotland) ("OPG") has statutory powers to supervise financial guardians, financial interveners and withdrawers, and powers to investigate them (and continuing attorneys) where there is a concern or risk of financial abuse.

The OPG aims to ensure that these appointed proxies act in the best interests of the adults with incapacity, and that they carry out their duties properly, within the scope of their powers. If there is a concern about how an appointed proxy is acting, an investigation may be undertaken, and the incapable adult's property or financial affairs may be appropriately safeguarded from risk from abuse or misuse.

Anyone who has concerns that an adult's funds/property are at a risk, can refer the matter to the OPG.They will need to provide evidence to support those concerns. Concerns might include:

- The way in which an attorney, who has authority to manage an adult's finances or property, is using that authority.
- An adult's property or financial affairs appears to be at risk, perhaps because of the involvement of a third party who has no authority to manage the adult's finances.

When investigating continuing attorneys, the Office of the Public Guardian only has a locus when the granter/adult has lost capacity; when a current and future risk has been identified (the Office of the Public Guardian does not have a remit to investigate historical matters); and, where no proxy (joint attorney) has been appointed who could investigate and safeguard the estate.

The Scottish Fire and Rescue Service (SFRS)

The Scottish Fire & Rescue Service ("SFRS") is a national organisation delivering front-line services locally across three Service Delivery Areas (SDAs) in the North, West and East of the country. SFRS works in partnership to reduce the incidences of fire in Scotland and, continues to play a key role in prevention, to ensure the safety and wellbeing of Scotland's communities.

The SFRS have a specialist fire investigations unit located in each SDA (Glasgow, Edinburgh and Aberdeen). The teams work exclusively on fire investigation. Their role allows them to build a comprehensive knowledge base, identify issues, track trends and understand the circumstances surrounding the fire event. The investigation process culminates in a detailed report that identifies the origin, cause and fire development. This information is shared across the organisation and partners (where appropriate) in order to learn from previous incidents and, improve community and firefighter safety. By jointly investigating fire incidents, the SFRS aim to reduce the instances of fire and reduce the number of fire deaths, injuries and trauma resulting from such incidents.

A multi-agency protocol to jointly investigate fires was introduced in 2013. This protocol commits SFRS, Police Scotland and Scottish Police Authority (SPA) Forensic Services to work together and share their specialist skills and expertise when dealing with certain levels of investigations. The protocol ensures that the approach to investigations is consistent across the organisations, and across the country.

Scottish Social Services Council

The Scottish Social Services Council ("SSSC") is the regulator for the social services workforce in Scotland. SSSC register social services workers, set standards for practice, conduct, training and education and support professional development. Where people fall

below standards of practice and conduct they can investigate and take action.

The fitness to practice process of a professional regulator, such as SSSC, may be running in parallel with a Learning Review. Where there are issues with the conduct of workers who are registered with the SSSC, it would be helpful to keep them informed. This will support the coordination of activity between organisations and minimise duplication.

Annex 8

Example Media Communications Plan

Prepared on behalf of the..... Adult Protection Committee/Chief Officers Group

Date last updated: …….

Title	**Learning Review – X**
Lead	Adult Protection Committee/Chief Officers Group
Initial preparation date	DD/MM/YY
Lead partners and key stakeholders	• Council • NHS board • Health & Social Care Partnership • APC • Police Scotland • Scottish Government • Care Inspectorate • The Crown Office
Main communications contacts	• Council • NHS • Health & Social Care Partnership • Police Scotland • Scottish Government • Care Inspectorate • Crown Office Procurator Fiscal Service
Context	Brief Description of the subject matter of the Learning Review together with key points.
Aims	• To reassure the local community • To provide a coordinated response to questions and concerns raised internally across all agencies and externally with the public • To deliver accurate information about the case, including roles and responsibilities and action taken

	• To ensure that public confidence in the member agencies is appropriately supported • To deliver a human and compassionate message about the tragic incident
Communications outcomes	• Balanced media reporting of the facts and key messages • Ensure internal audiences, including elected members and members of health boards, are aware of the facts and key messages and the actions that are being taken within their own organisation, as appropriate • Reporting of any action that has been taken or will be taken, as appropriate • Tone of compassion, openness, transparency and willingness to learn if there are improvements to be made
Target audiences	• Direct family/proxies and/or Adult subject to the review • Social work services across the Council and HSCP, as appropriate; NHS; Police Scotland (local) • Local Elected Members and NHS Board Members • Local communities • Scottish Government • Media • Other partner stakeholders, as appropriate
Other stakeholders for consideration	• Local MSPs and MPs • Care Inspectorate and Health Improvement Scotland • Social Care staff; public sector workers • General public • Social Work Scotland • SSSC • Office of the Public Guardian (Scotland) • Mental Welfare Commission
Potential risks	• Lack of coordination • Inconsistent messages from partners • Third-party media statements • Lack of understanding/awareness of roles and responsibilities • Off-the record briefing • Media presentation of adult or child protection issues – wider media agenda

	• Appearance of defensiveness • Public expectation of action by responsible organisations – call for people to step down
Strategy	• Be compassionate, open, available and responsive – even if there is little new information that can be shared • Hold information back by exception and only where there is precedent and/or a publicly justifiable reason to do so. Note – the reason will need to stand up legally and for example if information is requested under 'Freedom of Information' • Acknowledge any mistakes genuinely and upfront – explain circumstances consistently and clearly – confirm what action will be taken – why, by whom and when and what difference that will make • Front the review through a single spokesperson but ensure partner agencies have what they need to respond to specific questions and on a timely basis • Set the communication strategy – including the tone of response – through the APC/COG Group and deliver through the communication leads in each partner agency • Agree timetable and channels for release of information. Key findings of the Review to be published online and agreed statement through a release to media. Social media to be monitored by communications leads and co-ordinated responses agreed as appropriate through council communications. Deal with interviews on request. • Agree responsibilities for briefing target groups in advance of publication • Coordinate initial media enquiries through an agreed lead agency but route responses through communication leads in individual partner agencies.

Communications Action Plan

Requirements	Deadline	Audience	Action	Responsibility
Timetable agreed		APC COG Partner agency leads	• Communication strategy/action plan agreed by COG & APC	Lead Agency Communications (co-ordination)
Report and/or executive summary		APC COG Partner agency leads	• Full report and/or Executive Summary agreed and signed off	APC
Key messages		APC COG Partner agency leads	• Key messages from the report developed and agreed	Lead Agency Communications (co-ordination)
Spokespeople		APC COG Partner agency leads	• Lead spokesperson for the review agreed, following media training feedback	APC & COG
Public Statements		APC COG Partner agency leads	• Press statement and publication arrangements finalised and agreed • Questions and Answers – on process etc. • Background notes for Editors	Lead Agency Communications to draft and agree through Communications leads
Day of publication – internal briefings		Direct staff Family Administration	• Face-to-face briefing on key messages including findings, action	APC to upload report to Adult Protection website and

Requirements	Deadline	Audience	Action	Responsibility
		Group Leaders/Conveners All members MSPs MPs Other stakeholders as appropriate	and responsibilities, how to handle questions and timetable ahead • Provide link to report online • Provide copy of agreed media statement being issued	provide link to Communications leads Relevant services to carry out appropriate staff briefings Family liaison contact to meet with family. Communications leads to ensure their own appropriate stakeholders are provided with information
Day of publication - media		Media Public	• Report online • Intranet • Media statement • Partner websites • Social Media monitored • Interviews on request? • Media monitoring	Lead Agency Communications and Communications leads
Post publication		APC COG Partner agency leads	• Evaluation of media coverage • Report back to COG	Lead Agency Communications

Media response

Issues highlighted by the Learning Review:

Key media messages:

Potential media questions:

- Why is the Learning Review not being published in full?
- Why is the Learning Review not being published?
- Services are failing adults at risk of harm. Are vulnerable adults safe in in this area? Is the system broken?
- It seems that there is catastrophic service failure. Who is responsible? Why is no one losing their job over this?
- This Learning Review highlights recurring themes highlighted in previous reviews. Why are you not learning from past reviews?
- Staff don't appear to understand the processes and procedures they need to do their jobs properly. Is there an issue in terms of lack of training/resources? Or have staff been negligent?
- Will this happen again?

10. Additional Appendices

Annex 1

West Dunbartonshire Child Protection Committee

TERMS OF REFERENCE

West Dunbartonshire Child Protection Committee

Joint Learning Review –

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1 - Criteria for undertaking a Learning Review

A Child Protection Committees (CPC) will undertake a Learning Review when a child has died or has sustained significant harm or risk of significant harm, as defined in the National Guidance for Child Protection Committees Undertaking Learning Reviews in Scotland (2021 - Updated 2024)

And there is additional learning to be gained from a Learning 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 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 abuse or neglect is known or suspected to be a factor in the child 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
- the child's sustaining of or risk of significant harm is caused by attempted suicide, alleged attempted murder, reckless conduct, or act of violence
- the child is being managed under Care and Risk Management (CARM) processes and causes harm to another person or themselves.

2 - Decision to undertake a Learning Review –

(Provide details)

3 - Purpose of the Learning Review

The purpose of the Learning Review is to inform both practical and systemic improvements to the protection of children and young people in West Dunbartonshire.

West Dunbartonshire CPC acknowledges that reflecting on learning enables agencies to identify good practice in protecting children, and to ensure that any necessary practice changes are made, to better protect children in the future.

Of particular importance to the Learning Review is to:

4 - Methodology

The Review will be conducted in line with the expectations of the National Guidance for Child Protection Committees Undertaking Learning Reviews in Scotland (2021 - Updated 2024)

The Learning Review will apply a systems approach that includes case file reading, a practitioner and manager event and a senior managers event, professional discussion and some consultancy. It will follow the procedures as set out in the guidance and ensure the Care Inspectorate are informed at the start and end of the Learning Review. Parallel processes will be considered. The Reviewer will have unrestricted access to policies, protocols, procedures, and case records related to two children of Family M within the specified Review period.

Any significant risks/needs identified by the Reviewer during the Learning Review process will be reported immediately to the Chair of the Review, CPC Chair and / or Chief Officer from the agency concerned.

The new National Guidance for Child Protection in Scotland (2021) - Updated 2023 will support the Learning Review in its child protection considerations. Relevant Research will also be included.

5 - Time period to be covered

The period to be covered by the Review will be from

6 - Parallel or other processes

(Provide Details)

7 - Ethnicity, Religion, Diversity, Gender, Disability, Language & Equalities

The Learning Review will take account of any learning in respect of ethnicity, religion, diversity, gender, disability, language, and equalities.

8 - Reporting Arrangements

The Reviewer and Review Team will take a proportionate, flexible, and timely approach to ensure that a report of the learning is relevant to the current practice context, systematic in approach and moves beyond any shortcomings by seeking to understand why events took place, with a strengthened focus on how learning can be actioned and implemented.

No individual staff member will be identified in the report, and services identified in their widest sense wherever possible. Redaction prior to circulation may be necessary and will follow the suggested format contained in the National Learning Review Guidance.

The Reviewer and the Chair of the Review Team will present the Learning Review report to West Dunbartonshire CPC and Public Protection Chief Officers for consideration and sign off prior to any publication.

9 - The Review Team

Reviewer: (Name)

Review Chair: (Name)

Review Team	Agency	Job Title
	West Dunbartonshire	Lead Officer Child Protection
	West Dunbartonshire	Public Protection Assistant

The Review Team will be supported by West Dunbartonshire Child Protection Lead Officer with administrative support provided by the Public Protection Assistant.

The Review Team will act as single points of contact for any information required and to assist in setting up any professional discussions or meetings related to their service / agency and report back progress quickly to the Review Team.

Chief Officers from all partner agencies expect that all relevant services will assist the Learning Review process and be available for all meetings. Any difficulties will be addressed by the Review Chair with the relevant Chief Officer of the agency concerned.

10 - Staff Welfare

Full consideration will be given to staff welfare and support throughout the Learning Review, particularly for those who had direct involvement in the case and may be involved in the staff engagement sessions, or who may be invited to take part in individual conversations as part of the Learning Review process. It will be the responsibility of each service / agency to support this. Staff will be advised of contacts for support as required. Updates to those who took part and broader staff groups will be agreed by the Review Team and the Child Protection Committee.

11 - Timescale for the Learning Review

As suggested in the National Guidance for CPCs Undertaking Learning Reviews (2024), the Learning Review process is anticipated to be completed within nine months of the first meeting on the Review Team.

Review start date:

Annex 2

Learning Review Outline – West Dunbartonshire

National Guidance for CPCs Undertaking Learning Reviews in Scotland (2024)

National Guidance for APC's Undertaking Learning Reviews (2022)

START DATE –

FIRST DRAFT –

NB: National timescale is 6-9 months for a Review (pending any parallel process considerations)

Review Team		
Independent Reviewer		
Lead Officer		
Review Chair		

Terms of Reference (to be agreed)

NB: Those who agree to be part of the Review Team require to attend all six meetings. This assists in reducing potential delays in the agreed plan

Role of the Review Team

(a) First Review Team meeting (2hrs)

This first meeting introduces the methodology and considers practicalities including discussing the principles and ways of working, clarifying roles and functions, identifying practitioner and frontline manager event participants and senior manager event participants and their preparation.

The Review Team starts to make sense of the situation and with the Reviewer identify early key issues and questions to explore. This meeting can also include timetables, discussing parallel processes, arrangements for collating further information (if gaps identified), preparing for future work. Organising case records and verifying that the Care Inspectorate was notified of the decision to proceed to a Learning Review and have the agreed start date of the Review.
NB: It is helpful to begin planning case file retrieval as soon as Review timeline is agreed.

(b) Second Review Team meeting (2hrs)

The second meeting is to confirm agreed tasks have been done without delay. It looks to make final agreement on the family liaison strategy and associated planning. It checks on the preparation for the Practitioner and Frontline Manager Event (Full Day) and the Senior Manager Event (Half Day) including confirmations; numbers, information and support for practitioners attending.

This meeting further explores any final emerging issues and reflections at this stage and seeks to identify final gaps / queries in records made available to the Reviewer.

(c) Third Review Team Meeting (90 mins)

This third meeting is to navigate through any final issues / actions or observations for the Review Team ahead of the Practitioner and Frontline Manager event and the Senior Manager Event.

The Reviewer may use this time to discuss early emerging issues from case file reading and forthcoming events.

(d) The Practitioner and Frontline Manager Event –

*This is a **FULL DAY** event attended by the Reviewer, Review Chair, Lead Officer, and admin only from Review Team only.*

Here staff work with the reviewer to jointly discussing the story of involvement, identifying, and analysing significant events, alongside learning, identifying effective practice and possible strategies for improving practice and systems, including possible recommendations.

(e) The Senior Managers Event –

*This is a **HALF DAY** (pm) attended by the Reviewer, Review Chair, Lead Officer, and admin only from Review Team only.*

This takes place the day after the Practitioner Event. Where time is taken to discuss the outline of the situation, the challenges, and what worked well and why. It considers the changes needed and the strategies for improvement, together with the emerging recommendations.

(f) Meeting the Family – TBC

As agreed.

(g) Learning Points to Review Team

The Reviewer will offer a summary of the events and the identified areas likely to be highlighted in the report. This is sent to the CPC/APC Lead to share with Chair / Review Team. Any additional areas you feel MUST be covered to be returned to Reviewer by agreed date.

(h) REPORT WRITING PHASE (6 weeks) and REVIEW TEAM ACTIONS:

The Reviewer constructs and prepares the first draft of the report

REVIEW TEAM ACTION - This should be read by the team and tracked changes made ahead of the meeting in xxx. Tracked changes should be collated and returned to the Reviewer. This is a vital part of the process and relies on open and honest feedback to ensure the report can be developed to meet the needs / expectations of your service.

Revised version returned.

(a) Fourth Review Team meeting (90 mins)

The Review Team meets with the Reviewer to consider the **amended first draft of the report** to make final comments on accuracy, structure, and content.

(b) Reviewer finalises report and submits to Review Chair and Lead Officer .

(c) Presentation/dissemination to CPC /APC and COG (Executive Summary also provided).

(d) CPC/APC submit completed report to the Care Inspectorate

Annex 3

SW – Child&Fam	
Health	
Police	
Housing	

Multi Agency Chronology - LR – Name

West Dunbartonshire Child Protection Committee

West Dunbartonshire Adult Protection Committee "working together to protect adults"

Date	Source	Event	Intervention/Action Taken	Recorded By