



Pan-Ayrshire Learning Review Guidance

Sept 2025

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Appendix 'A' – Learning Review Process Map

Annex 1 (CPC) – provided under separate cover:

- Learning Review Notification (LRCP 1)
- Request for Information for Consideration of a Learning Review (LRCP 2)
- Learning Review Recommendation and Decision (LRCP 3)

Annex 1 (APC) – provided under separate cover

- Learning Review Notification (LRAP 1)
- Request for Information for Consideration of a Learning Review (LRAP 2)
- Learning Review Decision (LRAP 3)

1. INTRODUCTION

- 1.1 This guidance applies to learning reviews commissioned by both Child and Adult Protection Committees across North, East and South Ayrshire. It replaces the Pan Ayrshire Protocol for CPCs conducting an Initial or Significant Case Review (2015) and the guidance on ASP Learning Reviews that were operable in the three Ayrshires until the adoption of this 2023 pan Ayrshire guidance.
- 1.2 It has been locally adapted based on the National Guidance for Child Protection Committees undertaking Learning Reviews (Scottish Government, 2021), and the National Guidance for Adult Protection Committees Undertaking Learning Reviews (Scottish Government 2022).
- 1.3 Protecting adults and children is an inter-agency and inter-disciplinary responsibility overseen by APCs and CPCs and it is these committees who are responsible for deciding whether a Learning Review is warranted and, if so, for agreeing how the review is conducted. Both committees will keep their relevant Chief Officer Group advised of all cases referred for a potential Learning Review and will report their recommendations on these matters to the Chief Officer Group for consideration and ratification.
- 1.4 The overall purpose of a Learning Review is to bring together agencies, individuals, and families in a collective endeavour to learn from what has happened in order to improve and develop systems and practice in the future and thus better protect adults and children. 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](#) (UNCRC).
- 1.5 Learning Reviews should seek to:
 - understand the full circumstances of the death of, or serious harm to, an adult or child
 - examine and assess the role of all relevant services, relating both to the adult or child and also, as appropriate, to relatives, carers or others who may be connected to the incident or events which led to the need for the review
 - explore any key practice issues and why they might have arisen, including identifying systemic issues
 - consider the question of “How did the situation present itself to the practitioner at the time, and how did this lead to decisions and actions taken at the time?”

- establish whether there are areas for improvement and lessons to be shared, about the way in which agencies work individually and collectively to protect adults and children at risk
- identify areas for development, how they are to be acted on and what is expected to change as a result
- consider whether there are issues with the system and whether services should be reviewed or developed to address these
- establish findings which will allow the APCs and CPCs to consider what recommendations need to be made to improve the quality of services.

1.6 This guidance supports the Reviews of the APC or CPC by helping to:

- undertake them at a level which is necessary, reasonable, and proportionate
- adopt a consistent, transparent and structured approach
- identify the skills, experience and knowledge that are needed for the review process
- address the needs of the many different people and agencies who may have a legitimate interest in the process and outcome

2. DEFINITIONS

2.1 For the purpose of this guidance

- **a child** is a person under the age of 18, although there may be exceptions for care leavers who were in receipt of aftercare or continuing care at the time of the incident that led to a Learning Review Notification. A comprehensive definition is provided in the [National Guidance for Child Protection in Scotland](#).
- **an adult** is defined for the purposes of the Adult Support and Protection (Scotland) Act 2007 as a person aged 16 or over.
- an 'adult at risk' is defined as someone who meets **all** of the following three criteria (commonly known as the three-point test):
 - that they are unable to safeguard their own well-being, property, rights or other interests;
 - that they are at risk of harm; and
 - because they are affected by disability, mental disorder, illness or physical or mental infirmity they are more vulnerable to being harmed than adults who are not so affected

- 2.3 **Note:** Situations may arise for learning reviews, particularly for 16 and 17 year olds, where there are legitimate interests and engagement from services for both children and adults.
- 2.4 In such circumstances there should be discussions between the Child and Adult Protection Committees to determine which is the most appropriate to lead on a Learning Review, with agreement reached as to how each of the committees will be involved and updated on progress of the Review. This will require consideration on a case-by-case basis, and the involvement of the Chief Social Work Officer will be helpful in these deliberations.

3. KEY FEATURES OF LEARNING REVIEWS

3.1 The key features of a Learning Review are:

I. Inclusiveness, collective learning and staff engagement

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

II. Support for staff

Support for staff is critical and should be integral to the review process in order that they can participate fully in the process, reflect on their practice, share their knowledge and contribute to the emerging learning.

III. A systems approach

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

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

IV. Proportionality and flexibility

The situations under review will inevitably be complex and diverse and this therefore requires a streamlined, proportionate and flexible approach to ensure effective learning. This flexible approach remains grounded in the underpinning principles and values of Learning Reviews.

V. Timing and Timelines

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

4. UNDERPINNING PRINCIPLES AND VALUES

4.1 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 adults, children 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 adults, children and to support families
- 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

5. CREATING THE PRECONDITIONS FOR LEARNING

5.1 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.

- 5.2 It is important, therefore, to create and sustain a positive shared learning culture throughout the process of the Review.
- 5.3 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 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.
- 5.4 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.
- 5.5 Effective leadership is crucial to creating the preconditions for learning. Chief Officers, who are accountable for all the work of the Adult and Child Protection Committees, must promote and support national learning and improvement activity in the protection of children as a matter of course, providing leadership and guidance in relation to the need to carry out Learning Reviews.

6. CRITERIA FOR UNDERTAKING A LEARNING REVIEW

6.1 Child Protection

- 6.1.1 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,**
 - **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 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, 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.

6.1.2 The Child Protection Committee will undertake a Learning Review 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 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, culpable homicide, reckless conduct, or act of violence

Note: Following the establishment of the National Hub for Reviewing and Learning from the deaths of Children and Young People, all child deaths, as well as the deaths of 18-26 year-olds open to throughcare or aftercare services at the time of their death are eligible for a robust, quality review. 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), will be important to consider and agree the most appropriate review process

Note: The criteria do not preclude a CPC reviewing the death of a child pre-birth.

6.2 Adult Protection

6.2.1 The 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**

- 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
- For both CPCs and APCs Learning Reviews may also be undertaken where the criteria are not fully met but the Committee determines that there may be significant learning to be gained by conducting a Learning Review; or where effective working has taken place and outstanding positive learning can be gained to improve practice.

Note: A learning review will not generally be considered in cases where there has been only single agency involvement, but there may be circumstances where this will be appropriate. When a learning review is not considered appropriate in such cases, the relevant Committee will want to be assured that appropriate attention is being given to learning within that single agency.

7. Parallel or Other Processes

- 7.1 Learning Reviews are one of the many processes that exist to support continuous improvement, and will be important to be aware of, and liaise with, any parallel processes being undertaken.
- 7.2 The parallel processes to be considered may include (this is not an exhaustive list):
- Criminal investigations
 - Local Authority report on the death of a looked after child
 - NHS significant critical incident or Significant Adverse Event Reviews (SAER)
 - Drug Related Death Review
 - Fatal Accident Inquiries (FAI)
 - Investigations by, among others, the Care Inspectorate, Health & Safety Executive, Scottish Fire & Rescue Service, Procurator Fiscal, Scottish Prisons Service, Multi-Agency Public Protection Arrangement (MAPPA), Mental Welfare Commission, Office of the Public Guardian
 - 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 and Children (SUDIC)
 - Suicide Reviews
 - Large Scale Investigations
- 7.3 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 a potential 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.
- 7.4 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.
- 7.5 Good local liaison arrangements are important. Issues to be considered include how to:

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

- 7.6 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 practice, is understood and remains the focus. The COPFS and Police Scotland have a protocol which recognises that criminal proceedings can be managed simultaneously, and there 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. There is as yet no similar protocol regarding adults.
- 7.7 In all other cases, consideration must be given to the potential parallel processes listed above, with a multi-disciplinary meeting taking place to agree how best to proceed at the earliest opportunity, in order to minimise duplication and maximise learning. The Child or Adult Protection Committee will discuss the most appropriate review type and sequence with the body responsible for the parallel process.
- 7.8 Confidence in the agreed process and a joint commitment to keeping the child or adult and their family at the centre will ensure that a robust and shared learning culture takes place without delay.

8. National Child Death Review Process

- 8.1 A National Hub for Reviewing and Learning from the Deaths of Children and Young People has been set up by Scottish Government. It is hosted by Healthcare Improvement Scotland and the Care Inspectorate.
- 8.2 Reviews will be 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.

- 8.3 The aim is 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 to learning from all local review activity. Data generated will inform national policy, education and learning and contribute to the prevention of child deaths in the future.
- 8.4 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.
- 8.5 The National Hub 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.
- 8.6 As with all inter-agency assessment and action, a sensitive, collaborative, respectful approach is essential at every stage, with sharp attention to the necessary sharing of information and preservation of evidence. All inter-agency professionals should ensure that the family involved in the process are treated sensitively. Scottish Government have provided funding to develop National Bereavement Care Pathways (NBCP) for five types of baby loss including the sudden unexpected death of an infant. Chief Officers will ensure that staff have access to appropriate support during any investigations, particularly if the circumstances of the case lead to a Learning Review.
- 8.7 Within Ayrshire, the Paediatric Bereavement Liaison Nurse (PBLN) will contact the identified local authority Child Death Overview Process (CDOP) implementation lead, who will in turn make contact as early as possible with the relevant CPC Lead Officer, if they believe a case meets the criteria for a Learning Review. A discussion, and agreement on how this should be managed, should ensue.
- 8.8 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 Annex 3 of the national guidance.

9. INITIATION OF A LEARNING REVIEW: DECISION-MAKING

- 9.1 Child / Adult 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.
- 9.2 Any member of the Child or Adult Protection Committee, agency or practitioner can raise a concern about a case which it is believed meets the criteria for a Learning Review and submit a notification to the relevant committee. This should be used using the Potential Learning Review Notification template (**Annex 1**). Families are not able to request learning reviews but have access to complaints procedures within agencies where they feel dissatisfied with aspects of how cases have been dealt with.
- 9.3 When considering a Learning Review which relates to the death of a child, Child Protection Committees should consult with the local authority Child Death Review Implementation Lead to ensure that duplication is minimised. This consultation should continue until the CPC has reached a decision as to undertaking a Learning Review or not.
- 9.4 On receipt of a Learning Review Notification the relevant Committee Chair will, with the assistance of the Lead Officer and in consultation with other senior officers as required, confirm whether the criteria for a learning review have likely been met. In some cases, it may be helpful to convene a meeting to discuss, but this is not a meeting of the formal Case Review Panel. If it is agreed the criteria **are** met, then the formal process will be initiated with a request for further information from all agencies involved with the adult and family. This is done using the Information for Consideration of a Learning Review form (**Annex 1**). If it is decided that the criteria for a learning review have **not** been met this decision will be communicated to the initial referrer the CPC and COG along with notification to the Care Inspectorate.
- 9.5 The purpose of information gathering at this stage is to make a decision about whether or not to proceed with a Learning Review with reference to the criteria as specified in the previous section and therefore the data gathered should be only enough to assist in making that decision.
- 9.6 It will include a brief account of agency involvement prior to the event which triggered the notification and some very initial reflection regarding practice and decision-making within that agency.
- 9.7 After consideration of the data gathered, the Committee Chair will then convene a Learning Review Panel of senior managers from all agencies relevant to the case.

- 9.8 It is expected that for CPC cases this will routinely include the Committee chair and lead officer, senior officers from Education, the Health and Social Care Partnership, the Chief Social Work Officer, Police Scotland, SCRA, NHS acute services and other agencies as appropriate, and officers from any provider organisations involved, and the CPC Lead Officer.
- 9.9 A similar attendance will be expected for APC cases except for agencies who have a sole focus on children.
- 9.10 The attendance list should be agreed by the Committee Chair on a case-by-case basis.
- 9.11 The panel will review the information provide by agencies and will then make a recommendation to the APC or CPC on whether or not to proceed with a Learning Review. This will be recorded in the Learning Review Panel Recommendation form (**Annex 1**).
- 9.12 If progression to a Learning Review is recommended then the proposed Terms of Reference for the review should be included along with consideration of a communication strategy to interested agencies and parties (including the family): consideration of any support needs to workers and consideration of any likely media interest.
- 9.13 If progression to a Learning Review is not recommended consideration should be given to the need for any alternative approach for learning.
- 9.14 The recommendation should be considered by the Adult / Child Protection Committee and the Public Protection Chief Officers Group (COG) for ratification. The Care Inspectorate will also be informed, using its online [notification processes](#).
- 9.15 If the final decision ratified by the Chief Officers Group is to go ahead with a Learning Review, then a review team will be established and a chair of this team identified. Lead reviewer(s) will be appointed.

Potential Media Interest

- 9.16 Consideration of potential media interest should be discussed by the APC/CPC and Chief Officers Group.
- 9.17 When cases are likely to attract high public and media interest, a strategy should be prepared allowing for a range of scenarios. Media statements should make it clear that the purpose of the review is learning and not culpability.

Timeframe for the initial decision-making process

- 9.18 The timeframe for this initial decision-making stage will vary depending on the situation being considered. However, timeliness is important, so that any learning arising is relevant to the current practice context. Therefore, a maximum of 6 weeks (42 days) is an appropriate timeframe for the completion of this process.

Cross-authority cases

- 9.19 A Learning Review in one area may involve agencies from a different local authority, health board or police division.
- 9.20 In the case of a potential cross-authority Learning Review within Scotland, the relevant Committee Chairs from both areas should meet and agree a mechanism for joint working, including which Committee 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 COG for consideration, and the Chief Social work Officer should be kept informed.
- 9.21 In the case of a potential cross-border Learning Review, the Committee Chair should meet with the relevant Chair of the relevant Safeguarding Board or equivalent, to agree a mechanism for joint working.
- 9.22 If the subject of a review is a child over 16, the potential relevance of adult protection processes and legislation must be considered. The Adult Support and Protection Committee should therefore be contacted and consulted. Consideration should be given to the Review team including adult protection membership.

More than one individual

- 9.23 There may be cases where more than one individual is involved. The review process must consider each person's specific circumstances to ensure that learning arising from the individual circumstances is brought together in one Learning Review report.

The Learning Review and other formal staff processes

- 9.24 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

- 9.25 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 relevant committees give consideration to what might be learned and how that learning can be disseminated to the multi-agency workforce.
- 9.26 The Care Inspectorate is required to be notified of all cases where a formal request for a learning review to be considered has been submitted, so should be advised at this point of this outcome.
- 9.27 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 and should be considered as part of the Learning Review process. As such they need to conclude with a short and succinct report identifying key learning and if appropriate, some multi-level strategies for changing, improving, or strengthening practice in the future and for sustaining effective practice.

10. UNDERTAKING THE LEARNING REVIEW

10.1 A systemic approach

- 10.1.1 It is important to emphasise that a Learning Review is a collective endeavour and that, whilst the detail of how a review is undertaken may vary, all reviews must adopt a systemic approach.
- 10.1.2 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.
- 10.1.3 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.
- 10.1.4 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 or adult who is the subject of the review.
- 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.

10.2 Terms of reference

- 10.2.1 The terms of reference are a guiding statement which define the scope of the Learning Review. Terms of reference will be agreed by the APC/CPC and COG and should reflect the rationale for undertaking a review and be relevant and be specific to the situation under review. Based on the information known at the time, proposed terms of reference will be drawn up at the point a recommendation is made to the relevant committee to proceed with a Learning Review.
- 10.2.2 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 Committee should be informed of and in agreement with any changes to the Terms of Reference.
- 10.2.3 The final terms of reference will be included in the Learning Review report at the completion of the Review.

10.3 The Review Team

- 10.3.1 When a decision has been made to proceed to a Learning Review the first step is to set up a Review Team. The Review Team manages the whole process of the review and is a multi-agency group whose members will be senior officers should have a working knowledge of the relevant services involved in supporting the adult or child(ren) and families, but, as far as possible, not have had direct involvement in the situation under review.
- 10.3.2 The Review Team will be chaired by an officer with the knowledge skills and experience to undertake the role of chair. Deciding who will chair the review team will depend on the circumstances of each particular case. It is expected that the Lead Officer will always participate in the Review Team and will have administrative support agreed to support the work of the Review Team and the review process itself. The Lead Reviewer will be expected to attend meetings of the Review Team to provide updates on the overall progress of the review and to advise the Team of any assistance they may need to provide in facilitating the conduct of the review.
- 10.3.3 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.
- 10.3.4 The Review Team will receive regular updates from the lead reviewer on progress with the learning review.
- 10.3.5 Drafts of learning review reports will be shared with the review team who will ensure that reports focus on the issues identified in the remit and identify areas for consideration by agencies that are clear, succinct, and proportionate.

10.4 The role of the Chair of the Review Team

- 10.4.1 The key components of the role of the Review Team Chair are to:
- Consider whether there are parallel processes ongoing
 - 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 person-centred perspective throughout
- Meet with family members alongside the Reviewer as appropriate
- Attend practitioner and manager events alongside the Reviewer

10.5 The role of the Review Team members

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

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

10.6 The role of the Lead Reviewer

10.6.1 **Note:** Not all reviews will require the appointment of an external reviewer. There will be circumstances where it will be proportionate and appropriate that a review can be led by an officer of one of the local agencies. This will be subject to their having the necessary skills, knowledge and experience to undertake a Learning Review, and that they not been directly involved in the case under consideration and have not been overseeing work within the case.

10.6.2 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, the adult and their families
- Pull together the learning and write the report, with the assistance of the rest of the Review team

10.6.3 In some circumstances it may be appropriate to have two Reviewers.

10.6.4 For instance, if a case is particularly complex or there is more than one child or adult 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.

10.7 Enabling factors within the wider context

10.7.1 Chief Officers will ensure that Learning Reviews are effective and fulfil their purpose. This means the 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.

10.7.2 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.

10.8 Collecting and collating further information

10.8.1 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, but there will be circumstances where longer time frames will be appropriate. If agencies and services have been involved with an adult or child and their family for many years, then a brief summary of that earlier involvement should be prepared.

10.8.2 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.

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

10.8.4 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.

10.9 Managing emerging issues and challenges during the Review

10.9.1 There may be instances, when, during the course of 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 relevant committee and the Chief Officers Group must be informed.

10.10 Engaging the family in the Review process

10.10.1 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 adults, children and young people in the future. As the family are, therefore, integral to Learning Reviews, the Review Team must consider how to involve them in the process in a meaningful and sensitive way. This may involve developing a Family Liaison Strategy.

10.10.2 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 were provided and could be improved. Their thoughts, opinions and feelings contribute to the overall learning of the review.

10.10.3 Careful consideration should be given as to who constitutes the family group, and this will differ from review to review.

10.10.4 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.

10.10.5 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.

10.10.6 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.

- 10.10.7 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.
- 10.10.8 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.
- 10.10.9 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.
- 10.10.10 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.
- 10.10.11 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.

10.11 Involving practitioners, first line managers and strategic managers

- 10.11.1 All reviews must adopt a systemic and proportionate approach. Such an approach should be participatory and collective and, as well as engaging with families, should involve all relevant staff. This will include those practitioners and first-line managers who were involved in the situation under review as well as strategic managers, who, though not directly involved in a review situation, are responsible for the development of processes and structures to facilitate the delivery of services to children and their families.
- 10.11.2 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.

10.11.3 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. Guidance is available on how to facilitate and shape events for practitioners and first line managers and strategic managers (Annex 6 in national guidance).

10.12 The Report

- 10.12.1 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.
- 10.12.2 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.
- 10.12.3 Adult / Child Protection Committees are not Data Controllers and should satisfy themselves as to which relevant public authority will be the Data Controller in respect of the Learning Review prior to undertaking the review. The Data Controller will be the public authority that holds the collated learning review information and report on their system.
- 10.12.3 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.
- 10.12.4 It is recommended that suggested strategies for improving practice and systems should be CLEAR. This means that:
- **The Case for change:** the Review Team should clearly identify the issues that give rise to the need for change, outlining the likely consequences should no change occur. Any proposed change should be set within the context of current policy or that which is known to be in preparation.
 - **Learning orientated:** any suggested strategies should highlight key lessons for practice identified by the review process and should promote the transfer of learning.

- **Evidence based:** proposed strategies for improving systems and practice should draw on evidence of any shortcomings in policy or practice revealed by the review and only be made if evidence exists that their implementation will effectively address the shortcomings identified in the review report.
- **Assign responsibility:** each strategy should identify the discipline or organisation with responsibility for implementation, who will then in turn be responsible for identifying an appropriate officer, recognising that some strategies 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

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

10.13 Publishing the Report

10.13.1 The COG, informed by a recommendation in this regard from the Adult or 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 taken into account 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 Chief Officers Group meeting. **If a report is not published, then the learning should be extracted from the report and be published separately.**

10.13.2 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.

10.13.3 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.

10.13.4 It is important to note that publication of the report may need to be delayed until the conclusion of criminal or FAI proceedings. Where criminal, FAI or children's hearings proceedings are ongoing the publication of any report must be discussed with COPFS and/or SCRA.

10.14 Timescale for the Learning Review

10.14.1 If the learning identified throughout the review process is to be relevant and helpful to the development and improvement of child and adult 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.

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

11. DISSEMINATING AND IMPLEMENTING THE LEARNING FROM THE REVIEW

11.1 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

11.2 Implementation of suggested strategies

11.2.1 The final section of the report will often but not always contain areas for consideration by local agencies and suggested strategies that:

- improve practice and systems
- identify the case for change
- are learning orientated
- are evidence based, and
- assign responsibility

- 11.2.2 The APC/CPC must then ensure that a succinct action plan is drawn up to support the implementation of these strategies. The action plan will clarify who will do what and within what timescale.
- 11.2.3 The COG will consider the Action Plan, as well as any resource issues that are relevant for the production and progress of the Action Plan.

11.3 Dissemination of learning at a local level

- 11.3.1 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
- 11.3.2 There are a variety of approaches and models that can be used to disseminate learning at a local level. These may include multi-agency reflective sessions, seminars, learning summaries and briefings. To ensure dissemination of learning is sensitively tailored to meet the needs and learning styles of different individuals and groups, a variety of modes and approaches should be used. It is essential that dissemination takes place in a timely manner, is targeted at the right audience and allows space for consideration of the implications for practice and systems and identifies what needs to happen to ensure the learning is applied.

11.4 Dissemination of learning at a national level

- 11.4.1 The purpose of disseminating learning at a national level is to look at recommendations and suggested strategies that are outside the remit of an individual APC/CPC but require action; share learning across all areas; identify overarching themes and consider if issues need further exploration, or if they should underpin or inform the development of national policy.
- 11.4.1 Dissemination of learning at a national level is facilitated by the publication of regular overview reports by the Care Inspectorate and, for Child Protection, by regular meetings of the Learning Review Liaison Group.
- 11.4.2 This group, comprising representatives from the Scottish Government, the Care Inspectorate and CPC Scotland, has been established to provide a forum to discuss thematic findings from Learning Reviews that have national implications for policy and practice development.

11.5 Role of the Care Inspectorate

- 11.5.1 The primary role for the Care Inspectorate is to support continual improvement in the quality of services for adults, children and young people, including adult and child protection services.
- 11.5.2 The Care Inspectorate provides an overview on the effectiveness of the learning review process with a focus on the recommendations and learning points, elements of good practice and suggested areas for improvement within the context of organisational learning. This is informed by the notifications and reports that APCs / CPCs submit.
- 11.5.3 Once the decision on whether or not to proceed to a learning review has been agreed, the APC / CPC will submit a notification of the decision to the Care Inspectorate by logging into the 'eform system' on the Care Inspectorate website and submitting the information via the electronic form.
- 11.5.4 Completed and anonymised Learning Review reports will be submitted to the Care Inspectorate via secure e-mail to:
cistrategicteamnotification@careinspectorate.gov.scot
- 11.5.5 In some circumstances, APCs / CPCs agree to carry out an alternative approach for learning. When this occurs, anonymised completed reports or minutes that record learning and recommendations should be submitted to the Care Inspectorate via secure e-mail to:
cistrategicteamnotification@careinspectorate.gov.scot
- 11.5.6 Guidance on notifications and submissions you must make to the Care Inspectorate can be found at:
<https://www.careinspectorate.com/index.php/notifications>
- 11.5.7 In summary, the Care Inspectorate has the following responsibilities:
- acts as a central collation point for the notification of decisions for proceeding or not proceeding to a learning review taken by CPCs, in order to better understand the rationale
 - acts as a central collation point for all learning reviews completed across Scotland at the point at which they are concluded
 - identifies themes, aspects of good practice and learning opportunities to share nationally
 - provides feedback to individual Chief Officer Groups and CPCs

12. Staff Wellbeing Considerations

- 12.1 Learning Review processes should be trauma-informed, protective and supportive of staff wellbeing. This should be a foremost consideration from the outset as the impact on staff when a service user comes to significant harm or dies should not be underestimated.
- 12.2 It is the responsibility of the Independent Chair of the APC / CPC and the respective Lead Officers to ensure that staff wellbeing is an intrinsic part of the development of Terms of Reference and subsequent planning. It is important that the correct tone is set from the outset through the use of language and clear, concise and trauma informed written communications.
- 12.3 The Learning Review Panel has a duty to consider the impact of staff from their own agencies / departments that are nominated to be part of the Review Team. Thereafter, the Review Team Chair and team members will be responsible for ensuring all line managers and teams involved in the learning review will be compassionately considered from a trauma informed practice lens and have the necessary support mechanisms in place throughout and beyond the learning review process.
- 12.4 It is considered good practice that all Review Team members will have undertaken Trauma Informed Practice training in their existing roles, so that this knowledge can be applied to the learning review process. If Review team members have not had any relevant trauma training, then a bespoke training session would be beneficial to support them to fulfil the role.
- 12.5 Learning Review Staff Wellbeing Guidance is available to provide additional advice and support.

13. Further Resources

- 13.1 The two National Guidance documents for *Adult and Child Protection Committees undertaking Learning Reviews* include a number of annexes providing additional information that may be of help to local partnerships.
- 13.2 For Adult Protection these annexes include:
 - Person specification for lead reviewer
 - Facilitating and shaping practitioner and first line manager events and strategic manager events
 - Inter-related investigations, reviews and other processes or themes

13.3 For Child Protection these annexes include:

- National Protocol for the Police Service of Scotland, the Crown Office and Procurator Fiscal Service, and Child Protection Committees on Learning Reviews
- National Child Death Review and Learning Hub Process Map
- Family Liaison Strategy
- Learning Review Team – attributes, skills, experience and knowledge
- Facilitating and shaping practitioner and first line manager events and strategic manager events

13.4 These can be accessed at

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

and

<https://www.gov.scot/publications/national-guidance-child-protection-committees-undertaking-learning-reviews/pages/3/>

Learning Review Process Map

