care inspectorate

Learning reviews for children

National overview report

1 April 2021 to 31 March 2022

HAPPY TO TRANSLATE

Contents

Background

Over the past seven years, the Care Inspectorate has been the central collation point for all significant case reviews. In 2017 it also became the collation point for all initial case reviews. As part of a commitment to learning and improvement, we report publicly on thematic findings to provide an overview of review activity, findings and recommendations. This is to support improvements to child protection practices and policy across Scotland.

The Care Inspectorate has published three triennial reports which have provided national overviews of learning since 2012. This is our first annual national overview report. It is an interim report as we transition from being the central collation point for initial and significant case reviews to one for all learning reviews. It coincides with the implementation of the National guidance for undertaking learning reviews, published in September 2021, and the implementation phase of the National Hub for Reviewing and Learning from the Deaths of Children and Young People (the National Hub) which was established in October 2021.

This report offers initial reflections on the learning review processes based on the notifications we have received, and from the experiences of Child Protection Committees (CPCs) involved in the learning review process. We sent out a survey to the CPCs and held a focus group with members of the learning review community of practice[1] to gather their observations and learning. We have also included observations from the initial case reviews (ICRs) and significant case reviews (SCRs) that we received during the timeframe of this report.

Since our Triennial Review of Initial Case Reviews and Significant Case Reviews (2018-2021) which we published in May 2021, we have received:

- 11 significant case review reports (SCRs)
- 13 initial case review (ICR) notifications that did not proceed to full SCR
- 14 learning review notifications.

These notifications and reports considered the circumstances of 42 children and young people. Eleven children and young people were the focus of ICRs, 11 were the focus of SCRs, and 20 were subjects of learning review notifications.

Only two of the ICR notifications proceeded to a SCR, while nine of the learning review notifications indicated that they were proceeding to a learning review. Although the number of notifications was broadly similar compared to previous years, there has been an increase in the number of notifications where the decision was made to proceed to a review. This increase in decisions to proceed to a review relates primarily to learning reviews. (Appendix 1, table A).

We cover the ICR notifications received since 1 April 2021 in this report, submitted before the publication of the national learning review guidance in September 2021. Over the last five years, we noted that a growing number, just over half of ICRs, were **not** proceeding to SCRs. Yet, while the numbers of learning review notifications are still small (14), 64% of them are proceeding to a review. We will continue to monitor this to see if this trend continues.

[1] 'Learning review community of practice' is a support network for CPCs who are involved in learning review processes. It offers the opportunity for members to share learning and ask questions about the process

Section 1: The learning review process: initial reflections

This section provides reflections from CPC members involved in the learning review process. It also refers to information gathered through the collation of data from the learning review notifications that we have received (Appendix 2).

The national learning review guidance highlights that a learning review is:

'An opportunity for in-depth analysis and critical reflection 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.'

Although still in the initial stages of implementation, there have been indications about what has worked well and what the challenges have been. Members of the learning review community of practice helpfully shared their experiences of the key features and the implementation of the guidance.

Applying the criteria

Members of the community of practice highlighted that the current criteria are useful, allowing for an element of creativity and flexibility. The guidance helped set out the rationale for proceeding, or not, with a learning review. They valued the increased emphasis on the perspectives of staff. Practitioners were able to influence the shape of reviews and support reviewers to see what required a closer focus, helping to avoid unnecessary lines of enquiry. One CPC was able to use the learning review guidance in an unusual case, where the previous guidance would not necessarily have applied.

Our previous Triennial Review of Initial Case Reviews and Significant Case Reviews highlighted the reasons for not proceeding to a significant case review following an ICR. These included for example:

- the criteria were not met
- a single agency review being more appropriate to the circumstances
- another review process or learning event done as an alternative

The rationales for not proceeding to a learning review have been similar. In the national learning review guidance, part of the criteria for undertaking a learning review is that 'there is additional learning to be gained from a review being held that may inform improvements in the protection of children and young people.' From notifications we received, we see that 'no additional learning' was the predominant reason for not proceeding to a learning review. (Appendix 2).

In situations where all the learning review criteria were met, and a learning review did not proceed, the reasons for the decision were not always clear to us. From the perspectives of members of the community of practice, any decision not to proceed would still result in a form of alternative action, such as:

- the creation of a multi-agency group to reflect on practice and opportunities for learning
- an internal review
- a single agency review
- auditing work.

The community of practice did not always consider learning reviews to be most effective mechanism for gathering and disseminating learning, even when all the

criteria are met. Once we have received more notifications, we anticipate being able to build a fuller picture of decision making.

The learning review guidance suggests an appropriate and realistic timeframe for the completion of the initial decision-making stage would be 28 to 42 days. However, it acknowledges that the timeframe may vary depending on the circumstances being considered. Only four of the notifications sent to us were not within the suggested timescale and in these cases, the delays were out with the control of the team. The reasons for the delays included scheduling of child protection committee meetings, the impact of the pandemic and staff absences. Some members of the community of practice commented that the timescale of 28 to 42 days seemed unnecessarily long. (Table 4, Appendix 2).

In our last triennial report, CPCs highlighted that the capacity to identify and disseminate learning quickly was important so that the learning was current and had greater impact. It will be interesting to explore this and the timescale for completion of learning review reports further.

Engaging the family

Engagement and involvement with families was a key principle within the process for significant case reviews. Its importance is strengthened in the new learning review guidance. Members of the community of practice conveyed the view that the perspectives of families and the learning that these offer, should be as important as others involved with the review. Members of the community of practice valued the family liaison strategy guidance to support CPCs which is included as an annex of the learning review guidance. However, they have not widely used this yet.

Where it has been used, CPCs observed that it helped to improve the approach for engaging with families through the process. Some of the ongoing challenges to involving families in reviews are familiar. For example, factors such as ongoing complaints, pending criminal proceedings or requests from the Crown Office and Procurator Fiscal Service (COPFS) have restricted the way in which families have been informed and involved in current learning reviews.

Inclusiveness, collective learning and staff engagement

The learning review guidance, which supports the development of local strategies for staff engagement has been enhanced with improved digital connectivity in some CPC areas. Members of the community of practice felt that a stronger focus on preparation and planning around supporting staff and engaging with them was beneficial. The role of the review team has been key to effective engagement, communication, and liaison with staff.

Although some areas already had arrangements in place for reflective practitioner sessions, they noted that the new guidance strengthened this aspect. The guidance also strengthens the expectation for the review team chair and reviewer to facilitate sessions to bring practitioners and first line managers together in a group. This is to ensure that their voice directly contributes to the review. Some areas had already introduced strategies and resources to support staff engagement. Examples of these included:

- self-care guidance for staff directly involved in learning reviews
- local multi-agency communities of practice
- locality learning forums

- both one-to-one and small group reflective sessions.

Introducing a new process has not been without its challenges, particularly during a global pandemic. In some areas it has been difficult, on occasion, to coordinate opportunities for bringing all the relevant people together. Nevertheless, in others, sensitively managed workshops created opportunities to hear practitioners' voices about the circumstances or cases under review.

From the reports we read, it is evident that engagement of staff was encouraged within the significant case review process. The learning review process has strengthened this by firmly placing it within the context of a culture of organisational learning.

Members of the community of practice believed that the creation of supportive and sensitive opportunities for staff to describe what they did and why, empowered them to reflect upon and analyse assessments, decision-making and identify what could have been done differently. Staff involved in learning reviews have commented that the process has felt affirming, and that they feel valued, listened to and part of the review.

At this early stage, there are indications from staff who have been involved in learning reviews, that this collaborative approach is helping to foster a learning culture. It is improving interactions between practitioners across a range of services. It is helping them to better understand the complexities, challenges and areas of collaborative working in a way that they cannot conclude easily from a desk top exercise.

Proportionality, flexibility and timelines

Members of the community of practice highlighted that the 2021 guidance encourages a creative ethos around learning, and that it reflects a shifting culture. It gives permission to be more imaginative and proportionate in the learning review process, compared to the previous guidance.

We consider suggested timescales for learning reviews to have been helpful in clarifying expectations for those conducting reviews. Members of the community of practice said that they have been able to conduct learning reviews within the identified timescales so far. This reflects what we have seen in the notifications that we received. One CPC noted that neither of their two learning reviews have involved criminality but believed that this might impact upon timescales for conclusion.

The National Protocol for the Police Service of Scotland, the Crown Office and Procurator Fiscal Service, and Child Protection Committees on Learning Reviews at Annex 2 of the learning review guidance[2] was helpful to those who had applied it. Previously, when a case was also subject to police investigations or court proceedings, there could potentially be prolonged delays before a SCR started or completed because of concerns about its impact on of evidence. This new joint protocol provides a framework for sharing appropriate information that should not inhibit the setting up a learning review nor delay action to improve services. The focus group suggested that further awareness raising about the protocol would be helpful to embed it as part of the learning review process. This is to ensure that it is followed as intended. One CPC said that they followed the protocol and adapted

[2] Annex 2: National Protocol for the Police Service of Scotland, the Crown Office and Procurator Fiscal Service, and Child Protection Committees on Learning Reviews

their approach, completing the review within six-months which captured learning in a timely way. The CPC was clear on the rationale for not speaking with some key individuals. It will be interesting to explore the effectiveness of the protocol in our next annual overview report in relation to overcoming challenges experienced during the SCR processes.

We have been told by some CPCs that they have strategic groups in place to consider notifications and make decisions about whether to proceed with a learning review. From their perspective this has improved governance arrangements, meeting timescales, and has offered an element of increased consistency in decision making. It has given recognition of emerging themes and improved opportunities for learning and participants have had confidence in these groups where they existed.

Some CPCs described hybrid approaches at this early stage of the implementation of the guidance. These approaches have been part of transitioning from the previous guidance. They include continuation of ICR processes but progressing them to a learning review. The observations were that the new guidance was more helpful to framing the terms of reference, setting the context and principles for the reviews. It also helped focus on learning as well as offering some clarity in strategic direction.

Responses to our survey were positive about the attention given to multi-agency professional practice in the learning review guidance and a systems-based approach that draws the focus away from individuals and individual practice. Since 2015, we have seen increasing numbers of SCRs using a systems-based approach, but it had been variable across Scotland. As more learning reviews are completed, we anticipate that we will be able to provide a national overview of the consistency and quality of approaches in future annual reports.

From the experience so far, CPCs highlighted that the learning review guidance is more adaptable. It has allowed more flexibility in reviewing cases that would not previously have met the criteria. Whilst some CPCs remarked that the learning review guidance helped focus on proportionality, it was noted that this needs to be balanced with the thoroughness of approach. We have received three completed learning review reports, each of which have used the template suggested in the guidance. The three reports are not sufficient to provide any national overview of the thoroughness of the approaches and the proportionality of the reviews. This too will be an area that we hope to explore further in our next annual report.

Independent reviewers and review team

The 2015 national guidance for undertaking significant case reviews highlighted the importance of establishing a team to support the lead reviewer. It said that consideration should be given to the skills required of the lead reviewer and the review team. This was reinforced in the 2021 learning review supplementary guidance with Annex 5[3] included as a resource to support local processes of appointing and coaching review team members, lead reviewers and administrators for learning reviews. Members of the community of practice considered the review team to be critical in ensuring effective practitioner engagement. They help shape and influence the review. This minimises any negative impact on staff going through learning reviews, some of whom still see this as an adversarial process.

[3] Annex 5: Learning Review Team – attributes, skills, experience and knowledge. A supplementary guidance for CPCs

Members of the community of practice reflected that there have been varying experiences when commissioning independent reviewers and in ensuring the right skills and skill mix for the lead reviewer and review team. They considered it important that professional skills, knowledge and experience balanced with adaptability to learn and apply the 2021 guidance in its entirety, including meeting the key features. These are not new challenges, but we anticipate that Annex 5 will provide additional support to CPCs in the future.

Section 2: Review themes

In our Triennial Review of Initial Case Reviews and Significant Case Reviews (2018-2021), several themes were noted as areas for learning and development across a range of adult and children's strategic partnerships and services.

Similar learning and development themes have emerged in our analysis of reviews and notifications submitted this year. Seven of the eleven SCRs are historical with the circumstances that led to the SCR occurring in 2017 and 2018. They reflect many of the themes that were highlighted in our previous triennial report. We have drawn out key learnings emerging in ICRs, SCRs and Learning Review notifications below.

Analysis of ICR and SCRs findings indicated there continues to be some confusion about the application of Getting it Right for Every Child (GIRFEC) principles. This is in relation to the roles of the named person service (or person acting as the professional point of contact in universal services) and the lead professional. Appropriate, consistent information sharing, and effective inter-professional communication remains a challenge and featured in 10 SCRs, one themed review and three learning review reports we reviewed. Professional cultures were continuing to impact on information-sharing behaviour and attitudes within and across organisations. One of the impacts of this can be different thresholds for intervention or a delay in initiating action.

Identifying and responding to neglect continues to be a significant and contributory feature in the reviews and notifications submitted. As highlighted in our previous reports, review findings identified missed opportunities to intervene or to recognise signs or patterns of neglect early enough. This left children unnoticed in neglectful or harmful situations until a threshold for child protection was reached.

Our previous triennial report identified that responding to the mental health and wellbeing needs of older children and young people whose circumstances were subject to review was not addressed appropriately. The ICR, and SCR reports and Learning Review notifications and reports submitted this year indicate that providing an appropriate response to the mental health needs of young people continues to be a challenge. The issue featured in approximately one third of cases reviewed.

We identified themes in relation to the quality of assessments and decision making in a number of the ICRs, SCRs and learning review notifications that we received. Issues noted included:

- Delays in completing risk assessments.
- Limited information and analysis within assessments which impacted on decisions made about children.
- Differing opinions between professionals regarding the level of risk and intervention required.
- Understanding the role of the Scottish Children's Reporter Administration and Children's Hearing Scotland and legal frameworks to support children's plans.

The variability in the quality and effectiveness of pre-and post-birth assessment and planning for babies also emerges as a theme. We noted the following issues:

- Effectiveness of early identification and recognition of potential risks to unborn babies. This was due to parental circumstances such as substance misuse, domestic abuse, mental health and learning difficulties and the potential impact on parenting.
- Not engaging parents at an early stage in pregnancy to provide support, assess risk and plan for the unborn baby.
- Not convening Child Protection Case Conferences early enough to support planning.

We reported similar themes in our previous Triennial report 2018-2021. Other recurring themes emerging from ICRS, SCRs and learning review notifications we reported previously included disguised compliance by parents, joint working between children and adult services.

Section 3: Child deaths

Of the 42 children and young people for whom we have had a notification or report since 1 April 2021, 19 had died. However, not all died within the period between April 2021 and March 2022. The deaths of 14 children and young people were recorded through the ICR and SCR processes. Seven of them did not proceed to a full SCR. The deaths of a further five children and young people were recorded using the new learning review process. (Table D in Appendix 1 provides a breakdown on the type of harm that led to death).

The National Hub for Reviewing and Learning from the Deaths of Children and Young People (the National Hub) was established in October 2021. It aims to ensure that the death of every child in Scotland is subject to a quality review. The National Hub guidance promotes collaboration between agencies and organisations to reach a decision about the most suitable review process.

Since the launch of the National Hub, we received notifications that learning reviews were going to be undertaken because of the deaths of three children and young people. For two other children who sadly died, the decision was made not to undertake a learning review. None of the learning review notifications involved children or young people who were looked after or in receipt of aftercare support or continuing care when they died.

Some focus group participants commented that the process, following the death of a looked after child can be confusing and is a complex area. The Care Inspectorate issued guidance on this, along with a Scottish Government statement. Regulation 6 (Looked after Children (Scotland) Regulations 2009) still applies, but in many cases the death of a looked after child review could be conducted as a multi-agency review.

We are mindful that local governance arrangements are in place which determine the most appropriate and proportionate approach to review a child death for the national hub. Learning reviews will be one of the review mechanisms considered when the criteria have been met. The local arrangements are in the early stages of development, and it will be interesting to further explore the decision-making processes and the dissemination of learning, locally and nationally, once the arrangements are more established and embedded.

Conclusion

As expected, there have been some challenges in the transition from the 2015 national significant case review guidance to the 2021 national learning review guidance. These relate mainly to adapting to the new process, administration, and governance.

CPCs have been able to identify strengths of the learning review approach. They have acknowledged that there are opportunities to learn from each other through the community of practice that was set up to support CPCs undertaking reviews. There has not been extensive use of all the materials in the guidance's appendices or in the supplementary resources pack [4]. These include information for families and carers, and examples of a learning review report, action plan template and seven-minute briefing. However, those that used them considered them to be beneficial.

Unsurprisingly, themes that have emerged within this timeframe are familiar. CPCs continue to identify recommendations and actions to support improvement. Within the learning review approach there is a change in language and 'suggested strategies for improving practice and systems' replaces 'recommendations' in the report template. These identify the case for change, are learning orientated, evidence based, and assign responsibility. We look forward to exploring the effectiveness of strategies and action plans in terms of dissemination of learning, in more depth when there are more completed reports available.

The national learning review guidance is in its first year of implementation. To support this a learning review community of practice has been set up for those involved in the process enabling opportunities to share information and provide support and guidance. In addition to this, a short-term implementation group has been formed. This is to undertake detailed implementation planning as local areas engage with the guidance. We anticipate that these, along with the Care Inspectorate's quarterly updates to CPCScotland will raise awareness of the learning about the process at this early stage and provide opportunities to share learning and experiences. Together we will be gathering information that will help inform our next annual national overview report.

[4] National Guidance for Child Protection Committees Undertaking Learning Reviews: Resources

Appendix 1 - Data tables ICRs, SCR, and Learning Reviews

This appendix compiles data drawn from a collation of information from SCRs, ICRs and notifications of the decisions on whether to proceed to a learning review. In some instances, we have been able to highlight comparisons between the processes.

Table A below gives a breakdown comparison of the total number of notifications received between 1 April 2021 and 31 March 2022. It also gives a breakdown of the numbers proceeding to a SCR or learning review.

Table A

Year of notification	Total notifications	ICRs not proceeding	ICR proceeding to SCR	LR not proceeding	LR proceeding
1Apr 2020 - 31 Mar 2021	**22**	**13**	**9**	**N/A**	**N/A**
1Apr 2021– 31 Mar 2022	**27**	**11**	**2**	**5**	**9**

Table B: Trend information - total number of notifications

Year of notification	Total number of notifications	ICRs – not proceeding to SCR	ICR proceeding to SCR	LR notifications not proceeding	LR notifications proceeding
2015	22	12	10	N/A	N/A
2016	27	14	13	N/A	N/A
2017	26	13	13	N/A	N/A
2018	32	20	12	N/A	N/A
2019	32	21	11	N/A	N/A
2020	22	12	10	N/A	N/A
2021 (from 1 April)	19	11	2	2	4
2022 (up to 31 March)	8	N/A	N/A	3	5

Table C: Breakdown of non-fatal cases (number of children)

Type of harm	Number of children/young people subject of SCR	Number of children/young people subject of ICR ONLY	Number of CYP where notification of LR
Neglect	5	1	1
Physical	0	1	0
Sexual abuse/child sexual exploitation	0	0	1
Non – accidental injuries	0	2	2
Lack of parental care	0	0	1
Multiple abuse indicators	0	0	6
Breach of trust	0	0	1
Total	**5**	**4**	**12**

Table D: Breakdown of causes of deaths (number of children)

Type of harm	Number of children / young people subject to SCR	Number of children / young people subject to ICR ONLY	Number of CYP where notification of LR
Sudden unexpected death in infancy or childhood (SUDI/SUDIC)	0	1	0
Suicide	3	1	2
Neglect – child died	1	0	0
Drug related death	1	0	0
Physical injury	1	0	0
Accidental/misadventure	0	0	1
Health-related condition	0	4	0
Medical condition and impact of neglect	0	1	0
Unascertained	1		2
Total	**7**	**7**	**5**

Appendix 2 - Learning Review Notification Data

We compiled the following information from the learning review electronic notifications we received since July 2021

Introduction:

Between July 2021 and March 2022, the Care Inspectorate received fourteen Learning Review notifications. Nine notifications are proceeding to a Learning Review.

Rationale for NOT proceeding to a learning review

- There was no additional multi agency learning. The initial information gathering, and the analysis was sufficient to answer the raised questions.
- The information gathered reinforced previous identified learning from previous reviews.
- Local learning events
- Alternative Audit/Review instead of learning review.

Table: 1 Has the child died?

	Learning review **proceeding**		Learning review **not proceeding**	
	Frequency	**Percentage**	**Frequency**	**Percentage**
Yes	3	33%	2	40%
No	6	67%	3	60%
Total (notifications)	**9**	**100%**	**5**	**100%**

Table 2: Cause of death

CAUSE OF DEATH	Learning review **proceeding**		Learning review **not proceeding**	
	Frequency	**Percentage**	**Frequency**	**Percentage**
Suicide	1	33%	1	50%
Misadventure	0	0%	1	50%
Unascertained	2	67%	0	0%
Total CYP	**3**	**100%**	**2**	**100%**

Nine learning reviews (that were recorded as proceeding) answered the following question:

Table 3: Which of the criteria for a Learning Review apply? (tick all that apply)

	Frequency	Percentage
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	4	44%
The child is on, or has been on, the Child Protection Register (CPR) or a sibling is or was on the CPR	3	33%
Child is/was looked after (a care experienced child)	2	22%
Young person is / was receiving aftercare or continuing care from the local authority	0	0%
The child's death is by suicide, alleged murder, culpable homicide, reckless conduct or act of violence	1	11%
There is additional learning to gain from a review being held that will lead to improvements in the protection of children and young people	7	78%

(The total percentage may be greater than 100% as multiple responses possible)

Table 4: Was the decision, made between 28 and 42 days of the original referral for a Learning Review, being received?

	Learning review **proceeding**		Learning review **not proceeding**	
	Frequency	**Percentage**	**Frequency**	**Percentage**
Yes	6	67%	4	80%
No	3	33%	1	20%
Total (notifications)	**9**	**100%**	**5**	**100%**

If no, briefly describe the reasons for the delay.

- The date of the scheduled child protection committee meeting was outwith the timescale
- Impact of Covid-19 re response to information requests.
- Staff absences
- Introduction of the new guidance
- Awaiting the outcome of the post-mortem.

Table 5: Is there more than one child subject of the learning review notification?

	Learning review **proceeding**		Learning review **not proceeding**	
	Frequency	**Percentage**	**Frequency**	**Percentage**
Yes	2	29%	0	0%
No	7	71%	5	100%
Total (notifications)	**9**	**100%**	**5**	**100%**

Total number of 20 children and young people are included within 14 notifications

The following questions were answered for 20 children:

Table 6: Age of child

	Learning review **proceeding**		Learning review **not proceeding**	
AGE	**Frequency**	**Percentage**	**Frequency**	**Percentage**
Under one	5	33%	1	20%
1 – 4 years	4	27%	1	20%
5 – 10 years	3	20%	0	0%
11 – 15 years	1	7%	2	40%
16 – 17 years	2	13%	1	20%
Total (children)	**15**	**100%**	**5**	**100%**

Table 7: Gender of child

	Learning review **proceeding**		Learning review **not proceeding**	
GENDER	**Frequency**	**Percentage**	**Frequency**	**Percentage**
Male	9	60%	3 *	60%
Female	5	33%	2	40%
Not known	1	7%	0	0%
Total (children)	**15**	**100%**	**5**	**100%**

***One child transitioning from female to male. Recorded as male.**

Table 8: Ethnicity

	Learning review **proceeding**		Learning review **not proceeding**	
ETHNICITY	**Frequency**	**Percentage**	**Frequency**	**Percentage**
White Scottish	3	20%	4	80%
Other white British	0	0%	1	20%
Other white	1	7%	0	0%
Mixed or multiple ethnic group	2	13%	0	0%
Gypsy/traveller	6	40%	0	0%
Not known	3	20%	0	0%
Total (children)	**15**	**100%**	**5**	**100%**

Table 9: Is / was the child or young person disabled?

	Learning review **proceeding**		Learning review **not proceeding**	
DISABLED	**Frequency**	**Percentage**	**Frequency**	**Percentage**
Yes	0	0%	0	0%
No	15	100%	5	100%
Total (children)	**15**	**100%**	**5**	**100%**

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