Glasgow Public Protection Committees
Learning Review Protocol

December 2021

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Glasgow's Vision

Glasgow's citizens have a right to feel safe and protected. All services have a responsibility to ensure adults at risk and children are safe, and their needs are met. Services will work in partnership with adults at risk, children and young people and their families and communities to achieve this. To fulfil this vision, the committees will work to:

- Ensure strategic leadership and ownership of activity in Glasgow to protect adults at risk, and children and young people
- Improve co-operation between agencies in Glasgow
- Enhance the development and delivery of services in Glasgow

The Adult Support & Protection and Child Protection Committees form the primary strategic planning mechanism for inter-agency public protection work in Glasgow. They are responsible for ensuring that agencies work and act in a co-ordinated way on the prevention, identification and response to abuse. The committees report to the Chief Officers' Group.

Introduction

This Protocol has been updated in accordance with the National Guidance for Child Protection Committees Undertaking Learning Reviews (2021). All references to 'Initial Case Review' and 'Significant Case Review' in earlier policy and guidance documents will be understood as referring to a 'Learning Review'.

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 people.

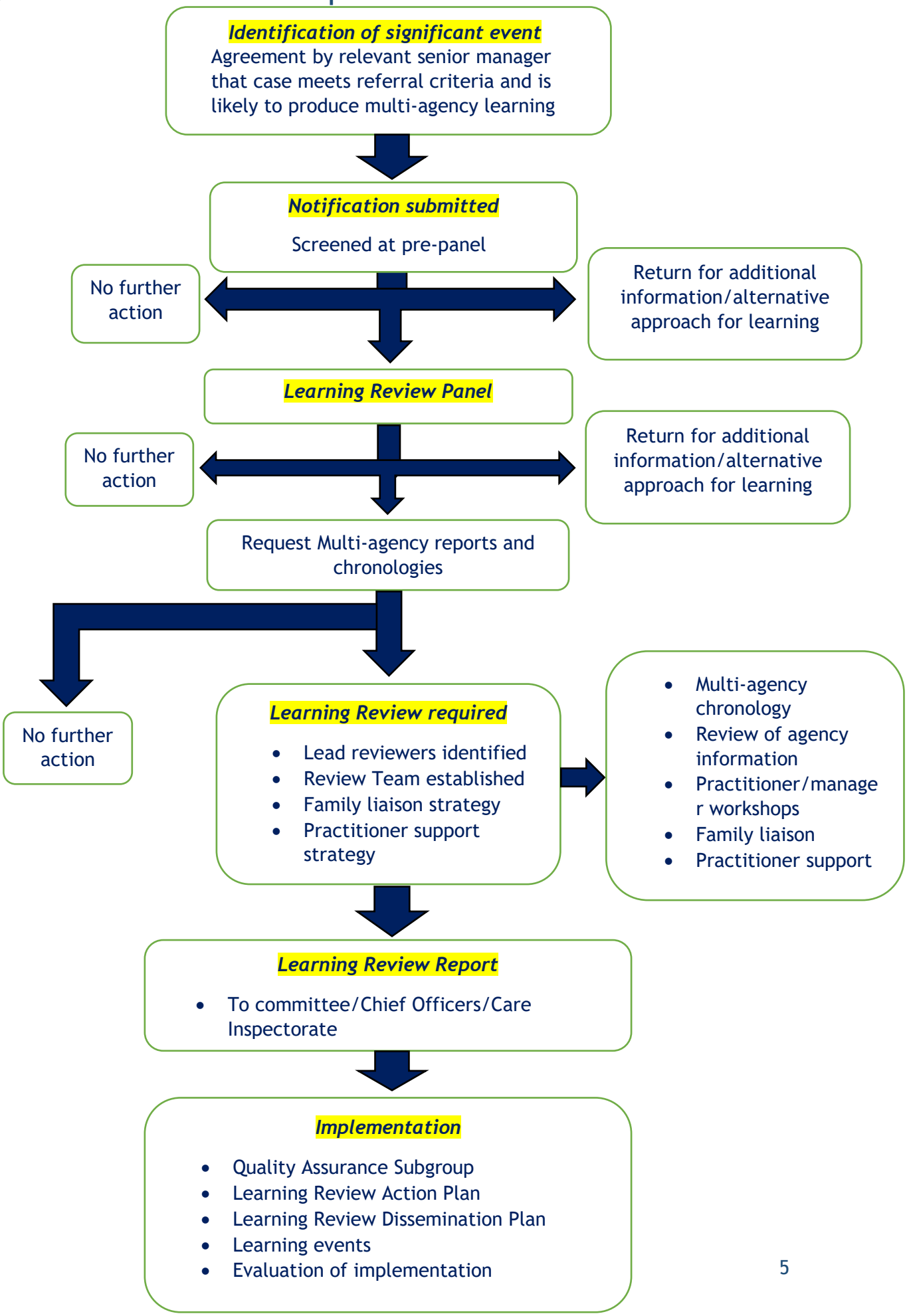
A Learning Review is a multi-agency process for establishing the facts of a situation where an adult or child has died or been harmed significantly, within an adult or child protection context, in order to learn lessons on how to better protect those at risk in our community. They are a critical part of the continuous improvement of practice and processes. The committees are responsible for the commissioning and undertaking of reviews, development of action plans based on the findings of reviews, and overseeing implementation of the action plans.

A Learning Review is not a process for apportioning blame to either individuals or organisations. They are underpinned by the following core principles and values:

- They promote a culture that supports learning
- Their emphasis is on learning and organisational accountability and not on culpability
- They recognise that a positive shared learning culture is an essential requirement for achieving effective multi-agency practice
- They are objective and transparent
- They are sensitive to the needs and circumstances of children and young people and families
- They ensure that staff are engaged and involved in the process and supported throughout the period of the review
- They recognise the complexities and difficulties in the work to protect children and young people 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

Overview of the case review process



Key Features of Learning Reviews

Learning Reviews are not investigations. They are an opportunity for in-depth analysis and critical reflection in order to gain greater understanding of complex situations and to develop strategic and support practice to improve systems across agencies.

The Learning Review 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:

- Establishing the full circumstances of the death/serious harm of the individual
- 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
- Explore any key practice issues and why they may have arisen
- Establish whether there are lessons to be learned or good practice to be shared about the way in which agencies work individually and collectively to protect individuals
- Identify areas for development, how they are to be acted on and what is expected to change as a result
- Identification of learning points and how these will be actioned and implemented in future practice and systems

Criteria for Learning Reviews

The Public Protection Committees will undertake a Learning Review when:

A child or adult has died or has sustained significant harm or risk of significant harm. Significant harm need not be about just one serious incident. In some cases, for example neglect, concerns may be cumulative.

and there is additional learning to be gained from a review being held that will lead to improvements in the protection of children and adults

and one or more of the following apply:

- Abuse or neglect is known or suspected to be a factor in the child/adult's death or the sustaining of or risk of significant harm
- The child is on, or has been on, the Child Protection Register (CPR) or a sibling is or was on the CPR or was a care experienced child (i.e. looked after, or receiving aftercare or continuing care from the local authority). This is regardless of whether or not abuse or neglect is known or suspected to be a factor in the child's death or sustaining of significant harm, unless it is absolutely clear to the Child Protection Committee that the child having been on the CPR or being care experienced has no bearing on the case
- The adult is, or has been, subject to Adult Support and Protection measures
- Where the adult was not subject to Adult Support and Protection measures, but the findings of an inquiry/review by another organisation or court proceedings, or a referral from another organisation gives rise to significant/serious concerns about lack of involvement in relation to the Adult Support and Protection (Scotland) Act 2007

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

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

Parallel or Other Processes

There are a number of parallel processes that may run alongside a Learning Review, for example:

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

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

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.

Where Learning Reviews cross disciplines or local authority boundaries, the relevant Committee Chairs should meet and agree a mechanism for joint working. It will be important that clear channels are identified for how information is shared across

authorities. If the subject of a review is a young person over 18 who was looked after by or receiving continuing care from the local authority, then recognition should be given to their status as an adult.

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

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

If the child or young person who was the subject of the Learning Review has died, then the National Hub requires the completion of the Core Review Data Set.

The Learning Review Panel and Initial Decision Making

Glasgow's Adult Support & Protection and Child Protection Committees have a Learning Review Panel which is chaired by the Chief Social Work Officer or designated Vice-chair (currently the Assistant Chief Officer for Public Protection and Complex Needs). The panel is comprised of representatives of the Health and Social Care Partnership, NHS Greater Glasgow & Clyde, Police Scotland, Education Services, the Crown Office and Procurator Fiscal Service (COPFS), and the Scottish Children's Reporter Administration (SCRA). The role of the panel is to oversee, on behalf of the committees, all matters relating to Learning Reviews. Its key responsibilities are to:

- Examine all evidence available and reach a decision on the level of investigative intervention required, given the circumstances of each case
- Request any additional information necessary in order to reach a decision
- Agree the scope of the review
- Appoint lead reviewers
- Appoint a review team
- Advise and agree to appoint or co-opt specific expertise into the review team to assist with the investigation
- Agree timescales for reporting progress, and provision of intermediary and final reports
- Monitor the progress of the review to ensure actions are undertaken expeditiously and barriers to completion are identified and addressed
- Agree the content of the final report, learning outcomes and recommendations

Any member of a Committee, agency or practitioner can raise a concern about a case which it is believed meets the criteria for a Learning Review. The case must be discussed with the agency's relevant senior manager who will exercise professional judgement as to whether the case is likely to produce multi-agency learning and therefore merits

consideration by the Learning Review Panel, and will quality assure the notification prior to submission. (Annex 1.1 Learning Review Notification)

Notifications will be screened at the pre-panel meeting, chaired by the Assistant Chief Officer Public Protection and Complex Needs and attended by the Principal Officer Child Protection, Service Manager Adult Protection, and Lead Officer Public Protection. The pre-panel group may decide that no further action is required, to return to the referrer for additional information or an alternative approach to learning, or to remit to the Learning Review Panel.

Notifications will then be presented to the Learning Review Panel by the referring agency's representative. The Panel may recommend no further action, to return to the referrer for additional information or an alternative approach to learning, or that multi-agency information should be collated with a view to undertaking a learning review.

The Lead Officer and Committees' Support Team will then:

- Issue a Request for Information template to agencies involved with the child and family or who may support the understanding of the situation (Annex 1.2 Request for information to conduct a learning review)
- Advise of timescales for completion of the template (within 14 calendar days)

After consideration of the gathered data, the Learning Review Panel will then make a recommendation and issue feedback. Recommendations available to the Learning Review Panel are:

- Criteria is met, and a Learning Review will be undertaken
- Criteria has not been met, however some other actions may be required to address learning issues arising from the case
- Criteria has not been met, appropriate action has already been taken and therefore no further action is required.

The Learning Review Panel reports details of recommendations and the underpinning reasons to:

- The relevant Public Protection Committee
- The Chief Officers' Group
- The Care Inspectorate

Learning Review Process

Review Team

When a decision has been made to proceed to a Learning Review the first step is to set up a Review Team. It is important to ensure that each agency's specialist knowledge and issues are understood. No-one should be involved in a review team if they were directly involved in the case. Each member of the review team will be the key contact for their agency; therefore they will need to be able to advise on, and broker access to, relevant practitioners and information. There is supplementary guidance on the attributes, skills, experience and knowledge required of Review Team members in Annex 5 of the national guidance. Some of the skills required in the review team are:-

- A broad knowledge of children's/adults' services
- Investigation skills
- Analytical and evaluation skills
- The ability to consider the wider impacts for practice and service delivery
- The ability to liaise with others and establish good working relationships
- A sensitivity to national and local issues

Lead Reviewers

The panel needs to ensure that the lead reviewers and review team, between them, have the necessary skills and competencies to undertake a Learning Review. The lead reviewers will, in the main, be drawn from committee members or other senior managers in the agencies represented on the committees.

Skills and qualities of a Lead Reviewer include:

- No preconceived views of the case/outcome
- A broad knowledge of protecting children/adults at risk of harm
- The ability to interpret and analyse complex multi-agency processes and information
- Logical thinking and ability to map out processes
- An understanding of the context in which services are delivered
- Experience of practice at various levels across an organisation
- Risk assessment and management
- Able to challenge constructively

The responsibilities of the lead reviewers are to:

- Work collaboratively and transparently with the Review Team
- Attend the meetings of the Review Team
- Develop Family Liaison and Practitioner Support strategies
- Review and assess all information available to develop a full and multi-faceted understanding of the case
- Interpret and analyse the workings and shortcomings of complex, multi-agency systems
- Establish effective relationships with contributors to the review
- Effectively facilitate group work and manage complex group dynamics
- Facilitate practitioner and manager events so that:
    - Participants understand the purpose of the review as well as the underpinning principles and values of Learning Reviews
    - Trust is established between participants
    - All participants can voice their views in a safe manner
    - Discussion, debate, probing, and constructive challenge are encouraged
- Use a range of participatory and creative approaches to obtain the views and experiences of children, young people, and their families
- Pull together the learning and write the report, with the assistance of the rest of the Review team

Collecting and collating further information

The preparation of single agency chronologies is an important first step in the collection and collation of further information. The decision about how far back to go in terms of the

timeframe preceding the incident will 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

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

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

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

Review Team Meetings

Regular meetings of the Review Team should be scheduled throughout the course of the Learning Review. The overall purpose of these meetings is to review the progress of the review, identify the emerging learning, highlight issues and questions for further exploration, set out the next steps and allocate tasks. The focus of each Review Team meeting will differ depending on the stage in the review process.

Engaging the Family in the Review Process

A Learning Review is a collective endeavour to bring together agencies, individuals, and families to learn from what has happened in order to better protect children and young people in the future. The family are integral to Learning Reviews, therefore the Review Team must consider how to involve them in the process in a meaningful and sensitive way.

The individual/family/carers should be kept informed of the various stages of the review as well as the outcomes, where appropriate. There will be occasions where they are subject to investigation or will otherwise have triggered the Learning Review. In these instances, information may need to be restricted therefore close collaboration with Police Scotland, COPFS and (for a child) SCRA will be vital.

There may also be cases where families are considering taking legal action against an agency or agencies. This does not fall within the scope or remit of the protection committees or the review team and should be dealt with by individual agencies under their existing procedures.

Learning Review reports should record whether they were informed and/or involved and, if not, the reasons for that decision. The review team should always consider if any additional supports are required to enable individuals/families/carers to understand and participate in the review process, e.g. the use of advocacy services or interpreters, accessibility issues. It may be useful to assign a member of staff as a single point of contact for families throughout the review.

Families and others involved in Learning Reviews may well be suffering from trauma. There is a commitment to ensuring that Scotland has a workforce that is fully aware of the

impact of trauma, and is equipped to respond appropriately to people who have experienced trauma at any age Scottish Government - a trauma-informed workforce.

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.

Involving Practitioners and Managers

The case group will be comprised of the practitioners and managers who were/are actively involved with the case. During the review process, staff should feel informed and supported by their agency. Each agency must have processes in place to ensure their duty of care is met in this regard.

Consideration must be given to any parallel processes in which staff may be involved relating to the case, for example, disciplinary proceedings.

During the course of the review, concerns may emerge regarding staff conduct in the case. Should this occur, the agency representative on the review team should convey this information to the appropriate manager in their organisation.

Case group members may be interviewed on an individual basis, or as part of a group workshop/discussion. There is guidance available exploring how to facilitate and shape events for practitioners and first line managers and strategic managers Annex 6 of the national guidance. The case group should be:

- Aware of the purpose and scope of the review
- Informed of the process of the review
- Advised of welfare support available to them
- Informed of the progress of the investigation
- Debriefed on the conclusion and findings of the review before the report is published

The Report

It is the responsibility of the Lead Reviewer to pull together the learning and draft the report, this should be done alongside the Review Team.

The report content should cover:

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

If not already included in the report, appendices should be attached which detail review team membership and remit, the multi-agency chronology, and sources of information, e.g. files accessed and people interviewed.

Alongside the full report, an executive summary should also be produced. This provides a brief, anonymised account of the case and agency involvement. Chronologies should not be included. Analysis of the key events has to be sufficient to allow context for the findings and learning points, but a balance has to be struck to ensure confidentiality issues are respected.

Using the findings and recommendations of the report, the review team will then draw up an action plan which seeks to address any issues identified, and improve practice, systems, and processes across the city.

Dissemination and Publication

For each Learning Review, the Committee – in conjunction with the Chief Officers' Group – should have a dissemination strategy that best serves the public interest and the purpose of improving service delivery. The following points should be considered:

- Timing
- Involvement of all agencies, including frontline practitioners
- Ensure any identified good practice is shared as part of the learning
- Sharing learning with other committees, the Care Inspectorate and the Scottish Government

It is for the Committee – with Chief Officers' approval – to decide whether to publish the full report or the executive summary. Factors influencing this decision will be sensitivities and balancing interests in terms of the right to private family life, data protection issues, and the need to increase public confidence in services. If the report contains any identifiable personal information, this should be anonymised before publication. It is imperative that the individual's right to privacy and right to be protected is paramount. The individual and/or family/carers should receive a copy of the report in advance of any publication unless they are subject to any criminal proceedings in respect of the case. Publication of the report may require to be delayed until the conclusion of criminal or Fatal Accident Inquiry proceedings.

Communications and Media Handling

The Learning Review report is a document intended for shared learning, and therefore requires a communication strategy. Each report should be assessed on its own merits, however the following should be considered when developing a communication strategy:

- All partner agencies should be involved in the development of the strategy and a lead agency identified
- Each agency should prepare its own press and legal guidance which aligns with the overall strategy
- The strategy must include plans for briefing all relevant persons/organisations, taking account of the sensitivities of the information and data protection legislation
- The method and timing of communication with individuals/families/carers and staff involved in the review

Most agencies will have their own communication officers and any protocols/handling issues should be developed in conjunction with them before the report is made public. The committees should:

- Agree who will link with the media on behalf of the Chief Officers/committee
- Brief the relevant communications officer(s)
- Approve the wording of any statements to the media

No information about a Learning Review should be released to the media unless it has been approved by Chief Officers and the relevant Committee.

Implementation and Monitoring of Learning

The Adult and Child Protection Committees have a dissemination process which ensures that single- and multi-agency learning outcomes are actioned by the relevant agencies and reported to the committee on a six-monthly basis. The reporting process will be monitored by the Quality Assurance Subgroup. Each agency should have a named lead person within their agency who is responsible for:-

- Prioritising action points/tasks
- Ensuring appropriate action is taken, whether singly or in partnership with other agencies
- Ensuring that six-monthly reports to the committee are completed and forwarded to the Quality Assurance Subgroup in the first instance

The Quality Assurance Subgroup will monitor the contents of the report, the effectiveness of the multi-agency process and the progress of the learning outcomes and report to the committee accordingly.

Governance of Learning Reviews

Chief Officers must ensure that their Adult and Child Protection Committees are properly constituted and resourced in order for them to discharge their duties, including Learning Reviews, effectively. Governance of the Learning Review process and ownership of the final report sit with the Adult and Child Protection Committees, and the Learning Review Panel manages and has oversight of reviews on their behalf.

Learning Review Annexes

1.1 Learning Review Notification
1.2 Request for information to Conduct a Learning Review
1.3 Learning Review Recommendation
1.4 Learning Review Decision
1.5 Learning Review Notification Response
1.6 Learning Review Report

2.1 Learning Review Notification to COPFS

Learning Review Supporting Documents

Learning Review Information Log

Family Liaison Strategy

Information Leaflet for Families

Letter to Family/Carers

Practitioner Support Strategy

Letter to Practitioners

Self-care Resource for Practitioners