DUMFRIES & GALLOWAY

PUBLIC PROTECTION COMMITTEE

Undertaking Learning Reviews (Children and Adults) Local Guidance

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Contents

Section One - Introduction

1. Audience

1.1. This guidance is primarily intended for members of the Public Protection Committee (PPC), Chief Officers' Group (COG) and any member of staff involved in a Learning Review in Dumfries and Galloway. However, it should also be read and understood by a wide multi-agency audience.

1.2. Protecting children, young people and adults at risk of harm is an inter-agency and inter-disciplinary responsibility. In Dumfries and Galloway, PPC have delegated this responsibility to the Learning Review Group (LRG)[1]. The LRG make a recommendation to the COG on how to proceed. The COG then decides whether a Learning Review is warranted and agree how the review is conducted.

2. Purpose

2.1. The overall purpose of a Learning Review is to bring together agencies, individuals and families in a collective endeavour to learn from what has happened in order to improve and develop systems and practice in the future and thus better protect children, young people and adults at risk of harm. For children and young people, 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).

3. Context

3.1. In 2017, a report[2] to the Scottish Government made recommendations to strengthen its learning culture by moving "beyond apportioning blame to learning together about what is helping and what is hindering efforts to help children'. The Scottish Government fully adopted the recommendations which led to the development of "National Guidance for Child Protection Committees Undertaking Learning Reviews" published in September 2021, revised in June 2024. In May 2022, "National Guidance for Adult Protections Committees Undertaking Learning Reviews" was published. It was aligned with the Child Protection Learning Review Guidance and therefore reflects a strong emphasis on learning from practice.

3.2. The COG should be advised by the Chair of the PPC/LRG of any circumstances that should be considered in respect of warranting a Learning Review. Once agreed that there is a need to undertake a Learning Review, the LRG should consider and agree how the review is to be undertaken, who should lead the review, and ensure that appropriate communication of the circumstances has taken place in respect of key contacts. Once a Learning Review is concluded, all findings and recommendations should be considered by the COG.

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[1] LRG consists of the Chair and Vice Chairs of PPC

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

4. Definitions

Definition of a Child

4.1. For the purpose of this document a child is a person under the age of 18, although there may be exceptions for care leavers up to the age of 26 who were in receipt of aftercare or continuing care at the time of the incident that led to a Learning Review Notification.

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

Definition of an Adult at Risk of Harm

4.3. The Adult Support and Protection (Scotland) Act 2007 refers to an "adult" as a person aged 16 or over, and Adults at Risk of Harm are defined as those adults who:

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

4.4. Paragraph 14.1 refers to Learning Reviews which involve a 16 or 17 year old person.

Section Two – Key Features of a Learning Review

5. Key Features

5.1. The key features of a Learning Review are:

I. **Inclusiveness, collective learning and staff engagement**

A Learning Review should be multi-agency; bringing practitioners, managers and others relevant to the circumstances 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. **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 Timeliness**

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.

6. Underpinning Principles and Values

6.1. 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 the subject person and their families.
- They ensure that staff are engaged and involved in the process and supported throughout the period of the review.
- They recognise the complexities and difficulties in the work to protect children, young people, adults at risk of harm, and to support families and carers.
- They produce learning which can be disseminated, both at local and national level, so it directly impacts on and positively influences professional practice and organisational systems.

7. Creating the Preconditions for Learning

7.1. Learning Reviews are not investigations. They are 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.

7.2. Reviewing complex situations can raise anxiety in individuals. 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 anxieties.

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

8. Criteria for Undertaking a Learning Review

8.1. The Public Protection Committee will undertake a Learning Review in the following circumstances:

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

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

and one or more of the following apply:

- abuse or neglect is known or suspected to be a factor in the child's sustaining of or risk of significant harm
- the child is on, or has been on, the Child Protection Register (CPR) or a sibling is or was on the CPR or was a care experienced child (i.e.

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

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

When a child has died

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

and one or more of the following apply:

- abuse or neglect is known or suspected to be a factor in the child's death or the sustaining of or risk of significant harm
- the child is on, or has been on, the Child Protection Register (CPR) or a sibling is or was on the CPR or was a care experienced child (ie 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 Public 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 CARM processes
- the child's death is by suicide, alleged murder, suspected culpable homicide, reckless conduct, or act of violence.

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

a) harm or neglect is known or suspected to be a factor in the adult's death;
b) the death is by suicide or accidental death;
c) the death is 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.

Where the adult who died or sustained serious harm was not subject to adult support and protection processes

(i) When the findings of an inquiry or review by another organisation or court proceedings, or a referral from another organisation gives rise to reasonable cause for concern about lack of involvement in relation to the Adult Support and Protection (Scotland) Act 2007.

Or

(ii) The Public Protection Committee determines there may be learning to be gained through conducting a Learning Review.

8.2. 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, young people, and adults at risk of harm.

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

9. Parallel or Other Processes

9.1. Learning Reviews are one of the many processes that exist to support continuous improvement. Depending on the circumstances, there could be a number of other processes to be considered and may include (this is not an exhaustive list):

- Local Authority report on the death of a looked after child
- NHS Significant Critical Incident or Significant Adverse Event Reviews
- Drug Related Death Review
- Fatal accident inquiries (FAI)
- Police investigations.
- Report of death to the Procurator Fiscal
- Ongoing criminal proceedings
- Independent investigations by the Police Investigations and Review Commissioner
- Death-in-prison learning audit and review held jointly within two weeks of a death in custody by the Scottish Prison Service and NHS
- Multi-Agency Public Protection Arrangements (MAPPA)
- Mental Welfare Commission Review
- Scottish Children's Reporter Administration (SCRA) – ongoing proceedings (possibly involving a children's hearing or court) following referral to the children's reporter
- 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

9.2. Where an individual is subject to police investigations, court proceedings or proceedings following referral to the children's reporter, these should not inhibit the setting up of a Learning Review nor delay immediate remedial action being taken to improve services. The COPFS and Police Scotland have a protocol which recognises that criminal proceedings can be managed simultaneously (see Annex 2 of National Guidance (CP) or Annex 7 of National Guidance (AP)

9.3. In all other circumstances, 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 LRG will discuss the most appropriate review type and sequence with the body responsible for the parallel process.

9.4. The priority is that the person is, and remains safe, regardless of other ongoing investigations (including criminal investigations).

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

10.1. 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. See Annex 3 of National Guidance (CP).

10.2. Child deaths in Dumfries and Galloway are reported to the Child Death Review Hub via a central mailbox (dg.adverse-incidents@nhs.scot). If a Child Death Review is undertaken, it is completed within 90 working days from the date of notification of the death and a completed dataset is submitted to the National Hub (Healthcare Improvement Scotland).

Section Three – Initiation of a Learning Review: The Decision-Making Process

11. Initiation of a Learning Review: The Decision-Making Process

11.1. Any member of the PPC, agency or practitioner can raise a concern about circumstances which it is believed meets the criteria for a Learning Review. The concern should be discussed with the Multi-Agency Safeguarding Hub (MASH) Managers and the appropriate Public Protection Lead Officer.

11.2. Where a child or young person dies, early discussion is important to consider and agree the most appropriate review process. When considering a Learning Review which relates to the death of a child, PPC should consult with the Child Death Review Group to ensure that duplication is minimised.

11.3. Where the criteria for Learning Review is met, the reporting agency should submit a notification form 1.1 to PPC at the earliest opportunity via the relevant Public Protection Lead Officer (Sandie.Donald@dumgal.gov.uk for adults and Clare.Cowan@dumgal.gov.uk for children) and copied to the Learning Review Co-ordinator via email to Learning.Review@dumgal.gov.uk.

11.4. National Guidance[3] suggests that the timeframe for the initial decision-making process is 28 to 42 days from receipt of a notification. This will vary depending on the situation being considered. However, timeliness is important, so that any learning arising is relevant to the current practice context.

11.5. On receipt of a notification the Public Protection Lead Officer and/or the Learning Review Co-ordinator will liaise with the Chair of the Initial Learning Review Panel (ILRP)[4] to agree which agencies should be contacted for further information. This discussion should take place within 2 working days of receipt of the notification. At this time, the Chair of ILRP and the Lead Officer will agree the date for the ILRP, which will be within 28 calendar days of receipt of the notification.

11.6. The Learning Review Co-ordinator will request further information from agencies involved with the person and their family using form 1.2 to be returned within 14 calendar days of receipt of the notification.

11.7. 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 make that decision. It will include a brief account of agency involvement prior to the event which triggered the notification and some very initial reflection regarding practice and decision-making within that agency.

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[3] Where reference is made to "National Guidance" without a CP or AP qualifier, the information is the same for both versions of National Guidance.

[4] The Initial Learning Review Panel (ILRP) consists of senior management from across the Public Protection Partnership, the relevant Lead Officer, and any other person considered appropriate by the Chair and Lead Officer.

11.8. After consideration of the gathered data the ILRP will meet to make a recommendation to the Learning Review Group (LRG) as to whether or not to proceed with a Learning Review.

11.9. The LRG will meet within 28 calendar days following receipt of a notification to consider the recommendations from the ILRP. The LRG will then decide whether or not to recommend to the COG to proceed with a Learning Review.

11.10. The LRG Chair will inform COG of the recommendation about whether to proceed with a Learning Review or the reasons for not doing so[5]. The final decision on whether or not to proceed to a Learning Review sits with the COG.

11.11. The referrer will be notified of the COG decision using form 1.3 within 42 calendar days of receipt of the notification.

11.12. The Learning Review Co-ordinator will inform Care Inspectorate of the final decision via an online form: Learning Review Decision Notification Form – Adults (office.com) or Learning reviews (children and young people) (careinspectorate.com)

11.13. If the decision is to go ahead with a Learning Review, a Review Team will be established, and a Reviewer will be appointed within 14 calendar days of COG decision.

12. Potential Media Interest

12.1. The COG and PPC will consider whether there is likely to be media interest at any stage in the review process and, if so, strategies for dealing with this will be prepared. See Section 3 of National Guidance for more information.

13. Cross-Authority Circumstances

13.1. When there is a potential cross-authority Learning Review within Scotland, the relevant PPC Chairs should meet and agree a mechanism for joint working, including which PPC 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.

13.2. For authorities outside Scotland, the PPC Chair should meet with the relevant Chair of the Safeguarding Adults and/or Children's Board, or equivalent to agree a mechanism for joint working. Any cross-border Learning Review should include an examination of how cross-border placement of high-risk children and young people can be supported in the future.

13.3. 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. The PPC Chair should decide how the review will be conducted and who will take the lead.

[5] In line with Scottish Government (2019), Protecting Children & Young People - Child Protection Committee and Chief Officer Responsibilities, section 2.9.

14. Links Between Services for Children and Adults

14.1. When a Learning Review involves a young person over 16, the LRG will determine which is the most appropriate service to lead the Learning Review and will consider relevant membership of the Review Team.

15. More than one child

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

16. The Learning Review and other formal staff processes

16.1. 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 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.

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

17.1. 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 LRG gives consideration to what might be learned and how that learning can be disseminated to the multi-agency workforce.

17.2. Whatever approach is used to access reflective learning, they are all part of a continuous programme of learning and development and should be considered as part of the Learning Review process. They must 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. Learning points for a Learning Review should be aligned to the quality indicators set out in the Care Inspectorate - A Quality Framework for Children and Young People in Need of Care and Protection (2022) or Care Inspectorate- Quality Indicator Framework for Adult Support and Protection.

Section Four – Undertaking the Learning Review

18. A Systemic Approach

18.1. All Learning Reviews must adopt a systemic approach which goes beyond individual or professional practice to explore underlying systemic factors, the links with organisational factors and the wider contexts.

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

18.3. Section 4 of the National Guidance sets out the components of an effective systemic model.

19. The Learning Review Group (LRG)

19.1. When a decision has been made to proceed to a Learning Review the LRG will co-ordinate the identification and engagement of the relevant partners and suitable contributors to the Learning Review. They will ensure that a clear and realistic timetable for the review process is set out and is adjusted where and when needed.

20. The Review Team

20.1. The Review Team manages the whole process of the review and is a multi-agency group whose members should have a working knowledge of the relevant services involved in supporting children and families (including child protection and adult services) or adults at risk or harm. Good practice and sound governance dictate that, as far as possible, Review Team members have no direct involvement in the situation under review.

20.2. 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 review 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.

20.3. It is the Review Team's responsibility to ensure the Learning Review remains proportionate and focussed and is conducted in accordance with the underpinning principles and values.

20.4. The Review Team works together within a culture of collaborative problem solving to review and assess all information available; clarify issues for further exploration and to identify any gaps or deficiencies in the information available to the review. The Review Team brings to the task the ability to reflect; to analyse and to look at the wider impact for practice and service delivery.

20.5. The Review Team consists of the separate roles of:

- team members
- the Reviewer
- the Learning Review Co-ordinator

21. The Role of the Review Team members

21.1. 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.

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

- Attend the meetings of the Review Team.
- Meet with family members alongside the Reviewer as appropriate.
- 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.
- Attend practitioner and manager events alongside the Reviewer.
- 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.

22. The Role of the Reviewer

22.1. 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.

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

- Work collaboratively and transparently with the Review Team Members.
- Chair the meetings of the Review Team.
- Review and assess all information available to develop a full and multi-faceted understanding of the circumstances.

- 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
- Ensure the review process has a consistent person-centred perspective throughout.
- Use a range of participatory and creative approaches to obtain the views and experiences of children, young people, adults at risk of harm and their families.
- Pull together the learning and write the report, with the assistance of the rest of the Review Team.
- Provide regular updates to PPC and/or COG as required.

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

23. The Role of the Learning Review Co-ordinator

23.1. To support and co-ordinate the Learning Review process it is essential that high quality administrative support is in place. The Learning Review Co-ordinator is an important member of the Review Team, and the key aspects of this support role are to:

- Support the Reviewer to identify professionals who will be part of the Review.
- Support the Reviewer to co-ordinate the work of the Review Team.
- Request 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.
- Administer meetings and events that are part of the review, including scheduling Review Team meetings, booking venues, managing some financial arrangements, and supporting with other associated practicalities.

- Prepare handouts, presentations, evaluations and other materials as required.
- Take minutes and notes of Review Team meetings and practitioner and manager events.
- Support the Review Team in the development of communications, including collating, distributing and storing documents and information as required.
- Format and proof-read the final report and executive summary.
- Provide final report to LRG.
- Co-ordinate staff debrief sessions.

24. Skills, attributes, experience, and knowledge

24.1. The skills, attributes, experience, and knowledge associated with the various roles within a Review Team will be dependent on the nature of the Review and the requirement of the Public Protection Committee and Chief Officers Group. Supplementary guidance to support the process of appointment is outlined in Annex 5 of the National Guidance (CP) or Section 4 of the National Guidance (AP).

25. Enabling factors within the wider context

25.1. A supportive COG is an essential enabling factor in ensuring that Learning Reviews are effective and fulfil their purpose. This means the COG 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.

25.2. PPC and COG will negotiate resources needed to support the Learning Review process. 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.

26. Terms of Reference

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

26.2. The final Terms of Reference will be included in the Learning Review report at the completion of the Review.

27. Collecting and collating further information

27.1. The preparation of single agency chronologies[6] 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. If agencies and services have been involved with a person and their family for many years, then a brief summary of that earlier involvement should be prepared.

27.2. 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.

27.3. 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.

27.4. 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.

28. Managing emerging issues and challenges during the Review

28.1. 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 LRG and the COG must be informed.

29. Engaging the person and their family in the Review process

29.1. 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 children, young people and adults at risk of harm in the future. The family are likely to be integral to Learning Reviews. The Review Team must consider how to involve them in the process in a meaningful and sensitive way by developing a Family Liaison Strategy- see Annex 4 of the National Guidance (CP) or Section 4 of the National Guidance (AP).

29.2. 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 the lives of the child or adult. This will include what they found helpful or

[6] Multi-Agency Guidance: Single Agency and Integrated Chronologies

unhelpful and their suggestions for how services could be improved. Their thoughts, opinions and feelings contribute to the overall learning of the review.

29.3. Careful consideration should be given as to who constitutes the family group. This will differ from review to review but may include parents, step-parents, carers, siblings, grandparents, aunts and uncles, the child/young person, the adult at risk of harm, other significant family members, including partners or spouses, close family friends.

29.4. The adult and the child and their families should be informed as soon as possible that a Learning Review is being undertaken and the purpose of that review should be clearly stated. Inviting them to take part in the review must be done sensitively. If there are professionals still involved with the adult or the child's 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. Consideration should be given to the need for any communication aids.

29.5. If the adult or child's family members wish to participate in the Learning Review, then a decision will be made as to who, from the Review Team, should meet with them and where. Usually this would be the Reviewer accompanied by a Review Team member. Where and how to meet will be dependent on the wishes of the person and/or 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.

29.6. 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.

29.7. There will be circumstances where the family/carers could be subject to investigation or have otherwise been involved in the events that led to the Review being commissioned. When this occurs, information may need to be restricted. Close collaboration with Police Scotland, the Procurator Fiscal, and any other relevant agency will be required.

29.8. At the end of the review process arrangements should be made to feedback to the adult and/or family the conclusion of the review, the learning contained within the report, any strategies to improve practice and systems in the future, and whether or not the report will be published. Again, this must be approached in a sensitive manner as the adult and/or family members may not agree with the findings of the Review. Gathering the views on how people found the process of the review itself and their feedback should inform the conduct of future Learning Reviews.

29.9. The feedback may provide validation or reassurance for families, but it may also cause distress or revive painful memories. Support from professionals may need to be available to family members[7].

[7] Knowledge and Skills Framework for Psychological Trauma

30. Involving practitioners, first line managers and strategic managers

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

30.2. 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.

30.3. 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.

30.4. Annex 6 of the National Guidance looks at how to facilitate and shape events for practitioners and first line managers and strategic managers.

31. Review Team Meetings

31.1. 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.

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

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National Trauma Training

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

32. The Report

32.1. 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.

32.2. Dumfries and Galloway Council is the Data Controller for Learning Reviews. They hold the collated Learning Review information and report on their system.

32.3. 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.

32.4. 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.

32.5. The report template (see Annex 1.4) may include the following content:

- 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.

32.6. It is recommended that suggested strategies for improving practice and systems should be CLEAR[8]. This means that:

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

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

32.7. The Learning Review report will be presented to the COG for consideration and sign off. It is recommended that the Reviewer take responsibility for presenting the report. The COG has the final say as to which if any or all recommendations are accepted.

33. Publishing the Report

33.1. The Chief Officers' Group will decide if and when to publish a report, following consideration of the recommendation from the LRG. 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.

33.2. 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.**

33.3. 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. See Annex 2 of the National Guidance (CP) or Annex 7 of the National Guidance (AP) for further information.

34. Timescale for the Learning Review

34.1. 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, and ensuring the learning identified is relevant and helpful to the development and improvement of practice and processes.

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

Section Five – Dissemination and Implementation of the Learning from the Review

35. Implementation of Suggested Strategies

35.1. The Learning Review Sub-Committee will ensure that an action plan is drawn up to support the implementation of the suggested strategies for improving practice and systems identified within the report.

35.2. The PPC will consider the action plan, as well as resource issues that are relevant for the production and progress of the action plan.

35.3. The implementation efforts should use data and evidence to periodically review and evaluate whether or not they have achieved the desired outcome.

36. Dissemination

36.1. The purpose of dissemination at a local level is to clarify what the learning is, what led to that learning, and to explore how that learning can be embedded in practice and systems.

36.2. The PPC will timeously agree arrangements for direct feedback of any identified learning, as well as good practice, and any recommendations to improve practice and systems to those front-line staff and managers, and with those services and agencies who were involved in the Learning Review.

36.3. The Learning Review Co-ordinator will submit the full, anonymised report to the Care Inspectorate.

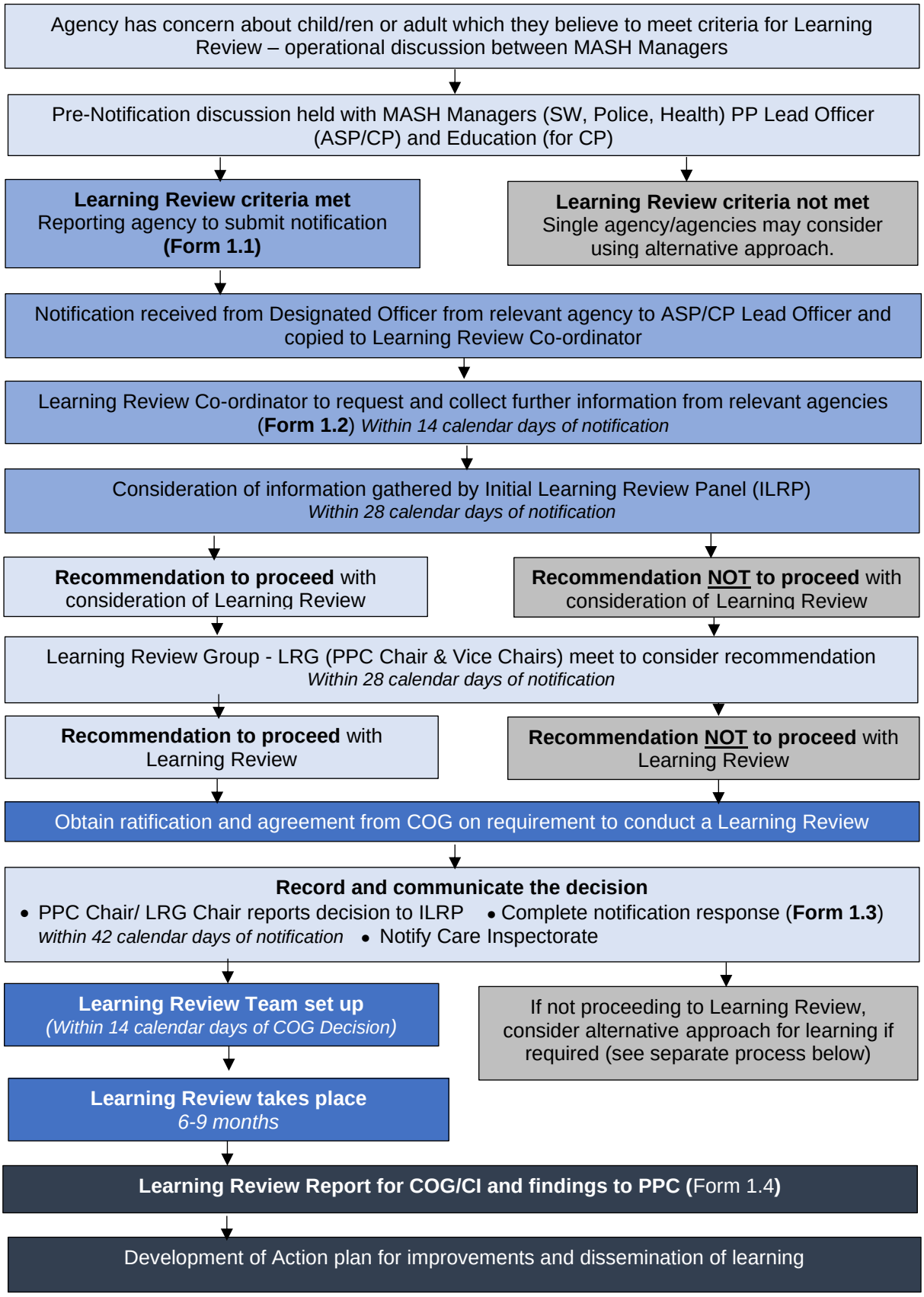
37. The Care Inspectorate

37.1. 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.

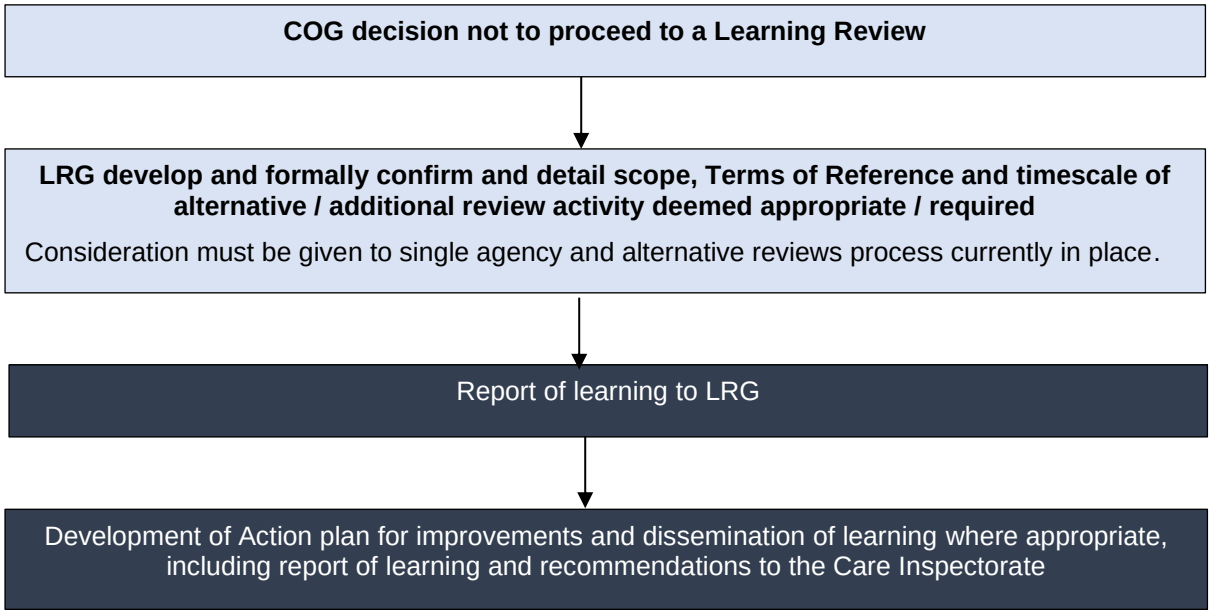
37.2. When the PPC agree an alternative approach for learning, an anonymised report or minutes that record learning and recommendations should be submitted to the Care Inspectorate via secure email to: cistrategicteamnotification@careinspectorate.gov.scot. This will enable the Care Inspectorate to use the learning identified to inform the content of annual national overview reports. The Care Inspectorate will not provide feedback on these types of submissions.

Annexes

Annex 1 - Learning Review Process Map



COG Decision Not to Proceed to a Learning Review and Further Learning Required



Annex 1.1 – Initial Learning Review Notification Template

Initial Learning Review Notification Template

Request from:	
Contact details:	
Agency:	
Date completed:	
Has a multi-agency discussion taken place prior to completion of this form?	
Date multi-agency discussion took place:	
Who took part in the multi-agency discussion? Please provide names and job titles:	
Are there any single agency review processes ongoing/required? Details:	

Any member of the Public Protection Committee, agency or practitioner with an interest in a child or adults wellbeing and safety can ask for the circumstances to be considered by Dumfries & Galloway Public Protection Partnership for a Learning Review if they consider it meets the following criteria.

Criteria for undertaking a Learning Review – Child

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

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

and one or more of the following apply:

- abuse or neglect is known or suspected to be a factor in the child's sustaining of or risk of significant harm
- the child is on, or has been on, the Child Protection Register (CPR) or a sibling is or was on the CPR or was a care experienced child (i.e. looked after, or receiving aftercare or continuing care from the local authority). This is regardless of whether or not abuse or neglect is known or suspected to be a factor in the child's sustaining of significant harm, unless it is absolutely clear to the Public Protection Committee that the child having been on the CPR or being care experienced has no bearing on the case.
- the child's sustaining of or risk of significant harm is caused by attempted suicide, alleged attempted murder, reckless conduct, or act of violence.
- the child is being managed under Care and Risk Management (CARM) processes and causes harm to another person or themselves.

When a child has died

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

and one or more of the following apply:

- abuse or neglect is known or suspected to be a factor in the child's death or the sustaining of or risk of significant harm
- the child is on, or has been on, the Child Protection Register (CPR) or a sibling is or was on the CPR or was a care experienced child (ie 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 Public 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 CARM processes
- the child's death is by suicide, alleged murder, suspected culpable homicide, reckless conduct, or act of violence.

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

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

Criteria for undertaking a Learning Review – Adult

1. **Where the adult is, or was, subject to adult support and protection processes and the incident or accumulation of incidents gives rise for reasonable cause for concern about how professionals and services worked together to protect the adult from harm,** and one or more of the following apply**:**

(i) The adult at risk of harm dies and

- harm or neglect is known or suspected to be a factor in the adult's death;
- the death is by suicide or accidental death;
- the death is by alleged murder, culpable homicide, reckless conduct, or act of violence or

(ii) The adult at risk of harm has not died but is believed to have experienced serious abuse or neglect.

2. **Where the adult who died or sustained serious harm was not subject to adult support and protection processes**

(i) When the findings of an inquiry or review by another organisation or court proceedings, or a referral from another organisation gives rise to reasonable cause for concern about lack of involvement in relation to the Adult Support and Protection (Scotland) Act 2007 or;

(ii) The Adult Protection Committee determines there may be learning to be gained through conducting a Learning Review**.**

For the purpose of this document a child is a person under the age of 18, although there may be exceptions for care leavers up to the age of 26 who were in receipt of aftercare or continuing care at the time of the incident that led to a Learning Review Notification.

Where the referring agency or individual considers that the circumstances meets the criteria above, they should complete and forward this Learning Review Notification form (1.1) to the Public Protection Committee at learning.review@dumgal.gov.uk

(The Referrer can discuss the referral with the Chair and/or the Learning Review nominated person within the PPC (Lead Officer, Adult Support & Protection or Lead Officer, Child Protection).

The decision about whether a Learning Review will be undertaken will be made by the Initial Learning Review Panel after information from services/agencies/individuals who are involved with the child/adult has been submitted and considered using the Learning Review Request for Information form (1.2). The request for information to other services/agencies/individuals will be by e-mail. The referrer will receive a Notification Response form (1.3).

Information For Consideration of an Initial Learning Review

Child/Adult details	
Name/identifier:	
Date of birth:	
Date of death (if applicable):	
Home address:	
Current residence:	
Gender:	
Any other Local Authorities involved:	
Child - current legal status: **Adult**: is/was the adult subject to any statutory powers, e.g. ASP, Adults with Incapacity or Mental Health (Care & Treatment) Act?	
Education establishment details (where applicable):	
Please include key additional factors such as disability, ethnicity, religion:	
Parents'/Carers'/Next of Kin/Guardian/Power of Attorney details	
Names and DOB of parents/carers/Next of Kin/Guardian/Power of Attorney:	
Address and Contact details of the above:	
Child Protection Register (where applicable)	
Is the child's name currently on the Child Protection Register?	
Are any siblings currently on the Child Protection Register?	
Has the child's name previously been on the Child Protection Register? If yes, provide details, including dates.	
Have any siblings previously been on the Child Protection Register? If yes, provide details, including dates.	

Looked After Child (where applicable)	
Has the child been looked after by, or received aftercare/continuing care from local authority? If yes, please give details, including dates.	
Have any siblings been looked after by, or received aftercare or continuing care from the local authority? If yes, please give details, including dates.	

When a Learning Review is being considered for more than one child/adult, please repeat or amend the relevant rows in the table above, making sure to present the information in a clear manner, with adequate differentiation (e.g. using 'parents of Child 1/Guardian of Adult 1' if they differ from the 'parents of Child 2/Guardian of Adult 2')

Criteria for Learning Review	
What grounds within criteria do you consider apply for a Learning Review?	
Immediate and general concerns	
Are there any immediate concerns? If yes: • What are the immediate concerns and have these been passed to the relevant agency for consideration/action? • What action has been taken?	
Are there any general concerns identified during this process of notification? If yes: • What are the general concerns and have these been passed to the relevant agency for consideration/action? • What action has been taken?	
Parallel processes	
Are you aware of any parallel processes for any other type of review being undertaken for this individual/family? If yes, please give details:	
Are you aware of any criminal procedures being undertaken in connection with this individual/family? If yes, please give details:	

Date of significant incident:
Summary of the circumstances: This section should contain a brief summary and analysis of the significant incident or circumstances which support the notification for an Initial Learning Review. (What happened, why we are concerned, and why an Initial Learning Review is required?) (This will be included in the request for single agency reports.)

Name of service/agency/individuals involved with the child(ren)/adult and/or family including non-statutory/Third Sector			
Service:	Role with the child/adult and the family:	Practitioner name and title:	Contact details:

The recommendation is that this notification will be responded to within 28 to 42 days, with the outcome of the nominated person/sub-group within PPC's consideration of whether or not to proceed with a Learning Review.

Annex 1.2 – Request for Information Template

Information for Consideration of a Learning Review

- You have been identified to participate in an Initial Learning Review and are asked to complete this request for information.
- This requires to be completed within 14 calendar days and sent electronically to learning.review@dumgal.gov.uk
- This report is required to contain information outlining your agency/service contact/interaction with the child/adult and family whose details are below.
- Please include a brief account of agency involvement prior to the event which triggered the notification and some very initial reflection regarding practice and decision-making within that agency. If you have historical information, please give a brief summary of the themes and issues you have identified in the background history section.
- **Please complete the Chronology template provided at the bottom of this form. You may find it helpful to complete this first**.

Initial Learning Review identifier:	
Date of the request for information:	

Details	
Name of child/adult:	
Date of birth:	
Date of death (if applicable):	
Date of significant incident:	
Gender:	
Names of parents/carers/next of kin/guardian/power of attorney and dates of birth:	Eg. Janet Bloggs, 12/10/84, Kinship Carer, Residence Order Jimmy Smith, 01/03/61, Son, Power of Attorney
Names of siblings and dates of birth/death (where applicable):	
Home address:	

Current address, if different from above:	
Education establishment details (where applicable):	

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

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

Summary of your agency's involvement with the child/adult:

This should include:

- How long your agency has been involved with the person?
- Overall assessment of the person's needs and circumstances.
- Current services and supports provided.

A Chronology template is provided at the bottom of this form and there is space for more detailed background information in the field below.

Background history:

This should include:

- Person's history and your agency's involvement with them.

Further background information as necessary to support the significant events, dates and responses as identified in the Chronology.

Key practice issues: Please provide your assessment of the following: • recognition and assessment of risk and need in relation to the child/adult • information sharing • strategies and actions to minimise harm • timely and effective action taken • multi-agency responses • evidence of planning and reviewing • quality of record keeping • appropriate use of legal measures • evidence of child/adult centred practice • any good practice identified any areas identified for practice improvement

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

Report completed by:	
Name	
Title	
Agency	
Email address	
Date	

CHRONOLOGY OF SIGNIFICANT EVENTS

Name:

DOB:

Single Agency Reference No: e.g. Mosaic *xxxxx*

CHI No:

Date & Time **Age of the Person**	**Source**	**Name & Role of Practitioner Recording Significant Event**	**Significant Event**	**Event Details**	**Impact**	**Outcome/Actions Taken**
Date of Event *Time* *Child's Age – this is helpful in contextualising historical events and their impact on the child.*	*This is where information comes from e.g. Police, Social Work, the person, their family, etc.*	*Name & Role of who is updating the chronology.*	*Title* *e.g. Birth of child, Domestic abuse; hospital admission; child placed on register; etc.*	*Summary of key points of the event – clearly referencing any key documents of further information which may be in the person's file.*	*Impact can be positive or negative and also in some circumstances not known at time of entry as impact can change over time.*	*What happened?* *Who did you discuss this with?* *What action did you take e.g. Amended care plan; informed others; Referral to MASH; meeting arranged; child referred to Reporter; etc.* *Please reference key documents.* *It is acceptable to put no action was necessary or n/a in this box if there was no follow-on action.*

Annex 1.3 – Initial Learning Review Notification Response Template

Initial Learning Review Notification Response Template

Request from:	
Contact details:	
Referring agency:	
Date of notification:	
Name of child/adult and date of birth:	
Initial Learning Review identifier:	

Thank you for the notification for consideration of an Initial Learning Review. COG has considered the information submitted and have decided:	
	To proceed with a Learning Review.
	Not to proceed with a Learning Review.

Completed by:	
Name:	
Title:	
Date:	
Email address:	

Annex 1.4 - Learning Review Draft Report Template

Dumfries and Galloway Public Protection Partnership

Learning Review Report

RE: [Insert Learning Review Identifier]

Introduction
To include a brief synopsis of the circumstances that led to the review, the age of the person, the precipitating incident and the criteria for a Learning Review.

The Process of the Review
To include: • the constitution of the Review Team including the Reviewer(s) • how many times the Review Team met/level of engagement • details of reviews of records and compilation of chronologies • the length of the review process (and the initial notification date) • the terms of reference and the time-period under review • the Family Liaison Strategy: how were family members/carers involved in the review? Which family members participated? When were they seen? How were they kept informed of the progress of the review? How were their views represented throughout the review? • when the practitioner/ first line manager event was held; how many attended and from what agencies and the shape of the event? • when the strategic manager event was held; how many attended and the shape of the event? • details of any individual meetings with practitioners/ managers/ family members/ carers.

The Circumstances that Led to the Learning Review/the Facts
To include: • family composition, background and circumstances • a brief account of the main events in the family history, a succinct chronology or timeline of significant events • what involvement the child/adult had with professionals and services • details of all significant others in the child/adult's life

Analysis
This section critically assesses the key circumstances, the interventions offered, and decisions made. For example, were the child/adults' circumstances sufficiently assessed, were responses appropriate, were key decisions justifiable, was the relevant information sought or considered and were there early, effective and appropriate interventions. Key issues will be identified, and the reader should be assisted to understand the "why" of what happened in the overall context of, for example, organisational culture, training, policies and resources.

Practice and Organisational Learning
Identify and analyse each area of learning emerging from the review with supporting evidence from the relevant circumstances to substantiate that learning. This section highlights the key learning points from the review. This can helpfully be done by laying out key issues or expectations relevant to the circumstances and then commenting on how these were dealt with in the particular case, for example: *Practitioners should operate in a clear policy strategic context and should be supported by guidance, procedures and processes that promote positive practice.* ➢ *In this situation policy, procedures and guidance relating to the assessment of capacity was not readily accessible to front line workers and was not consistently understood across all agencies.* *For assessment and care planning to be meaningful and robust it needs to be a multi-agency activity, using a range of tools to collect, collate and analyse information, to formulate effective protection plans and to measure change.* ➢ *In this situation some agencies felt they were excluded from some planning meetings where they felt that they would have been able to contribute to a broader understanding of the adult's circumstances and to the development of protection plans.*

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

Suggested Strategies for Improving Practice and Systems
This section contains recommendations for PPC to consider. Any suggested strategies must be CLEAR i.e. • set out the need for change and the likely consequences should no change occur • be learning orientated • be evidence based • assign responsibility – who should do what • be amenable to review In some situations the review may conclude that practice and processes have not failed or been inappropriate and, therefore, at this point, no changes are required.

Signed and dated by:	
Reviewer(s):	
Date:	

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

See Annex 2 of National Guidance (CP) or Annex 7 of National Guidance (AP)

Annex 3 – National Child Death Review and Learning Hub Process Map

See Annex 3 of National Guidance (CP)

Annex 4 – Family Liaison Strategy

See Annex 4 of National Guidance (CP)

Annex 5 – Learning Review Team – attributes, skills, experience and knowledge

See Annex 5 of National Guidance

Annex 6 – Facilitating and Shaping Practitioner and First Line Manager Events and Strategic Events

See Annex 6 of National Guidance