Learning reviews for children in Scotland
Data report for 1 September 2021 – 31 March 2023

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Introduction

The Care Inspectorate became the central collation point for all significant case reviews (SCRs) in 2012 and initial case reviews (ICRs) in 2017. This role continued with the introduction of the National guidance for child protection committees undertaking learning reviews (September 2021) (the learning review guidance). We now receive all learning review notifications and completed reports. In 2022, we published our first annual overview report, covering the transition from ICRs and SCRs to learning reviews.

Evidence base

This report provides an overview of the data from learning review notifications and reports, submitted by child protection committees to the Care Inspectorate. The data in this report covers the period from 1 September 2021 to 31 March 2023. We have also included trend information drawn from previous years' data.

Ten completed learning review reports have been submitted to the Care Inspectorate since the learning review guidance was introduced. This is an insufficient number to comment on any significant themes or trends. We have therefore limited our reporting this year to this data report.

Learning review notifications are part of the process for gathering information to inform the decision whether or not to initiate a learning review. Any member of the child protection committee, agency or practitioner can raise a concern about a case they believe meets the criteria for a learning review and submit a notification to the child protection committee. Once the decision is taken to proceed or not to a learning review, the committee submits the notification and decision to the Care Inspectorate.

Learning review reports

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 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). Once a learning review report has been completed, the child protection committee submits it to the Care Inspectorate.

Criteria for undertaking a learning review

Child protection committees undertake a learning review when a child has died or sustained significant harm or is at risk of significant harm 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. Additional criteria apply and include one or more of the following:

- 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, or a sibling is or was on the child protection register 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 child protection register or being care experienced has no bearing on the case.

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

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

Context

The events that prompt a learning review are invariably tragic, however they affect a relatively small number of children and young people. Around one in five (21%) of the 5.47 million people in Scotland are aged 19 and under. The children who are the subjects of learning review are not necessarily typical of those who fall under the systems and processes designed to keep children safe from significant harm. The Children's Social Work Statistics Scotland: 2021 to 2022 records 11,473 child protection investigations and 4,058 initial and pre-birth case conferences, resulting in 3,210 child protection registrations. As at 31 July 2022, Scotland had 12,596 looked after children; 696 young people in continuing care; and 8,132 young people eligible for aftercare services.

Number of learning review notifications

Notification data collected between 2015 and 2020 was recorded in calendar years. In 2021, we began to record the data in fiscal years, reflected in tables 1 and 2. Table 2 includes data during the period of transition from initial case reviews (ICRs) and significant case reviews (SCRs) to learning reviews.

Compared to the number of notifications received annually since 2015, there has been no significant difference in the number of learning review notifications received in the 19 months to 31 March 2023. There was a slight reduction in notifications during the covid-19 pandemic, but numbers are rising again.

Between 1 September 2021 and 31 March 2023, we received 43 notifications from 19 child protection committees, relating to 59 children. Twenty-six of these noted the intent to proceed to a learning review, while 17 did not. We will continue to monitor the conversion rate from notification to learning review.

Table 1: Trend information - total number of notifications (calendar year)

Year of notification (calendar year)	Total number of notifications	ICRs – not proceeding to SCR	ICR Proceeding to SCR
2015	22	12	10
2016	27	14	13
2017	26	13	13
2018	32	20	12
2019	32	21	11
2020	22	12	10
Average*	**27**	**15**	**12**

* Calculated to nearest integer

Table 2: Initial case review and learning review notifications (fiscal year)

Year of notification (fiscal year)	Total number of notifications	ICRs not proceeding to SCR	ICR proceeding to SCR	Learning review not proceeding	Learning review proceeding
2021/22	27	11	2	5	9
2022/23	29	N/A	N/A	12	17

Demographics of those subject of learning review notifications

The data in the following tables relates to the 59 children for whom a learning review notification was submitted during the period under review. Six notifications involved more than one child.

Twenty-six notifications in respect of 42 children were proceeding to a learning review. Six of the children's names, or the name of a sibling, were or had been listed on the child protection register. Five children were looked after, and two were receiving aftercare or continuing care from the local authority.

The learning review guidance provides criteria to help child protection committees determine the value of undertaking a learning review. Table 3 shows that more than one criterion applied in some of the 26 notifications proceeding to a learning review. The criteria concerned with additional learning are core and should apply to all learning reviews.

Table 3: Criteria applied

Criteria applied	Frequency
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	13
The child is or has been on, the child protection register or a sibling is or was on the register	9
The child is or was looked after (a care experienced child)	6
The young person is or was receiving aftercare or continuing care from the local authority	1
The child's death is by suicide, alleged murder, culpable homicide, reckless conduct or act of violence	2
There is additional learning to be gained from a review being held that will lead to improvements in the protection of children and young people	19

Multiple criteria can apply.

Age of child

At 48%, just under half of children who were the subject of a learning review were under the age of five years. Thirty-five percent of those not proceeding to learning review were 16-17 years old, while almost a quarter were aged 11-15 years. While it is difficult to draw firm conclusions, emerging data suggests that children under the age of five years are more likely to become the subject of a learning review than children or young people in other age groups.

Table 4: Age range of child or young person subject of learning review notification

	Learning review **proceeding**		Learning review **not** proceeding	
Age	**Frequency**	**Percentage**	**Frequency**	**Percentage**
Under one	10	24%	3	18%
1 – 4 years	10	24%	3	18%
5 – 10 years	10	24%	0	0%
11 – 15 years	4	9%	4	24%
16 – 17 years	6	14%	6	35%
Not known or not recorded	2	5%	1	5%
Total (children)	42	100%	17	100%

Gender of child

Males represented around two-thirds of all learning review notifications.

Table 5: Gender of child or young person

	Learning review **proceeding**		Learning review **not proceeding**	
Gender	**Frequency**	**Percentage**	**Frequency**	**Percentage**
Male	30	70%	11*	65%
Female	11	28%	6	35%
Non-binary	0	0%	0	0%
Not disclosed	0	0%	0	0%
Not known	1	2%	0	0%
Total (children)	42	100%	17	100%

*One child transitioning from female to male, recorded as male.

Table 6: Ethnicity of child or young person

	Learning review **proceeding**		Learning review **not proceeding**	
Ethnicity	**Frequency**	**Percentage**	**Frequency**	**Percentage**
White Scottish	21	50%	13	76%
Other white British	1	2%	1	6%
Other white	3	7%	0	0%
Mixed or multiple ethnic group	2	5%	1	6%
Gypsy/traveller	6	14%	0	0%
Not known	6	14%	0	0%
Not disclosed	3	7%	2	12%
Total (children)	42	100%	17	100%

Table 7: Disabled children and young people

Three children and young people who were proceeding to a learning review and two children not proceeding had a reported disability.

	Learning review **proceeding**		Learning review **not proceeding**	
Disabled	**Frequency**	**Percentage**	**Frequency**	**Percentage**
Yes	3	7%	2	12%
No	36	86%	14	82%
Not known/not recorded	3	7%	1	6%
Total (children)	42	**100%**	17	**100%**

Types of harm

Twenty-five notifications related to non-fatal incidents and 18 related to incidents where a child or young person had died.

Table 8: Fatal and non-fatal harm

	Notifications **proceeding** to a learning review		Notifications **not proceeding** to a learning review	
	Frequency	**Percentage**	**Frequency**	**Percentage**
Fatal	7	27%	11	65%
Non-fatal	19	73%	6	35%
Total (notifications)	26	100%	17	100%

Non-fatal incidents

Forty-one children were the subject of the 25 notifications of non-fatal incidents: six sibling groups and 19 individual children. All the notifications involving sibling groups proceeded to a learning review. Table 9 provides a summary of the risks identified in notifications. Neglect remains the most common form of risk.

Table 9: Type of harm

Type of risk	Number of notifications	Number of children	Number of notifications that did not proceed to a learning review
Physical abuse	8	11	2
Substance misuse by parent(s)	3	3	2
Neglect	8	21	2
Risk of harm to self and or others	3	3	1
Sexual abuse	3	3	1
Total	25	41	8

Fatal incidents and cause of death

The National Hub for Reviewing and Learning from the Deaths of Children and Young People was launched in October 2021. Not all children and young people who die become the subject of a learning review. However, the Hub aims to ensure that the death of every child and young person in Scotland is reviewed to an agreed minimum standard. Of the 59 children subject of learning review notifications, 18 had died. Seven of these children and young people became the subject of a learning review.

The causes of death are listed in table 10. The language used reflects what was recorded in the notification. The number of older young people whose death is related to suicide is significantly higher than the other causes of death. This reflects what we reported in our Triennial report of initial case reviews and significant case reviews: impact on practice. [1]

The cause of death for four children was reported as unascertained or not known. At the point of notification, there was ongoing investigation or post-mortem results were pending.

In the 'other' category, one child died as a result of a brain injury and for another, it was not possible to determine if the cause of death was suicide or due to misadventure.

Table 10: Cause of death

Cause of death	Learning review **proceeding**		Learning review **not** proceeding	
	Frequency	**Percentage**	**Frequency**	**Percentage**
Suicide	2	29%	7	63%
Drug related	1	14%	0	0%
Misadventure	0	0%	1	9.5%
Alleged murder	1	14%	0	0%
Not known or unascertained	3	43%	1	9.5%
Other	0	0%	2	18%
Total number of children and young people	7	100%	11	100%

[1] Triennial report of initial case reviews and significant case reviews (2018 – 2021): Impact on practice.

Learning review process

The learning review guidance suggests that an appropriate and realistic timeframe for the completion of the initial decision-making stage is 28 to 42 days. However, it acknowledges that this may vary, depending on the circumstances being considered. Table 11 indicates that this timescale was achieved in about half of cases. One child protection committee had undertaken a learning review when areas of strength across the multi-agency partnership were identified. The committee-highlighted professional empathy, relationship building, communication and valuable working across UK borders.

Effective practice was identified in six of the 10 learning review reports. Areas of effective practice included the commitment of staff; communication between staff; flexibility of support to families; understanding of the child's needs; and the provision of support to families, other children and staff following the death of a child.

Table 11: Decision-making timeline

Decision taken in 42 days or less	Learning review **proceeding**		Learning review **not** proceeding	
	Frequency	**Percentage**	**Frequency**	**Percentage**
Yes	13	50%	9	53%
No	13	50%	8	47%
Total (notifications)	26	100%	17	100%

In some of the notifications we received, multiple reasons for delay were noted. The most frequent reasons for delay were:

- impact of the Covid-19 pandemic
- changes of personnel
- implementation of the learning review guidance
- schedule of child protection committee meetings
- delays due to staff absence or leave
- awaiting the outcome of post-mortem examination
- awaiting information to determine if the criteria were met
- time needed to plan and gather information
- awaiting procurator fiscal agreement to proceed
- initial review to decide about the need for a learning review.

Conclusion

In order to maximise the reach of this report, we have included all learning review reports and notifications submitted since publication of the national guidance in September 2021. As there were only 10 completed learning review reports submitted to us during the period under review, we are not yet able to meaningfully comment on any significant themes or trends. The Care Inspectorate continues to provide quarterly updates to Child Protection Committees Scotland, including a section on the most recent learning review data.

The Care Inspectorate will continue to provide annual data reports. The timing of the next full analytical report will be kept under review and will be largely dependent on the number of completed learning review reports received.

Along with the Centre for Excellence for Children's Care and Protection (CELCIS) the Care Inspectorate continues to facilitate the learning review knowledge hub, sharing learning with national reach. The learning review community of practice continues to provide peer support, learning and direction in implementing the national guidance.

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