Learning reviews for children in Scotland
Data report 2024
Data for period 1 April 2023 – 31 March 2024

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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). The Care Inspectorate now receives all learning review notifications and completed reports. In 2022, we published an overview report, covering the transition from ICRs and SCRs to learning reviews. In 2023, we published our first annual data report for learning reviews.

Criteria for undertaking a learning review

A child protection committee will undertake a learning review in the following circumstances:

When a child has died or has sustained significant harm or risk of significant harm as defined in the National Guidance for Child Protection in Scotland 2021

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 (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 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.

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

Evidence base

This report presents 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 April 2023 to 31 March 2024. Where relevant, we have included trend information drawn from previous years' data.

Eleven completed learning review reports were submitted to the Care Inspectorate during the last fiscal year.

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 situation 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 to a learning review or not, 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 to learn from what happened, in order to improve and develop systems and practice in the future to help 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.

Using the learning into practice quality markers and the learning review guidance as a framework, we have made observations about all 11 reports.

Issues noted in reports included:

- the absence of adequate assessment of family circumstances, despite concerns and length of agency intervention
- limited analysis of information including the impact of parental drug use, mental ill-health and domestic abuse
- information from parents being taken at face value, without evidence or triangulation
- not drawing from and sharing appropriate professional knowledge and expertise.

All 11 reports contained multi-agency recommendations, findings or strategies for improving practice and systems, while some also contained those aimed at single agencies. The number of these ranged from four to 22.

Seven of the 11 reports identified practitioner difficulties in engaging with parents or carers. Some families were difficult to engage with due to their transient nature. Other reports noted disguised compliance and a lack of professional curiosity. Some staff experienced difficulties in managing parental aggression, whilst others found it difficult to balance supporting families with challenging them and holding them to account.

The application of Getting it Right for Every Child (GIRFEC) continued to be a challenge, which was evident in eight of the 11 learning reviews. In some situations, there was no early assessment of children's circumstances until they were considered to reach the threshold for child protection. The GIRFEC continuum did not always ensure that the young person's needs were addressed and that vulnerability and risk were effectively managed. There was some practitioner confusion about how GIRFEC processes sat with statutory responsibilities to looked after children at home. Some assumptions were made by staff about professional responsibilities and actions being undertaken.

Issues in relation to information sharing and professional communication featured in all 11 reports. Information was not always shared timeously. In some instances, partial information was shared, or information was not shared at all between colleagues within the same organisation, or on a multi-agency basis. This meant that records and assessments were incomplete. The outcomes of previous interventions, assessments and decisions were not always recorded. Assumptions were made about what other staff knew and how they would respond.

Identifying and responding effectively to neglect continues to be a feature in learning reviews and was evident in seven out of the 11 reports submitted. Neglect was not identified and responded to early enough, with some children living in neglectful situations for long periods of time. Parental drug use, mental ill-health and domestic abuse were mentioned in some reports, but the impact was not fully explored. We reported similar themes in our previous Triennial report 2018-2021 and our 2023 learning reviews for children data report.

Number of learning review notifications

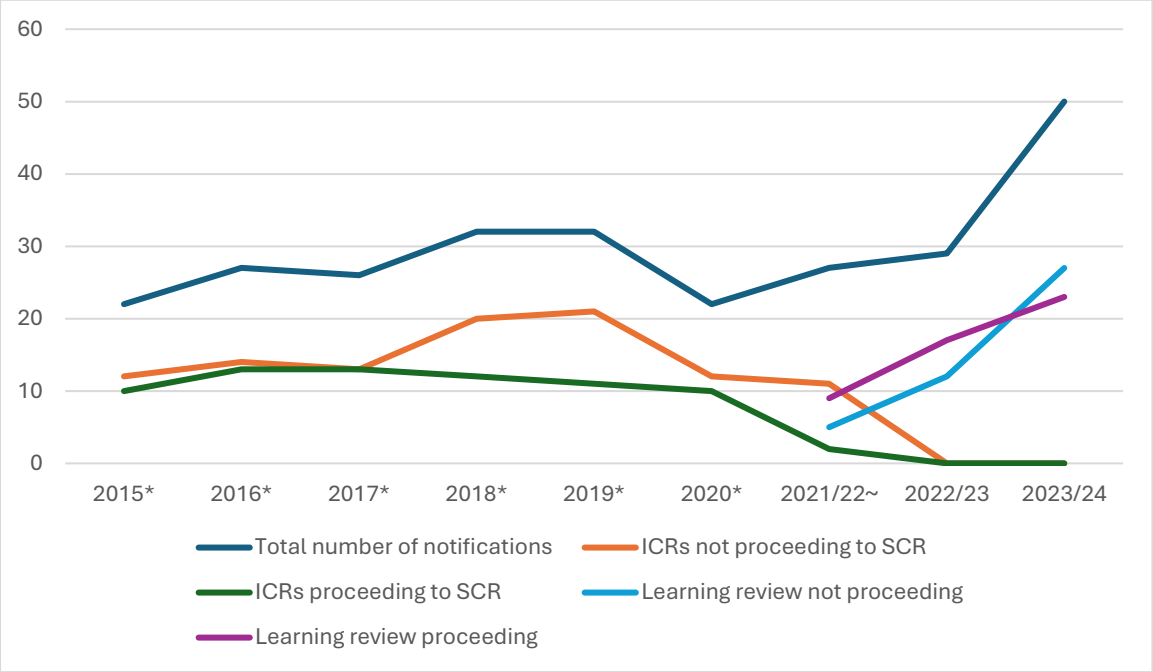
By way of context, the events that prompt a learning review are invariably tragic, however they affect a relatively small number of children and young people. Around one in five (21%) of the 5.47 million people in Scotland are aged 18 and under. The circumstances of the children who are the subjects 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: 2022 to 2023 records 12,077 child protection investigations and 4,120 initial and pre-birth case conferences, resulting in 3,170 child protection registrations. As at 31 July 2023, Scotland had 12,206 looked after children and 8,517 young people eligible for aftercare services. During 2022-23, 911 young people aged 16 years or over ceased to be looked after and were eligible for Continuing Care. Of these young people, 29% (261) entered Continuing Care.

During the year 2023/24, the Care Inspectorate received 50 learning review notifications in respect of 79 children and young people, from 20 child protection committees. As reflected in chart 1, this represents an increase this year, compared with the number of ICR and learning review notifications received annually since 2015. This is also higher that the numbers seen in the 18-months from 1 September 2021 to 31 March 2023, covered in our previous data report. During that period, there were 43 notifications in respect of 59 children from 19 child protection committees.

Notification data collected between 2015 and 2020 was recorded in calendar years. In 2021, we began to record the data in fiscal years. Chart 1 includes data during the period of transition from ICRs and SCRs to learning reviews. The learning review guidance was published on 2 September 2021. ICRs therefore continued to be reported from 1 April to 02 September 2021.

We can see that the number of learning review notifications this year were markedly higher than for the average number of notifications over the previous eight reporting years. However, a higher number of learning review notifications were not proceeding, than for notifications in previous years.

Chart 1: Number of notifications, notifications proceeding and not proceeding



*Calendar year

~Implementation of the National Guidance for Child Protection Committees Undertaking Learning Reviews

Over the last year, twenty-three (46%) of notifications proceeded to learning a review, while in the period from 1 April 2022 to 31 March 2023, 17/29 (59%) of notifications proceeded to a learning review.

Areas of effective practice were identified in all 11 learning review reports submitted. These included:

- the commitment of staff
- tenacity of staff in working with families
- communication between staff

- effective cross-UK border working
- flexibility of support to families
- caring relationships
- understanding of the child's needs
- the provision of support to families, other children and staff following the death of a child.

Criteria applied

The learning review guidance provides criteria to help child protection committees determine the value of undertaking a learning review. Table 1 shows that more than one criterion applied in some of the 23 notifications which proceeded to a learning review. The criteria concerned with additional learning are core and should apply to all learning reviews.

Table 1: 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	16
The child is or has been on, the child protection register or a sibling is or was on the register	11
The child is or was looked after (a care experienced child)	8
The young person is or was receiving aftercare or continuing care from the local authority	3
The child's death is by suicide, alleged murder, culpable homicide, reckless conduct or act of violence	4
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	21

Learning review process

The learning review guidance recognises that there might be some unavoidable delay at any stage in the review process. However, for learning to hold most currency, it is important that the review is completed as soon as possible. Since

publication of the national guidance, until 31 March 2024, the Care Inspectorate has received 21 completed learning review reports from a total of 49 notifications proceeding to a learning review. Eight reports remain outstanding from fiscal year 2022/23 and eight remain outstanding from 1 April 2023 to 30 September 2023. Therefore, accounting for the six-to-nine-month timescale in the national guidance, we would expect to have received a higher volume of completed learning review reports than have been submitted. While we are unable to account for the reasons for delay in all circumstances, child protection committees have informed us that they have experienced delays due to ongoing criminal proceedings, staff absence and the availability of the reviewer and review team.

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 2 shows that this timescale was achieved in less than half of all notifications.

Table 2: Decision-making timeline

Decision taken in 42 days or less	**Proceeding**	**Not proceeding**
	Frequency	**Frequency**
Yes	7	9
No	16	18
Total (notifications)	**23**	**27**

Table 3 shows that multiple reasons for delay were noted in some of the notifications submitted to the Care Inspectorate. The most common reason was delay in the reporting of information, or that further information was required to inform decision-making.

Table 3: Reason for delay in decision-making

Reason for delay	Frequency
Delays in reporting or further information required	**10**
Difficulty in coordinating diaries for key personnel	**4**
Changes in personnel	**4**
Operational pressures	**2**
Schedule of child protection committee or chief officer group	**6**
Complexity of review	**4**
Extended period to engage and support family in review process	**2**
Extended period to engage and support staff in review process	**2**
Liaison with Crown Office and Procurator Fiscal Service	**3**

Demographics of those subject of learning review notifications

The data in the following tables relates to the 79 children for whom a learning review notification was submitted during the past year. Learning reviews proceeded in respect of 49 children.

As noted in table one, 11 of the children's names, or the name of a sibling, were or had been listed on the child protection register. Eight children were looked after, and three young people were receiving aftercare or continuing care from the local authority.

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 79 children and young people subject of learning review notifications, 34 had died. Fourteen of these children and young people became the subject of a learning review. The causes of death are listed in table 4. The language used reflects what was recorded in the notification.

Seven young people completed suicide. None of the notifications submitted for these young people proceeded to a learning review. However, in line with National Hub for Reviewing and Learning from the Deaths of Children and Young People guidance, an appropriate review of these deaths would be required. The method for the review

should be based on muti-agency discussion to agree the most appropriate approach. The outcome data from these reviews should be sent to the Hub for analysis and subsequent reporting.

All three children and young people who died as a result of alleged murder became the subject of separate learning reviews. One of the learning reviews was to be conducted thematically, involving multiple young people unrelated by birth. One learning review was to include the siblings of the child who died.

One thematic learning review was to include four young people with a history of homelessness.

Please note that it in the following tables where percentages are used, these are calculated to the nearest integer and may not total 100%.

Table 4: Cause of death

Cause of death	Learning review proceeding		Learning review not proceeding	
	Frequency	Percentage*	Frequency	Percentage*
Accidental death	0	-	1	5%
Suicide	0	-	8	40%
Drug related	6	43%	1	5%
Misadventure	0	-	1	5%
Alleged murder	3	21%	0	-
Sudden unexplained death in infancy / childhood	1	7%	3	15%
Not known at this stage / investigations ongoing	0	-	4	20%
Not known at this stage-post mortem awaited	2	14%	0	-
Other (please specify)**	2	14%	2	10%
Total CYP	**14**	**-**	**20**	**-**

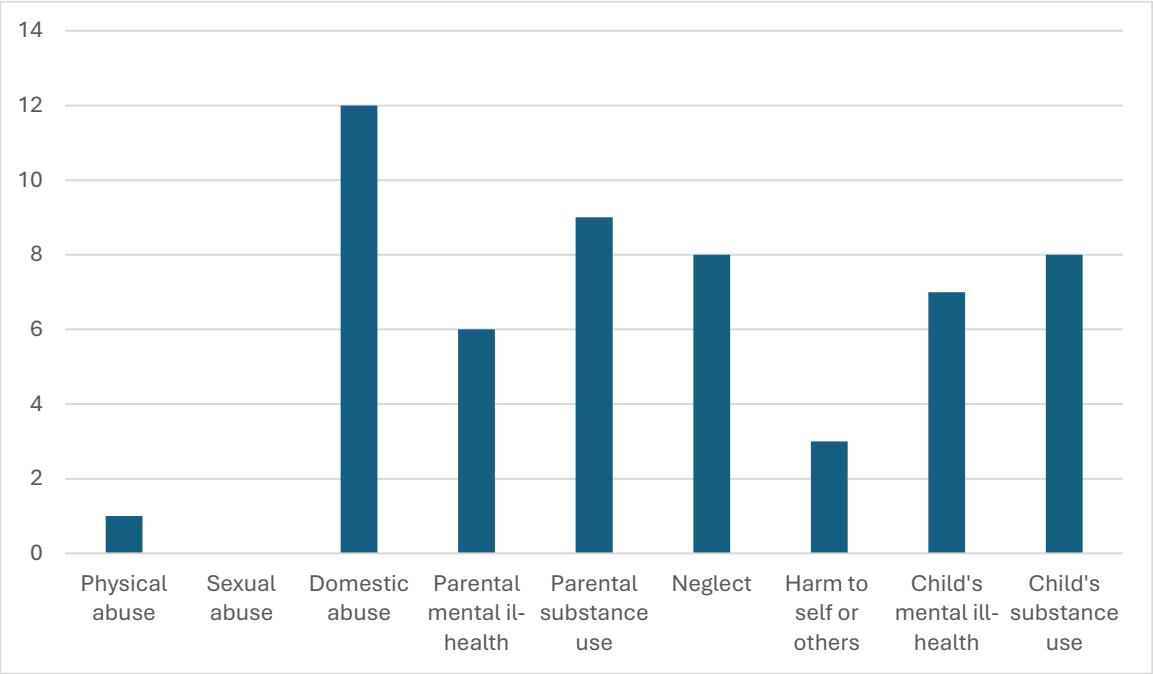
* Calculated to nearest integer

****** Two deaths were unascertained. One child was stillborn. The initial cause of death for one child was multiple organ failure, but toxicology results were awaited.

Types of harm experienced by children who then died

Not all harms or adversities experienced by children and young people were recorded in notifications. Types of harm identified in notifications as being experienced by children prior to their death are recorded in table 5. Multiple harms were recorded in some notifications.

Table 5: Types of harm or adversity experienced by children who then died

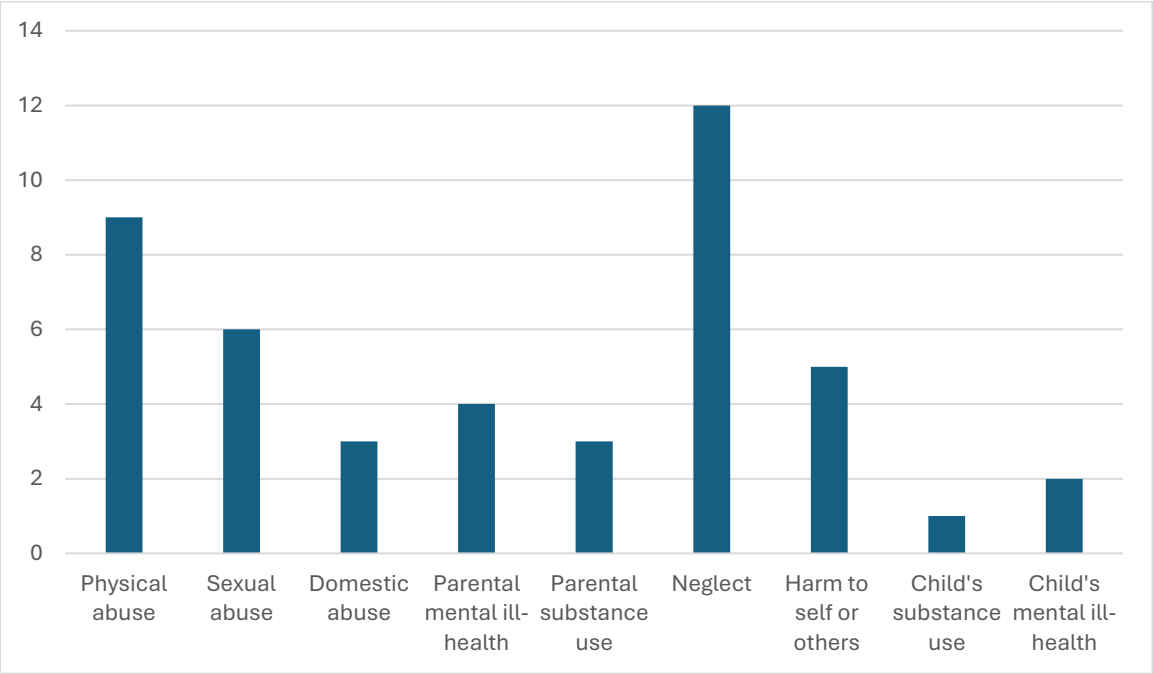


Non-fatal incidents

Forty-nine children were the subject of 24 notifications regarding non-fatal incidents; eight involving multiple children and 16 involving individual children. Six of the notifications involving multiple children proceeded to a learning review. Table 6 provides a summary of the types of harm identified in notifications. Multiple types of harm were recorded in some notifications. Neglect remains the most common type of harm identified.

Table 6 displays types of harm identified in notifications when the child has not died. Some notifications have described incident(s) which have led to the notification, rather than the types of harm experienced by the child. Multiple harms were recorded in some notifications. Individual harms where multiple children are included in a single notification are not recorded.

Table 6: Prevalence of harm by type (non-fatal)



Age of child

At 32%, just under one-third of children who were the subject of notifications which proceeded to learning review were under the age of five years. This compares with 48% during the period under review in our last learning review data report. Although more learning reviews were held for children under the age of five years than for other age groups, this age group also represented over half (53%) of learning reviews which do not proceed beyond notification.

Those young people aged 16 years and over made up 28% of those whose situation led to a learning review. One child protection committee was conducting two thematic learning reviews, which both included multiple young people aged 16 years and over.

Table 7: Age range of child or young person subject of a learning review notification

	Learning review **proceeding**		Learning review **not** proceeding	
Age	**Frequency (number of children)**	**Percentage of children***	**Frequency (number of children)**	**Percentage of children***
Under one	9	18%	10	33%
1 – 4 years	7	14%	6	20%
5 – 10 years	8	16%	1	3%
11 – 15 years	11	22%	5	17%
16 – 17 years	6	12%	7	23%
18 years and over	8	16%	0	-
Age not provided	0	-	1	3%
Total (children)	**49**	**-**	**30**	**-**

* Calculated to nearest integer

Table 8: Child's gender

	Learning review **proceeding**		Learning review **not** proceeding	
Gender	**Frequency**	**Percentage of children***	**Frequency**	**Percentage of children***
Male	28	57%	17	57%
Female	21	43%	11	37%
Gender not provided	0	-	2	7%
Total (children)	**49**	-	**30**	-

* Calculated to nearest integer

Table 9: Child's ethnicity

	Learning review **proceeding**		Learning review **not** proceeding	
Ethnicity	**Frequency**	**Percentage of children***	**Frequency**	**Percentage of children***
White Scottish	45	92%	22	73%
Other white British	1	2%	1	3%
Mixed or multiple ethnic group	0	-	2	7%
Gypsy/traveller	0	-	1	3%
Not provided	1	2%	0	-
Not known	2	4%	4	13%
Total (children)	**49**	-	**30**	-

* Calculated to nearest integer

Table 10: Is / was the child or young person disabled?

	Learning review **proceeding**		Learning review **not** proceeding	
Disabled	**Frequency**	**Percentage of children***	**Frequency**	**Percentage of children***
Yes	7	14%	2	7%
No	39	80%	27	90%
Not known	0	-	0	-
Not provided	3	6%	1	3%
Total (children)	**49**	-	**30**	-

* Calculated to nearest integer

Conclusion

This is the second annual data report for learning reviews since the Care Inspectorate began to receive learning review notifications and completed reports in 2021.

Many of the themes emerging from the 11 learning review reports submitted reflect those seen in previous national overview reports. The majority of learning review reports explored difficulties experienced by practitioners in engaging meaningfully with parents or carers. The majority of reports highlighted that neglect was not identified and responded to early enough. There continued to be some challenges in the application of GIRFEC, with some confusion and a lack of professional understanding around thresholds for intervention and roles and responsibilities. Concerns about information sharing and professional communication were evident in all of the reports submitted.

The number of learning review notifications this year were markedly higher than for the average number of notifications over the previous eight reporting years. However, at over half, a higher number of learning notifications were not proceeding to a learning review than for notifications in previous years. While it is too early to suggest a significant shift in trend, this is something that we will continue to monitor.

In some circumstances, child protection committees agreed to carry out an alternative approach for learning. In future, when this occurs and the criteria for learning review is met, CPCs will be asked to submit anonymised completed reports or minutes that record learning and recommendations to the Care Inspectorate. This will enable the Care Inspectorate to broaden its ability to identify themes, aspects of good practice and learning opportunities to share nationally.

The Care Inspectorate will continue to provide annual data reports. It is anticipated that from 2025 learning review reports for both children and adults in Scotland will be published concurrently, or as a joint report. 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.

The Care Inspectorate continues to provide quarterly updates to Child Protection Committees Scotland, including a section on the most recent learning review data.

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.