National Guidance for Adult Protection Committees

Undertaking Learning Reviews

Scottish Government
Riaghaltas na h-Alba
gov.scot

May 2022

Ministerial Foreword

I welcome the publication of this strengthened Adult Support and Protection Learning Review Guidance and thank all those involved in its development. The guidance has been updated to align with the national guidance for child protection committees undertaking learning reviews, and the previous process and terminology of "Significant Case Reviews" has been replaced with "Learning Reviews" accordingly.

It is critical that we continue to strengthen our approach to Adult Support and Protection and this guidance helps us do that. The guidance will ensure that knowledge and learning is shared across the adult protection system to enable practice improvements locally and nationally. Consistency of approach, and the embedding of a learning culture, further encourages Adult Protection Committees to evaluate and learn from critical incidents. In sharing best practice, I would encourage Adult Protection Committees to use the findings arising from their reviews, and those of other committees, to enhance their ongoing work.

I hope this guidance also helps reassure individuals and families who have been directly affected by a critical incident that their experiences will not be repeated. I am confident Learning Reviews will have a positive role in shaping the way in which agencies work together to provide joined up safeguarding, and appropriate support and care to those who need it. – the right care at the right time is what we all strive to deliver.

Finally, I would like to reiterate my thanks to the Adult Protection Committees and all those working in Adult Support and Protection for the work you continue to do to protect adults at risk of harm.

Contents

1. Introductions 3
2. Key Features of a Learning Review 4
3. Initiation of a Learning Review: The decision making process 7
4. Undertaking a Learning Review 9

Annexes

1. Learning Review Process Map 17
2. Learning Review Notification form 18
3. Consideration of Learning Review form 21
4. Exemplar Learning Review Report template 23
5. Person specification for lead reviewer 27
6. Facilitating and shaping practitioner and first line manager events and strategic manager events 28
7. Inter-related investigations, reviews and other processes or themes 31
8. Communications and Media Plan 41

1. Introduction

The purpose of this guidance is to support a consistent approach to conducting Adult Protection Learning Reviews and improve the dissemination and application of learning both locally and nationally. Supporting and protecting adults at risk of harm is an inter-agency and inter-disciplinary responsibility supported strategically by the Adult Protection Committee.

This guidance is primarily intended for members of Adult Protection Committees (APCs), but is also of clear relevance to Chief Officer Groups, the Care Inspectorate, and a wide range of agencies and their staff.

This guidance replaces the Interim National Framework for Adult Protection Committees for Conducting a Significant Case Review (2019). It has been drafted to reflect and align to the fullest possible extent with the Guidance for Child Protection Committees Undertaking Learning Reviews (2021). As such it reflects a strong emphasis on learning from practice. Accordingly, the previous process involving Initial and Significant Case Reviews has been replaced with an overarching Learning Review process.

An Adult Support and Protection Learning Review is a means for public bodies and office holders with responsibilities relating to the protection of adults at risk of harm to learn lessons from considering the circumstances where an adult at risk has died or been significantly harmed. It is carried out by the Adult Protection Committee under its functions of keeping procedures and practices under review, giving information and advice to public bodies and helping or encouraging the improvement of skills and knowledge of employees of public bodies as set out in section 42(1) of the Adult Support and Protection (Scotland) Act 2007.

Learning Reviews should be seen in the context of a culture of continuous improvement and will focus on learning and reflection around day-to-day practices, and the systems within which practice operates.

A Learning Review should seek to:

- understand the full circumstances of the death of, or serious harm to, an adult
- examine and assess the role of all relevant services, relating both to the adult and also, as appropriate, to relatives, carers or others who may be connected to the incident or events which led to the need for the review
- explore any key practice issues and why they might have arisen, including identifying systemic issues. Consider the question of “How did the situation present itself to the practitioner at the time, and how did this lead to decisions and actions taken at the time?”
- establish whether there are areas for improvement and lessons to be shared, about the way in which agencies work individually and collectively to protect adults at risk
- identify areas for development, how they are to be acted on and what is expected to change as a result
- consider whether there are issues with the system and whether services should be reviewed or developed to address these
- establish findings which will allow the Adult Protection Committee to consider what recommendations need to be made to improve the quality of services.

This guidance supports the achievement of the Adult Protection Committee’s objectives by helping those responsible for reviews to:

- undertake them at a level which is necessary, reasonable and proportionate

- adopt a consistent, transparent and structured approach
- identify the skills, experience and knowledge that are needed for the review process
- address the needs of the many different people and agencies who may have a legitimate interest in the process and outcome

2. Key Features of Learning Reviews

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 case together with the review team in a structures 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 practise, share their knowledge and contribute to the emerging learning.

III. **A systems approach**
The learning review does not stop at the points when shortcomings in professional practise 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 practise and systems

IV. **Proportionality and flexibility**
The situations under review will inevitably be complex and diverse and this therefore requires a streamlines, 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 Timelines**
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 practise context.

Underpinning Principles and Values

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 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 adults at risk of harm, and their 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

Creating the preconditions for learning

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

Reviewing complex situations can raise anxiety in individuals and organisations. This anxiety can block learning by generating defensiveness, with a consequent inability to review and reflect. In order to create the preconditions for learning it is essential that individuals who are part of the review process feel safe so that they can begin to honestly consider what has happened and engage in appropriate and constructive questioning and challenge. This will then result in the development of ideas and realistic and realisable action plans.

Effective leadership is crucial to creating the preconditions for learning. Chief Officers, who are accountable for all of the work of the APC, must promote and support local and national learning and improvement activity in the protection of adults at risk of harm as a matter of course, providing leadership and guidance in relation to the need to carry out Learning Reviews.

Criteria for undertaking a Learning review

An Adult Protection Committee will undertake a Learning review in the following circumstances:

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 orcourt proceedings, or a referral from another organisation gives rise to reasonable cause for concern about lack of involvement in relation to the AdultSupport and Protection (Scotland) Act 2007

   or

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

Definition of an adult at risk of harm

The Act 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

Who Can Request a Learning Review?

Any agency with an interest in an adult's wellbeing and safety can request that a case be considered for review by the Adult Protection Committee where they consider the criteria for review is met. It should be noted that concerns raised by families and addressed through the relevant agency's normal complaints procedure may also be a trigger for a Learning Review, where the agency considers the criteria for a review is met. The agency addressing the complaint should refer the circumstances to the Adult Protection Committee for their consideration at the earliest opportunity.

Inter-related Investigations, reviews and other processes

As elaborated in Annex 7, there are a number of other processes, including criminal investigations and NHS Significant Adverse Event Reviews, that could be running in parallel with a Learning Review and this raises a number of issues including:

- relationship of the Learning Review with other processes, such as criminal proceedings and Health Board reporting and reviewing frameworks
- securing co-operation from all agencies, including relevant voluntary sector interests in relation to the release and sharing of information
- minimising duplication through the integration and coordination of these processes wherever possible
- ensuring a sufficient degree of rigour, transparency and objectivity

Depending on the case, there could be a number of processes which come into play which are driven by considerations wider than service failure or learning lessons across agencies. These can include disciplinary processes, criminal investigation, report of death to Procurator Fiscal or a Fatal Accident Inquiry. In addition to this, agencies should ensure that the areas for improvement identified and shared learning are directed through the relevant clinical and care, or quality assurance, governance arrangements.

These processes may impact on whether a review can be easily progressed or concluded; criminal investigations always have primacy. To help establish what status a Learning Review should have relative to other formal investigations, on-going dialogue with Police Scotland, COPFS or others to determine how far and fast the Learning Review process can proceed in certain cases must take place. Issues to be considered include:

- how to link processes
- how to avoid witness contamination
- how to avoid duplicate information being collected
- whether to postpone a Learning Review until determination of a parallel proceeding

There could be cross-cutting issues, for example, gender-based violence, human trafficking, or problematic alcohol and drugs use.

Processes can, and do, run in tandem, and the basic principles to follow are: check if there are other processes going on from the start; ensure good communication with each other; and ensure the relevant information is shared with the right parties. Above and beyond this, the priority is that the adult is, and remains safe, regardless of other ongoing investigations (including criminal investigations). Consideration should be given to the safety of other adults who could also be at risk of harm. The rights of staff or others who are under investigation, but have not been charged or found guilty, is another factor to be taken into account.

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

A learning review process map is attached at Annex 1.

Adult Protection Committees should have in place mechanisms for deciding whether or not to initiate a Learning Review. The decision-making process should embody the key features of proportionality and timeliness. The responsibility for initiating a learning review and overviewing the process, and implementing any agreed recommendations, including the development and monitoring of an action plan, rests with the Adult Protection Committee, and should be reported to and ratified by, the Chief Officer Group.

Any agency with an interest in an adult's wellbeing or safety can raise a concern about a case which it is believed may meet the criteria for a Learning review and submit a notification to the APC using the Learning Review notification form (Annex 2). Families are not able to request learning reviews but

have access to complaints procedures within agencies where they feel dissatisfied with aspects of how cases have been dealt with.

On receipt of this notification the nominated person or sub-group within the APC should request further information from agencies involved with the adult and family. This is done using the information for Consideration of a Learning Review form (Annex 3).

The purpose of information gathering at this stage is to inform a decision about whether or not to process with a Learning review with reference to the criteria as specified in the previous section. The information gathered should be only enough to assist in making 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.

After consideration of the gathered date the nominated person or sub-group will then make a recommendation to the APC on whether or not to proceed with a Learning Review. The recommendation will contain the following information;

- A brief outline of the case and the basis for referral
- The current circumstances of the adult and what actions have been taken
- Any other formal proceedings underway including criminal investigation

The Chief Officers Group, which should include the Chief Social Work Officer, should be informed of the decision about whether to proceed with a Learning Review or the reasons for not doing so, and will determine whether they ratify this decision or seek further actions through the APC.

The Care Inspectorate must be informed of this decision using its online notification form.

If the final decision ratified by the Chief Officers Group is to go ahead with a Learning Review, then a review team will be established and a chair of this team identified. Lead reviewer(s) will be appointed.

Consideration should be given by the COG and APC as to the engagement required with the adult and their family. Consideration should also be given as to whether there is likely to be media interest at any stage in the review process and, if so, strategies for dealing with this should be prepared. A Communications and Media Guide is provided in Annex 8.

Timeframe for the initial decision-making process

The timeframe for this initial decision-making stage will vary depending on the situation being considered. However, timeliness is important, so that any learning arising is relevant to the current practice context. It is suggested that 28 to 42 days from the receipt of a referral would be an appropriate and realistic timeframe for the completion of this initial process.

Cross-authority cases

A Learning Review in one APC area may involve agencies from a different local authority, health board or police division.

In the case of a potential cross-authority Learning Review, the relevant Adult Protection Committees should agree a mechanism for joint working, including which Adult Protection Committee should take the lead, and if required there should be joint commissioning of a lead reviewer. It will also be important that clear channels are identified for how information is shared across authorities. This should be authorised by the Adult Protection Committee Conveners and coordinated through the Adult Protection Committees, with authority delegated to Coordinators or Lead Officers. Any disputes (between local authorities) should be escalated to the Chief Officers' Group or equivalent for consideration, and Chief Social Work Officers should be kept informed.

In the case of a potential cross-border Learning Review, the APC Convener should meet with the relevant Chair of the Safeguarding Adults and/or Children's Board, or equivalent, in order to agree a mechanism for joint working.

Links between services for children and adults

Situations may arise for learning reviews, particularly for 16 and 17 year old people, where there are legitimate interests and engagement from services for both children and adults. In such circumstances there should be discussions between the Child and Adult Protection Committees to determine which is the most appropriate to lead on a Learning Review, with agreement reached as to how each of the committees will be involved and updated on progress of the Review. This will require consideration on a case by case basis, and the involvement of the Chief Social Work Officer may be helpful in these deliberations.

The Learning Review and other formal staff processes

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

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 APCs give consideration to what might be learned and how that learning can be disseminated to the multi-agency workforce. Such cases should be brought to the attention of the APC.

4. Undertaking the Learning Review

A systemic approach

This guidance is not prescribing a model for undertaking a Learning Review as it is recognised that APCs have a variety of review models that work well for them. However, it is important to emphasise that a Learning Review is a collective endeavour and that, whilst the detail of how a review is undertaken may vary, all reviews must adopt a systemic approach. Such an approach goes beyond individual or professional practice to explore underlying systemic factors, the links with organisational factors and the wider contexts.

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.

An effective systemic model has the following components:

- it is truly participatory and collective, involving all relevant professionals, managers, agencies, and the adult and their family where appropriate. All participants in the Review contribute to the critical reflection and analysis of the situation under review and the development of strategies to support practice and improve processes and systems across agencies

- it adopts an analytical and evidence-based approach
- there is an appreciation that learning is not something 'done' to people but rather something that people themselves do and own
- it takes learning to a deeper level by examining systems, structures, and cultural and contextual factors
- it explores the interrelated and interdependent parts of different services and agencies and the impact this has had on the lived experience of the adult who is the subject of the review
- it explores how user friendly systems are for adults at risk of harm, as well as for professionals
- it considers legislative, social policy and societal systems as well as local policy and practice
- it does not focus solely on what went wrong but also includes an examination and analysis of effective practice
- learning does not just come at the end of the Review once the report is published, there is a 'thread of learning' throughout the review process. The learning develops with each Review Team meeting and professionals' event, as hypotheses are formulated and tested, and issues identified and explored
- the learning from a Review is disseminated and implemented in practice and in systems at both a local and a national level

The Review Team

When a decision has been made to proceed to a Learning Review the first step is to set up a Review Team. The Review Team manages the process of the Review and is a multi-agency group whose members should have a working knowledge of the relevant services involved in supporting adults at risk of harm. Consideration must be given to ensuring a group size that is conductive to learning and joint working. The number and composition of the Review Team will be specific to each case 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.

Good practice and sound governance dictate that only in unusual circumstances should a review team member have been directly involved in the case under consideration, have been overseeing the work within the case, or have been directly engaged in meetings with the lead reviewer(s).

It is the Review Team's responsibility to ensure the Learning Review remains proportionate and focused and is conducted in accordance with the underlying principles and values set out in this guidance.

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 practise and service delivery.

The Review Team consists of the separate roles of:

- the Chair
- team members
- the Reviewer(s)
- the Administrator

The role of the chair of the Review Team

The key components of the role of the Review Team Chair are to:

- Consider whether there are parallel processes ongoing i.e. criminal proceedings/FAI.
- Coordinate the identification and engagement of the relevant partners and suitable contributors to the Learning Review
- Coordinate the work of the Review Team
- Ensure that a clear and realistic timetable for the review process is set out and is adjusted where and when needed
- Ensure timely requests are made for 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
- Chair and facilitate meetings of the Review Team
- Contribute to the development of the learning emerging through the review process
- As appropriate, meet with family members and attend practitioner and manager events alongside the Reviewer
- Provide regular updates as required to the APC and COG

The role of the Review Team members

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.

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

- Attend the meetings of the Review team
- 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 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
- 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

The role of the Reviewer

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

- Work collaboratively and transparently with the Review Team Chair and members
- Attend the meetings of the Review Team
- Review and assess all information available to develop a full and multi-faceted understanding of the case
- Interpret and analyse the workings and shortcomings of complex, multi-agency systems
- Effectively facilitate group work and manage complex group dynamics
- Facilitate practitioner and manager events so that;
    - Participants understand the purpose of the Review as well as the underpinning principles and values of Learning Reviews
    - Trust is established between participants
    - All participants can voice their views in a safe manner
    - Discussion, debate, probing, and constructive challenge are encouraged

- Use a range of participatory and creative approaches to obtain the views and experiences of adults as risk of harm and their families/carers
- Pull together the learning and write the report, with the advice and guidance of the rest of the Review Team

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

The role of the Administrator

To support and coordinate the Learning Review process it is essential that high quality administrative support is in place. The Administrator is an important member of the Review Team and the key aspects of this support role are to:

- Administer meetings and events that are part of the Review, including scheduling Review Team meetings, booking venues, and supporting with other associated practicalities.
- Take minutes and notes of Review Team meetings and practitioner and manager events
- Support the communications of the Review Team, including collating, distributing and storing documents and information as required

Skills, attributes, experience, and knowledge

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 Adult Protection Committee and Chief Officers Group. A person specification for the lead reviewer is attached at Annex 5.

Enabling Factors within the wider context

A supportive Chief Officers Group, including the active engagement of the Chief Social Work Officer, is an essential enabling factor in ensuring that Learning Reviews are effective and fulfil their purpose. This means the Chief Officers Group taking ownership of and a constructive interest in the review process, findings and learning, with a strategic level commitment to implement the actions and learning stemming from the Review.

The APC will need access to resources to support the Learning Review process. This will be negotiated as appropriate at a local level according to the needs of the particular review. Staff time must be made available to the Learning Review process. The APC may wish to consider additional supports that may assist the Review process; this could include (but is not limited to) a Communications Subgroup and/or a supervisor or mentor for the Lead Reviewer(s).

Terms of reference

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. Based on the information knows at the time, proposed terms of reference will have been drawn up at the point a recommendation is made to the APC 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 APC should be informed of and be in agreement with any changes to the terms of reference.

The final terms of reference will be included in the Learning Review report at the completion of the

Review.

Collecting and collating further information

The preparation of single agency chronologies is an important first step in the collection and collation of further information. The decision about how far back to go in terms of the time frame 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 the adult for many years, then a brief summary of that earlier involvement should be prepared.

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

Once single agency chronologies have been complied, they will be merged, thus providing 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.

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.

Managing emerging issues and challenges during the Review

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 the conclusion, then the APC and the COG must be informed.

Engaging the adult and family in the Review process

A Learning Review is a collective endeavor to bring together agencies, individuals, and families to learn from what has happened in order to better protect adults at risk of harm. As in many instances 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.

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 adult. This will include what they found helpful or unhelpful and their suggestions for how services could be improved. Their thoughts, opinions and feelings contribute to the overall learning. The adult and any family and relevant carers 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 family then they may be involved as appropriate in explaining to the purpose of the Review and ascertaining their wishes as to if, how and when they want to be involved.
Where and how to meet will be dependent on the wishes of the adult and others who will be involved and consideration should be given for the need for any communication aids.

It is helpful if meetings can be arranged before any practitioner events or managers' events. This means that views can be taken into those forums for reflection and discussion.

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. In these cases, information may need to be restricted. Close collaboration with Police Scotland, the Procurator Fiscal, and any other relevant agency will be required.

At the end of the review process arrangements should be made to feedback to the adult and family the conclusion of the Review, the learning identified and any strategies to improve practice and systems in the future. Again, this must be approached in a sensitive manner as the findings of the Review may not always be accepted by the adult or family members. Gathering views on how people found the process of the Review itself and their feedback should inform the conduct of future Learning Reviews.

Families may need support at the end of the review process, and in advance of and following publication of the review. The level and nature of support should be determined on a case by case basis.

Involving practitioners, first line managers and strategic managers

Whilst this 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 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 process and structures to facilitate the delivery of services.

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; the 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.

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 multi-agency perspective.

Annex 6 provides guidance on how to facilitate and shape events for practitioners, first line managers and strategic managers.

The report

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.

Where a living individual can be identified from the report 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.

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 scrutinize, challenge appropriately and ensure that the report represents all the learning that has been generated by the Review process.

An exemplar report format is as provided at Annex 4. The report should include:

- 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 is recommended that suggested strategies for improving practice and systems should be CLEAR. This means:
    - **Case for change**: the report 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.

The Learning Review report will be presented to the APC and the COG for consideration and sign off. It is recommended that the reviewer and the Chair of the Review Team take responsibility for presenting the report.

It may be that not all recommendations will be accepted by the APC. In such circumstances the APC will have to justify such actions, and again this will be ratified by the Chief Officer Group.

Publishing the Report

The COG, informed by a recommendation in this regard from the Adult Protection Committee, will decide if and when to publish the report. In making this decision issues of confidentiality and data protection principles must be considered. The adult and family should also be consulted, and their views taken into account and given due weight in arriving at a decision. 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 COG meeting. If a report is not published, then the learning should be extracted from the report and be published separately.

Even if a decision is reached not to publish the report, there is always a possibility, particularly in high profile cases, that a Freedom of Information (FOI) request may be received. In such cases the relevant public authority will be obliged to disclose information on request, unless one of the fairly narrow exemptions apply, particularly where there is a public interest in doing so. Although there is an exemption for Personal Data when disclosure of which would breach the data protection principles, it may be difficult to justify withholding the report in its entirety and it may need to be issued under redaction of Personal Data.

Timescale for the Learning Review

If the learning identified throughout the review process is to be relevant and helpful to the development and improvement of adult protection practice and processes it is important that the Review is completed as soon as possible. Once a decision has been made to undertake a Learning Review, the process should aim to be completed within a timeframe of six to nine months.

However, in some situations there may be some unavoidable delay at any stage, for instance because of parallel processes. The Chair of the Review Team should communicate the reasons for any delay back to the APC, with a revised timescale.

Dissemination

The Adult Protection Committee will timeously agree a local dissemination approach which ensures the spread of any identified good practice as well as learning, particularly to front line staff.

Arrangements should be agreed for direct feedback of the conclusions and recommendations contained within the report to those front line staff and managers and with those service and agencies who were involved in the Learning Review.

The APC should submit the report to the Care Inspectorate.

The Care Inspectorate

The Care Inspectorate is the central repository for all Learning Reviews conducted in Scotland.

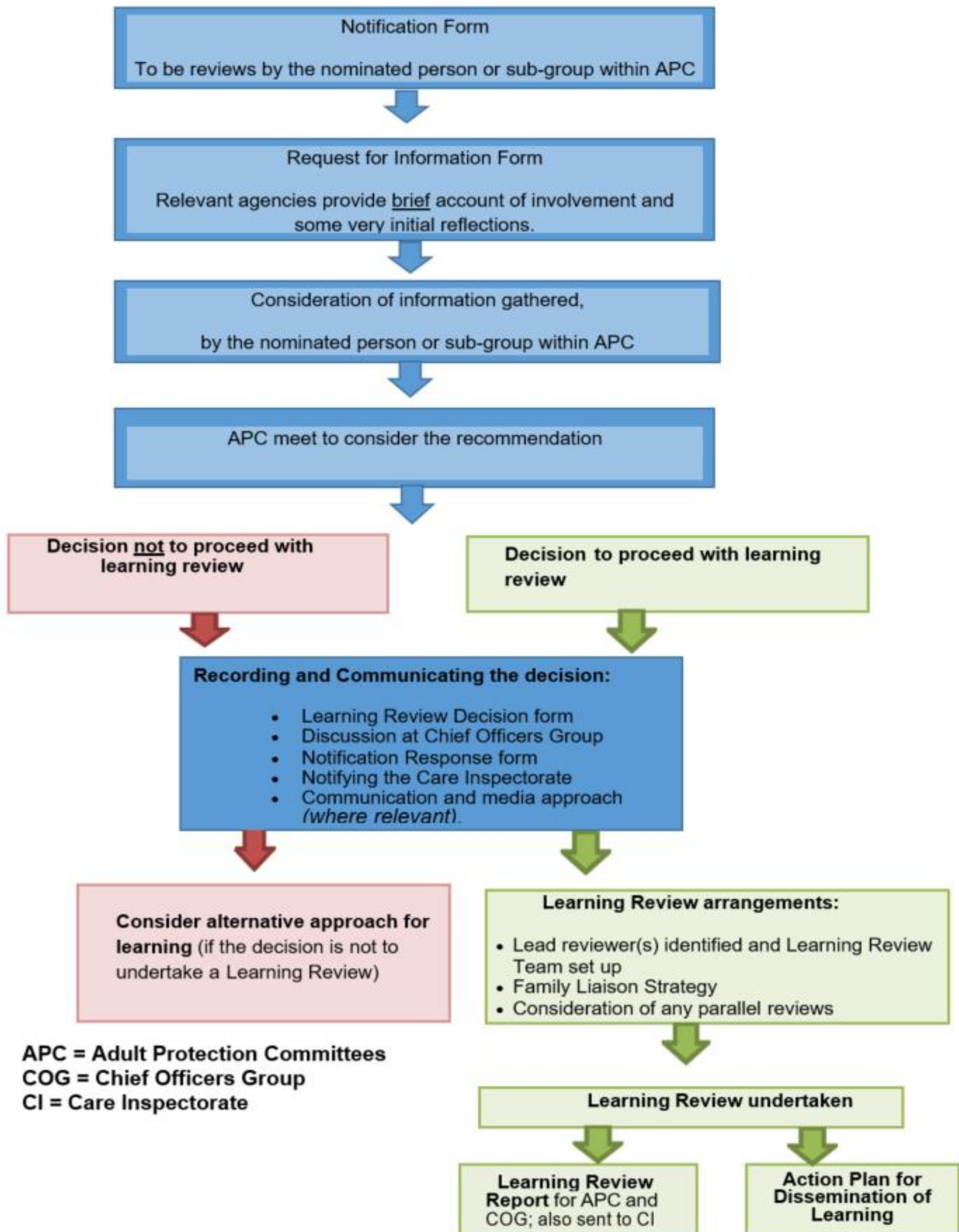
As identified above, the Care Inspectorate should be notified of the outcome of the decision making process as to whether or not to initiate a Learning Review in relation to a particular case. The APC is also required to submit the full, anonymised report to the Care Inspectorate. Both these submissions should be made through the Care Inspectorate's on line process.

The Care Inspectorate will support practice improvement as a result of national learning identified by Learning Reviews by holding learning events and by exploring the development of mechanisms to support better sharing of learning from Learning Reviews across the country.

The Care Inspectorate will conduct a regular review of the Learning Reviews completed in Scotland (as well as of Initial and Significant Case Reviews undertaken since November 2019) and report nationally on the key learning points for the benefit of relevant services across Scotland and the Scottish Government.

Annex 1

Adult Support and Protection Learning Review process



Annex 2

Adult Support and Protection Learning Review Notification

Request from:	
Contact details:	
Agency:	
Date completed:	

Any agency with an interest in an adult's wellbeing or safety can raise a concern about a case which it is believed may meet the criteria for a Learning Review and submit a notification to the APC using the Learning Review notification form.

This notification will be acknowledged and then responded to with the outcome of the Adult Protection Committee's consideration of whether or not to proceed to a Learning Review.

Criteria for undertaking a learning review

An Adult Protection Committee will undertake a Learning review in the following circumstances:

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 ofviolence 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.

Adult’s details	
Name:	
Date of birth:	
Date of death:	
Home address &/or current residence:	
Gender:	
Next of Kin/carers address if different:	
Any other Local Authorities involved:	
Is/was the adult subject of any statutory powers at time of concerns arising in relation to Adult Support and Protection, Adults with Incapacity or the Mental Health (Care & Treatment) Act?	
Contact details for any Guardian or Power of Attorney, if known	
Criteria for Learning Review	
What grounds within the criteria do you consider apply for a Learning Review in this case?	
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 immediate concerns and have these been passed to the relevant agency for consideration/action?	

<table>
<tr><td>

- What action has been taken?

</td><td></td></tr>
<tr><td colspan="2">Summary of the case:</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td colspan="2">Are other reviews, criminal investigations or other statutory proceedings underway? If so, please give details.</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td colspan="2">Name of service/agency/individuals involved with the adult, with contact details</td></tr>
<tr><td colspan="2"></td></tr>
</table>

Annex 3

Request for Information to Allow Consideration to be Given to the need for an Adult Protection Learning Review

<table>
<tr><td colspan="2">This request for information follows a referral for consideration to be given to the need for a Learning Review in relation to the adult named below.

• Please respond within 2 weeks, returning the completed form to xxxx
• Please provide a brief account of your agency's contact with the adult named below, and provide your reflections on the key practice issues listed.

Enter name & return address of person initiating the request for information

Enter date of request</td></tr>
<tr><td>Name of adult</td><td></td></tr>
<tr><td>Date of birth</td><td></td></tr>
<tr><td>Date of death (if applicable)</td><td></td></tr>
<tr><td>Adult's address</td><td></td></tr>
<tr><td colspan="2">Brief details of the immediate precipitating factors leading to the referral for consideration of a Learning Review</td></tr>
<tr><td colspan="2">…to be completed by the person initiating this request for information…</td></tr>
</table>

Summary of involvement with the adult:
Background history:

Key practice issues: Please provide information on: • Recognition and assessment of Risk and need in relation to the adult • Information sharing in this case • 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 • Any good practice identified • Any areas identified for practice improvement

Parallel processes	
Are you aware of any current or planned reviews being undertaken for this case? If yes, please give details.	
Are you aware of any criminal proceedings associated with this case? If yes, please give details.	

Report completed by:	
Name:	
Title:	
Agency:	
Email address:	
Date:	

Annex 4

Exemplar Learning Review Report

Core Data – Adult	
Adult's Identifier	
Age of adult	
Gender	
Sexual Orientation	
Disability	
Health needs (including mental health and /or learning difficulties	
Education	
Living circumstances prior to incident	
Position in family/ number of siblings	
Ethnicity	
Religion	
Nature of injury/cause of death	
Legal status of adult	
Agencies/Services involved	
Family/carer factors (if applicable)	
Age	
Mental health issues	
Disability	
Health needs (including mental healthand/or learning difficulties)	

Substance use (if applicable)	
Convictions (if applicable)	

Problems in childhood (if applicable)	
Domestic abuse (if applicable)	
Add antisocial behaviour (if applicable)	
Ethnicity	
Religion	
Marital/relationship status e.g. co-habitation	
Living circumstances	
Agencies/Services involved	
Environmental Factors	
Financial problems	
Housing	
Support from extended family/ community	

Introduction

This includes a brief synopsis the circumstances that led to the review.

The review process

This includes the approach taken to the review, the engagement with the Review Team, details of reviews of records and the compilation of any chronologies, details of any individual meetings with practitioners and managers and of group meetings with practitioners and managers. Details of the involvement of the adult and any family members and carers should also be provided.

The facts

This includes the family background and circumstances, and agencyinvolvement. A succinct chronology or timeline of significant events may also be included if it is essential to an understanding of how learning points were identified.

Details of all significant others in the adult's life should also be included.

Analysis

This section critically assesses the key circumstances of the case, theinterventions offered, and decisions made. For example, were the family and adult's circumstances

sufficiently assessed, were the 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

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 case and then commenting on how these were dealt with in the particular case. For example:

Practitioners should operate in a clear policy and 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 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

This section allows for the identification of good practice as evidenced by the review'

Suggested strategies for improving practice and systems

This section contains recommendations for the Adult Protection Committee to consider

Appendices

These will include, if not already within the body of the report

- Review Team membership
- Terms of reference for the review
- Files accessed/relevant documents
- People interviewed (identified anonymously through their professional role or relationship to the adult)

Annex 5

Person Specification for Lead Reviewer/s

Chairing

- Consider practice experience required for person chairing review – this may differ depending on the particular circumstances of the case
- Responsible for ensuring the required skills and experiences of the review team are made available
- Role of body/person setting terms of reference and providing progress reports
- No preconceived views of the case/outcome
- Quality – ability to set out ground rules

Knowledge base

- Should have an in-depth knowledge of protecting adults

Analytical skills

- Those chairing/leading reviews must have the ability to interpret and analyse complex multi-agency processes and information.
- Identify what sounding boards the group may have
- Identify where to seek knowledge specific area/profession
- Logical thinking ability to map out review process
- Need to understand the context in which services are delivered.

Person qualities

- Those conducting reviews require to be open minded, fair, a good listener and a logical thinker.
- Experience of practice at various levels across an organisation
- A blend of confidence and humility (to be prepared to learn)
- Need to understand professional backgrounds of those involved and be a multi-agency team player

Skills for undertaking the review

- Approachable
- Need to have awareness of adult support and protection
- Risk Assessment/Management
- Ability to challenge constructively
- Open mindedness/fairness
- Good listener
- Fair person

Annex 6

Facilitating and shaping practitioner and first line manager events and strategic manager events

Learning Reviews are a collective endeavour to learn from what has happened in order to improve systems and practise in the future and thus better protect adults at risk of harm. Bringing together practitioners and their first line managers in a facilitated event is an opportunity for them to reflect on practice and also to ensure that their voice directly contributes to the review. A sensitively facilitated event can also generate immediate learning at both an individual and a group level; learning which can be applied directly to current practice. For strategic managers, meeting together in a facilitated 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 multi-agency perspective.

However, reviewing complex situations where an adult has been harmed or been at risk of harm can raise anxiety in organisations and individuals. This anxiety can block learning by generating defensiveness, with a consequent inability to review and reflect, or to acknowledge the need for change and development in processes and practice. It is essential, therefore, that careful consideration is given to the shape and structure of group events and that they are well facilitated.

Careful preparation is essential if the events for practitioners and their first line managers and events for strategic managers are to be effective and make a meaningful contribution to the Learning Review. Preparation includes identifying participants so that the relevant people attend, selecting an appropriate venue, and thinking about the duration of the event.

At this preparation stage all participants need clarity about the purpose of the group session and a sense of how it will be conducted. They also need a framework to help them prepare and for participants and their first line managers, this will consist of asking them to revisit their involvement with the situation under review and to think about the assessments they completed, the decisions they made, the actions they took and their interaction with other professionals and services. They should also be asked to identify areas of effective practice and areas where, in retrospect, they realise that something could have been done better.

Review Team members have an important part to play in preparing participants and should be the link with those staff from their service area or organisation to ensure that they are well briefed and understand the purpose. Review Team members should also be prepared to answer any queries prior to the event.

Group sessions may vary in duration depending on the situation under review, but for practitioners and first line managers it is advisable to set aside a full day. Sessions for strategic managers can usually be completed in half a day.

The venue, as well as the structure of the day, must facilitate the process and so needs to be comfortable and fit for purpose. The layout of the room is an important factor and it is helpful if participants are able to see another in order that they can develop a conversation together. Rooms laid out in boardroom style or horseshoes or circles should assist this, together with space to move in and out of small groups and sub-sets if required. If the event is to be held for the duration of a day, then it is preferable to provide lunch. This will help participants to continue thinking together in a less formal way and avoid disruption to the process.

The discussions at this group event do need to be captured as they will directly contribute to the overall learning and to the review report. A note taker should be

identified before the events and this will usually be the Review Team Administrator. It should be noted that what they will produce are not formal minutes, but working notes to assist the Reviewer(s) and the Review Team in identifying key learning and recommended actions.

Practitioner/first line manager events and strategic manager events require the facilitators to work in the moment with the material generated by the group and cannot be rigidly structured. However, in order that they have some coherency and provide a framework in which participants can work productively they need some shape with carefully crafted beginnings, middles and endings.

However well-prepared participants are there will still be some apprehension as they gather for the group session and so a careful introduction is essential. This should cover:

- introductions to everyone in the room and why they are there
- reiteration of purpose and process
- an acknowledgement of the apprehensions and anxiety within the room
- setting out working principles for the sessions
- a brief overview of the situation under review

For practitioner and first line manager events the next stage is the exploration of their involvement in the situation under review. This is best done chronologically and, as the story unfolds, it will be important to remind participants to differentiate between their thoughts and actions at the time, and the wisdom of hindsight afforded by a retrospective reflection. In other words, it is about exploring the question 'why did we do that then?' and following this up with the question 'could we have done it differently and what would have helped us to do so?'

As the discussions and thinking develops within the group, the Reviewer(s) should ensure that the following areas are covered:

- were the risks in the situation identified and understood?
- how were the family members engaged with?
- How did the professionals work together?
- What went well? This is about identifying effective practice and what facilitated that practice
- What could have been done better and why did it not happen at the time?

To help participants make sense of the emerging issues and learning it is essential that the Reviewer(s) pause from time to time to summarise the discussion.

How the practitioner/first line manager event is brought to a close is important if it is to have some ongoing value and should not be rushed. This final session of the day should include:

- A summary of the key learning
- An outline of the next steps
- An opportunity for participants to think about their personal learning from the day and how to take it forward
- Checking out how participants feel about the process they have been through

The events for strategic managers also need a careful and thorough introduction similar to the one for practitioner events. However, they will need to input on the circumstances leading to the review so that they have material to work with for the rest of the session. The session will then cover:

Small group work to think about:

- Challenges and missed opportunities in this situation
- What worked well and why?

Followed by careful feedback to identify themes and issues, feedback from the practitioners and frontline managers event, with an opportunity for discussion;

- Input on the views of the family, again with an opportunity for discussion
- Discussion on 'what needs to change' to think about:
    - what changes have already been made?
    - what else can be done?
- Summary and agreement on the emerging recommendations/future actions
- Setting out next steps in terms of the process of the Learning Review

For the reviewer(s) these group events will bring to the fore their facilitation skills. This includes managing the group dynamic but also working sensitively with the individuals within the group. It is about creating an atmosphere of safety and trust, which encourages participants to openly and honestly express their views and reflect on their involvement in the situation. It is about opening up discussion, allowing people to consider and debate but also knowing when to intervene and lead from the front so that the event does not lose its focus.

Annex 7

Inter-related investigations, reviews and other processes

Processes, which may need to be considered in addition to a Learning Review include:

Adverse Events (Significant Adverse Events NHS)

In collaboration with NHS boards, Healthcare Improvement Scotland has led the development of the National Framework: **Learning from Adverse events through Reporting and Review: A National Framework for Scotland (Third edition 2018).**

As per the mental Welfare Commission report *recommendation Left alone – the end of life support and treatment of Mr. JL (July 2014)*, processes should make reference to this document.

An adverse event is defined as an event that could have caused (a near miss), or did result in, harm to people or groups of people. The National Framework describes 3 categories of reviews for significant adverse events and a senior manager or Director is assigned to ensure the review is undertaken at the appropriate level**.**

Category I**:** Events that may have contributed to or resulted in permanent harm, for example death, intervention required to sustain life, severe financial loss (£>1m), ongoing national adverse publicity

Category II: Events that may have contributed to or resulted in temporary harm, for example initial or prolonged treatment, intervention or monitoring required, temporary loss of service, significant financial loss, adverse local publicity

Category III: Events that had the potential to cause harm but i) an error did not result, ii) an error did not reach the person iii) an error reached the person but did not result in harm (near misses).

The management of adverse events should incorporate the following six stages

1. Risk assessment and prevention
2. Identification and immediate actions following an adverse event, including consideration of duty of candour
3. Initial reporting and notification
4. Assessment and categorisation, including consideration of duty of candour
5. Review and analysis
6. Improvement planning and monitoring

The report outlining the findings, conclusions and recommendations from the review should be presented through local NHS management structures. The third edition of the framework was produced following the implementation of the statutory organisational Duty of Candour legislation in Scotland on 1 April 2018.

Criminal Investigations (CI)

Within Scotland the core functions and jurisdiction of the police are specified by the Police and Fire Reform (Scotland) Act 2012. This includes a duty to protect life and property. The police are an independent investigative and reporting agency to the Crown Office and Procurator Fiscal Service (COPFS). The police have a duty to investigate both crimes/offences and also any sudden and unexplained deaths.

Crimes and offences

The paramount consideration in any decision or arrangement in respect of learning reviews taking place alongside other investigations is the need to protect adults from harm. In some instances this will be achieved by the successful prosecution of those who pose a threat to adults, in conjunction with securing improvements in systems that exist to prevent adults being exposed to harm.

Should the police receive information, by whatever means, that a crime or offence has been committed, they are duty-bound to investigate that occurrence. Principally the role of the police is to establish the following:

a) Whether or not a crime or offence has been committed;
b) Whether there is sufficient evidence to support a criminal charge;
c) Whether there is sufficient evidence to justify the detention and/or arrest of the alleged offender; and thereafter to
d) Submit a report to the Procurator Fiscal

Where allegations of physical, sexual and emotional abuse are made involving adults, the police consider, in collaboration with other agencies the following before initiating the investigation. Reports of Adults at Risk of Harm being received under the Adult Support and Protection (Scotland) Act 2007 include physical harm, conduct which causes psychological harm (e.g. by causing fear, alarm or distress, unlawful conduct (e.g. Theft) or conduct which causes self-harm:

- The immediate safety and wellbeing of the adult at risk
- The need for medical attention, immediate or otherwise
- The opportunity of access to the victim and to other adults by the alleged perpetrator
- The relationship of the alleged offender to the victim
- The proximity in time over which the alleged abuse has occurred
- The need to remove the adult or other adult from the home to a place of safety, although this will only take place after discussion between the supervisor on duty in both the police and the relevant Social Work Departments
- The need to obtain and preserve evidence

After consideration of the above, which should ascertain the risks and needs of the adult, the investigation, will begin. In many such cases a Senior Investigation Officer (SIO) will be appointed to oversee the investigation.

In matters where a serious crime or offence has been committed, the investigation will usually be conducted by specially trained officers of the Criminal Investigation Department.

The evidence of the crime or offence will be gathered in a variety of ways such as the obtaining of statements from witnesses who have knowledge of the events under investigation, the gathering of forensic evidence such as DNA, fingerprints, hairs, fibres, etc. and the interviewing of those person(s) suspected of being responsible.

Upon conclusion of the investigation the police will prepare a report of the circumstances and this will be submitted to the Procurator Fiscal. Decisions will also be made as to whether the accused should remain in police custody pending his/her appearance in court, whether they should be released on an undertaking which may specify certain restrictions/provisions or whether they should be released pending report and summons.

In the event of an adult fatality or a case of serious harm which may be subject to a learning review, it is essential for the APC, Police Scotland and COPFS to confirm the likely processes of review and investigation to which the case is likely to be subjected (e.g. learning review, criminal investigation,

Fatal Accident Inquiry (FAI), Health and Safety investigation, Scottish Fire and Rescue Service investigation).

At the earliest possible opportunity, where it is identified that a learning review may be appropriate, the Convenor of the APC or designated member should contact Police Scotland to confirm:

- Whether a death report or criminal case has been reported to COPFS; or
- That there is evidence of a crime having been committed although no report has been submitted to COPFS

Consideration should be given to arrangements that allow reviews of systems critical to the welfare of adults to get underway, in the context of the need to secure and preserve the integrity of best evidence within criminal and other investigations.
If agreed by Police Scotland and COPFS, a learning review may involve the reviewer interviewing members of staff of the relevant authorities who may have had engagement with the adult, as well as people who may be considered as having a significant part in the life of the adult. The material generated from this activity, including interview notes, is likely to contain information which is of relevance to any potential criminal proceedings or FAI.

Police Scotland has a duty to reveal the existence of relevant information to COPFS and all such information must be made available to the Reporting Officer/SIO as soon as possible for consideration. To allow Police Scotland to fulfil this duty, in these circumstances close collaboration between the Lead Reviewer and the SIO will be required.
The timing of different processes will be determined by the particular circumstances of individual cases. It should not be necessary to postpone the initiation of a learning review until the conclusion of criminal proceedings or FAI but care must be taken that the learning review does not prejudice or put in jeopardy either of these proceedings. Therefore, in some instances, a learning review process may have to be adjourned after an initial review of critical systems until the conclusion of aspects of the criminal or other investigations. Alternatively, it may be possible to take information from a limited number of witnesses at first.

Criminal cases and FAIs can take a long time to resolve and there may be some circumstances where the APC, in carrying out its duties to conduct the learning review, considers it would not be appropriate to wait to gather all possible learning about how best to safeguard adults. If, prior to charge or conclusion of a trial or FAI, those engaged in the learning review wish to undertake interviews with people who are either witnesses, suspects or who have been charged with a criminal offence or potential witnesses in a FAI, this should be agreed beforehand with Police Scotland and COPFS.

Where there is an FAI, or potential for one, and where no criminal proceedings are anticipated, the conclusions of the learning review may assist the decision-making and such interviews should be encouraged.

Where there are criminal proceedings anticipated or ongoing and COPFS are giving consideration as to whether witnesses can be interviewed as part of the learning review process, the following are some of the factors which may be taken into account:

- The risk around the rehearsal of evidence in advance of trial
- The vulnerability of witnesses
- The risk of any confusion about two processes
- The impact of information being in the public domain

It is good practice that carers and significant family members are interviewed or otherwise engaged during the learning review process to seek any learning from them. The APC, COPFS and, where appropriate, the police officer leading the investigation, or their representative, must discuss the

timing and scope of such interviews or other engagement. While there may be no need to delay learning review interviews pending the outcome of criminal proceedings or FAI, a balance must be achieved between the need to capture relevant data and learning in order to protect adults and the investigation of a death or prosecution of a criminal case in the public interest.

The best timing of such interviews will differ depending on the circumstances and features of the case and as such arrangements should be made on a case-by-case basis.

Persons conducting learning review interviews must be conversant with rules of evidence and competent in the management of investigative processes running in tandem with criminal investigations.

In circumstances where there is an ongoing criminal investigation, prosecution or death investigation, the APC must seek permission from COPFS before publishing learning from a learning review. Publication may need to be delayed if it is likely to prejudice an ongoing criminal investigation, prosecution or death investigation.

Fatal Accident Inquiry

A Fatal Accident Inquiry is a court hearing which publically makes inquiries into the circumstances of a death. It will be presided over by a sheriff and will usually be held in the sheriff court. If the death occurred as a result of an accident while the deceased was in the course of employment or where the person who died was at the time of death in legal custody, for example in prison or police custody, an FAI is mandatory. The Lord Advocate has discretion to instruct an FAI in other cases where it appears to be in the public interest that an Inquiry should be held into the circumstances of the death.

The purpose of a Fatal Accident Inquiry is to ascertain the circumstances surrounding the death and to identify any issues of public concern or safety and to prevent further deaths or injuries. The Procurator Fiscal has responsibility for calling witnesses and leading evidence at an FAI, although other interested parties may also be represented and question witnesses.

At the end of a Fatal Accident Inquiry, a Sheriff will make a determination. The determination will set out:

- Where and when the death occurred
- The cause of death
- Any precautions whereby the death might have been avoided
- Any defect in systems which caused or contributed to the death
- Any other facts which are relevant to the circumstances of the death

The court has no power to make any findings as to fault or to apportion blame between individuals. The Sheriff has the power to make recommendations as to steps which ought to be taken to prevent a death occurring in similar circumstances in future. While there is no compulsion on any person or organisation to take such steps it would be unusual for such a recommendation to be disregarded.

MAPPA Significant Case Review

The fundamental purpose of MAPPA is public protection and managing the risk of serious harm posed by certain groups of offenders. It Is understood that the responsible authorities and their partners involved in the management of offenders cannot eliminate risk – they can only do their best to minimise that risk.

It is recognised that, on occasions, offenders managed under the MAPPA will commit, or attempt to commit, further serious crimes and, when this happens, the MAPPA processes must be examined to, firstly, ensure that the actions or processes employed by the responsible authorities are not flawed

and, secondly, where it has been identified that practice could have been strengthened, plans are put in place promptly to do so.

There are five stages to a MAPPA Significant Case Review:

1. Identification and notification of relevant cases
2. Information gathering
3. Decision to proceed, or not to a Significant Case Review
4. Significant Case Review process
5. Report and publication

The criteria for undertaking a Significant Case Review in MAPPA is:

- When an offender managed under MAPPA at any level, is charged with an offence that has resulted in the death or serious harm to another person, or an offence listed in schedule 3 of the Sexual Offences Act 2003;
- Significant concern has been raised about professional and/or service involvement, or lack of involvement, in respect of the management of an offender under MAPPA at any level;
- Where it appears that a registered sex offender being managed under MAPPA is killed or seriously injured as a direct result of his/her status as a registered sex offender;
- Where an offender currently being managed under MAPPA has died or been seriously injured in circumstances likely to generate significant public concern.

Offences

Obstruction

Section 49 of the Adult Support and Protection (Scotland) Act 2007 provides that it is an offence to prevent or obstruct any person from doing anything they are authorised or entitled to do under the act. It is also an offence to refuse, without reasonable excuse, to comply with a request to provide information made under section 10 (examination of records etc.). However, if the adult at risk prevents or obstructs a person, or refuses to comply with a request to provide access to any records, then the adult will not have committed an offence.

A person found guilty of these offences is liable on summary conviction to:

- A fine not exceeding level 3 on the standard scale; and/or
- Imprisonment for a term not exceeding 3 months.

Offences by corporate bodies etc.

Where it is proven that an offence under Part 1 of the Act was committed with the consent or connivance of, or was attributable to any neglect on the part of a “relevant person”, or a person purporting to act in that capacity, that person as well as the body corporate, partnership or unincorporated association is also guilty of an offence. A “relevant person” for the purposes of this section means:

- A director, manager, secretary or other similar officer of a body corporate such as limited company, a plc, or a company established by a charter or by Act if Parliament;
- A member, where the affairs of the body are managed by its members;
- An officer or member of the council;
- A partner in a Scottish Partnership; or
- A person who is concerned in the management or control of an unincorporated association other than a Scottish Partnership.

An unincorporated association is the most common form of organisation within the independent and third sector in Scotland. It is a contractual relationship between the individual members of the organisation, all of whom have agreed or “contracted” to come together for a particular charitable purpose, unlike an incorporated body the association has no existence or personality separate from its individual members.

Post Mortem Examination

The Procurator Fiscal will instruct a Post Mortem Examination for all suspicious deaths; all deaths which remain unexplained after initial investigation; and in a number of other situations where there are concerns about the circumstances or cause of death.

Serious Incident Review

A serious incident is defined as an incident involving: -

> ‘Harmful behaviour, of a violent or sexual nature, which is life ‘threatening and/or traumatic and from which recovery, whether physical or psychological, may reasonably be expected to be difficult or impossible.’ (Framework for Risk Assessment Management and Evaluation: FRAME)

And includes:

- An offender on statutory supervision or licence is charged with and/or recalled to custody on suspicion of an offence that has resulted in the death or serious harm of another person.
- The incident, or accumulation of incidents, gives rise to significant concerns about professional and/or service involvement or lack of involvement.
- An offender on supervision has died or been seriously injured in circumstances likely to generate significant public concern.

The purpose of a serious incident review is to ensure that local authorities and partner agencies identify areas for development and areas of good practice.

Following a serious incident, the Care Inspectorate must be notified of such within 5 working days. The Care Inspectorate will forward to Scottish Government Criminal Justice division. The local authority is then required to undertake a review of the serious incident and submit this to the Care Inspectorate within 3 months of the notification. The review can be completed in two ways: firstly, and initial analysis review is completed – this may be enough with the local authority concluding no further detailed review is required or; secondly following an initial analysis review a more comprehensive review is required.

The Care Inspectorate will then provide a written response to the review and the case will then either be closed or additional information sought.

Sudden and Unexplained Deaths

All sudden and unexplained deaths must be reported to the Procurator Fiscal. The death is usually reported by a doctor (either a General Practitioner (GP) or a hospital doctor), by the police or a local Registrar of Births, Deaths and Marriages. Whether or not the cause of death is known, if a doctor is of the view that a death is not known or is not clear to a doctor, this is described as an “unexplained death”.

Once a person’s death is reported to the Procurator Fiscal, it is for the Procurator Fiscal to decide what further action, if any, will be taken. The Procurator Fiscal may decide that further investigation is required which may include, but is not limited to, the instruction of a post mortem examination to

determine the cause of death and/or instructing the police to carry out further enquiries and provide a report.

While some death investigations may conclude once a cause of death is known, others may require further detailed and sometimes lengthy investigation, for example, those involving complex technical and medical issues which may require the instruction of independent experts to provide an opinion. At the conclusion of the Procurator Fiscal's investigation, it may be necessary for a Fatal Accident Inquiry (FAI) to be held.

Once a death has been reported to the Procurator Fiscal, the Procurator Fiscal has legal responsibility for the body, usually until a death certificate is issued by a doctor and given to the nearest relative. The Procurator Fiscal will usually surrender legal responsibility for the body once the nearest relative has the death certificate.

In a small number of cases, it may be necessary for the Procurator Fiscal to retain responsibility for the body for a longer period of time to allow for further investigations to be carried out into the circumstances. This happened with only a very small number of deaths, most likely where the death is thought to be suspicious. If this is necessary, nearest relatives will be advised by the Police or the Procurator Fiscal.

Suspicious Deaths

Where there are circumstances surrounding the death which suggest that criminal conduct may have caused or contributed towards the death, this is described as a "suspicious death". The Procurator Fiscal will instruct the Police to investigate the circumstances and consider whether criminal charges should be brought which may lead to a prosecution. All deaths where the circumstances are thought to be suspicious must be reported to the Procurator Fiscal.

In circumstances where the death is considered to be potentially suspicious, the Procurator Fiscal may direct that a two Doctor post mortem examination be carried out for corroboration purposes of the finding. This would be an essential element in the chain of evidence, particularly where criminal investigations and/or proceedings were to be instigated later.

Normally, a Senior Investigating Officer (SIO) will be appointed to investigate suspicious deaths and specially trained officers would carry out these investigations. These investigations may well identify criminality and also those who may be responsible and in these circumstances the police would follow their well-established investigative procedures. Good practice would always suggest that a Family Liaison Officer acts as the single point of contact between them and the police.

Public bodies with responsibility for scrutiny and improvement support include:

Care Inspectorate

The role of the Care Inspectorate is to regulate and inspect care, social work and child and adult protection services so that:

- Vulnerable people are safe
- The quality of these services improves
- People know the standards they have a right to expect

The Care Inspectorate reports publicly on the quality of these services across Scotland. The Care Inspectorate has a duty to support improvement in care and social work services and promulgate good practice. The Care Inspectorate is strongly committed to supporting strategic partnerships such as adult protection committees in their continuous improvement by proving support and feedback

locally and by identifying and reporting on wider themes and learning which could improve practice nationally.

The Health and Safety Executive

The Health and Safety Executive ("HSE") is a statutory body established under section 10 of the Health and Safety at Work Act 1974. The Health and Safety Executive's main statutory duties are to:

- Propose and set necessary standards for health and safety performance, including submitting proposals to the relevant SoS for health and safety regulations and codes of practice;
- Secure compliance with these standards, including making appropriate arrangements for enforcement;
- Make such arrangements as it considers appropriate for the carrying out of research and the publication of the results of research and encouraging research by others;
- Make such arrangements as it considered appropriate for the provision of an information and advisory service, ensuring relevant groups are kept informed of and adequately advised on matters related to health and safety; and
- Provide Ministers on request with information and expert advice

Local authorities also have a role in enforcing health and safety legislation in some privately-owned care homes. The HSE and Scottish local authorities have signed an agreement with the Care Inspectorate. The agreement has been developed to assist staff by:

- Promoting co-ordination of investigations, where appropriate, into incidents that have resulted in service user deaths or serious injuries, which could have been prevented
- Encouraging appropriate information to be shared in a timely manger
- Establishing and maintaining liaison arrangements

The Care Inspectorate agreement document can be found on the Health and Safety Executive website.

Healthcare Improvement Scotland

Healthcare Improvement Scotland ("HIS") is an organisation with many parts and one purpose – better quality health and social care for everyone in Scotland. They have five key priorities. These are areas where they believe they can make the most impact and where they focus efforts and resources.

- Enabling people to make informed decisions about their care and treatment
- Helping health and social care organisations to redesign and continuously improve services
- Provide evidence and share knowledge that enables people to get the best out of the services they use and helps services improve
- Provide quality assurance that gives people confidence in the services and supports providers to improve.
- Making the best use of resources, we aim to ensure every pound invested in our work adds value to the care people receive

HIS provides public assurance about the quality and safety of healthcare through the scrutiny of NHS hospitals and services, and independent healthcare services. HIS reports and published findings on performance and demonstrates accountability of these services to the people who use them. HIS also supports health and social care services to continuously improve and redesign services alongside the provision of evidence and sharing of knowledge. This makes a positive impact on the healthcare outcomes for patients, their families and the public, and feeds the improvement cycle by providing further evidence for improvement.

Mental Welfare Commission for Scotland

Investigations by the Mental Welfare Commission for Scotland focus on one person, but have lessons for many organisations. The Commission carries out investigations into deficiencies in an individual's care and treatment, particularly when it believes there are similar issues in other people's care and where lessons can be learned for services throughout Scotland. Their work is specific to individuals with mental ill health, learning disability, and related conditions. (See section 11 Mental Health Care and Treatment (Scotland) Act 2003).

The Mental Welfare Commission should be notified of significant events that meet particular criteria. It is difficult to be prescriptive, as each and every circumstance will be different. The criteria can be found on the Mental Welfare Commission website.

In the Scottish Government review of arrangements for investigating the deaths of patients being treated for mental disorder report (December 2018) Action 1 is:

The Scottish Government will ask the Mental Welfare Commission for Scotland to develop a system for investigating all deaths of patients who, at the time of death, were subject to an order under either the Mental Health (Care and Treatment) (Scotland) Act 2003 or Part VI of the Criminal Procedure (Scotland) Act 1995 (whether in hospital or in the community, including those who has their detention suspended).

This process should take account of the effectiveness of any investigations carried out by other agencies and should reflect the range of powers the Commission has to inspect medical records, carry out investigations, and hold inquiries (as set out in sections 11-12 and 16 of the 2003 Act). The design and testing of the new system should involve, and be informed by the views of carers, families and staff with direct experience of existing systems. It should include appropriate elements of public scrutiny and should involve staff, families and carers. The new system should have clear timescales for investigation, reporting and publication.

The commission is working to develop this system of reviews and further information and guidance will be issued to all stakeholders at an appropriate stage.

The Office of the Public Guardian

The Office of the Public Guardian (Scotland) ("OPG") has statutory powers to supervise financial guardians, financial interveners and withdrawers, and powers to investigate them (and continuing attorneys) where there is a concern or risk of financial abuse.

The OPG aims to ensure that these appointed proxies act in the best interests of the adults with incapacity, and that they carry out their duties properly, within the scope of their powers. If there is a concern about how an appointed proxy is acting, an investigation may be undertaken, and the incapable adult's property or financial affairs may be appropriately safeguarded from risk from abuse or misuse.

Anyone who has concerns that an adult's funds/property are at a risk, can refer the matter to the OPG.They will need to provide evidence to support those concerns. Concerns might include:

- The way in which an attorney, who has authority to manage an adult's finances or property, is using that authority.
- An adult's property or financial affairs appears to be at risk, perhaps because of the involvement of a third party who has no authority to manage the adult's finances.

When investigating continuing attorneys, the Office of the Public Guardian only has a locus when the granter/adult has lost capacity; when a current and future risk has been identified (the Office of the

Public Guardian does not have a remit to investigate historical matters); and, where no proxy (joint attorney) has been appointed who could investigate and safeguard the estate.

The Scottish Fire and Rescue Service (SFRS)

The Scottish Fire & Rescue Service ("SFRS") is a national organisation delivering front-line services locally across three Service Delivery Areas (SDAs) in the North, West and East of the country. SFRS works in partnership to reduce the incidences of fire in Scotland and, continues to play a key role in prevention, to ensure the safety and wellbeing of Scotland's communities.

The SFRS have a specialist fire investigations unit located in each SDA (Glasgow, Edinburgh and Aberdeen). The teams work exclusively on fire investigation. Their role allows them to build a comprehensive knowledge base, identify issues, track trends and understand the circumstances surrounding the fire event. The investigation process culminates in a detailed report that identifies the origin, cause and fire development. This information is shared across the organisation and partners (where appropriate) in order to learn from previous incidents and, improve community and firefighter safety. By jointly investigating fire incidents, the SFRS aim to reduce the instances of fire and reduce the number of fire deaths, injuries and trauma resulting from such incidents.

A multi-agency protocol to jointly investigate fires was introduced in 2013. This protocol commits SFRS, Police Scotland and Scottish Police Authority (SPA) Forensic Services to work together and share their specialist skills and expertise when dealing with certain levels of investigations. The protocol ensures that the approach to investigations is consistent across the organisations, and across the country.

Scottish Social Services Council

The Scottish Social Services Council ("SSSC") is the regulator for the social services workforce in Scotland. SSSC register social services workers, set standards for practice, conduct, training and education and support professional development. Where people fall below standards of practice and conduct they can investigate and take action.

The fitness to practice process of a professional regulator, such as SSSC, may be running in parallel with a Learning Review. Where there are issues with the conduct of workers who are registered with the SSSC, it would be helpful to keep them informed. This will support the coordination of activity between organisations and minimise duplication.

Annex 8

Example Media Communications Plan

Prepared on behalf of the ……………………… Adult Protection Committee/Chief Officers Group

Date last updated: ………………

Title	Learning Review – X
Lead	Adult Protection Committee/Chief Officers Group
Initial preparation date	DD/MM/YY
Lead partners and key stakeholders	• Council • NHS board • Health & Social Care Partnership • APC • Police Scotland • Scottish Government • Care Inspectorate • The Crown Office
Main communications contacts	• Council • NHS • Health & Social Care Partnership • Police Scotland • Scottish Government • Care Inspectorate • Crown Office Procurator Fiscal Service
Context	Brief Description of the subject matter of the Learning Review together with key points.
Aims	• To reassure the local community • To provide a coordinated response to questions and concerns raised internally across all agencies and externally with the public • To deliver accurate information about the case, including roles and responsibilities and action taken

	• To ensure that public confidence in the member agencies is appropriately supported • To deliver a human and compassionate message about the tragic incident
Communications outcomes	• Balanced media reporting of the facts and key messages • Ensure internal audiences, including elected members and members of health boards, are aware of the facts and key messages and the actions that are being taken within their own organisation, as appropriate • Reporting of any action that has been taken or will be taken, as appropriate • Tone of compassion, openness, transparency and willingness to learn if there are improvements to be made
Target audiences	• Direct family/proxies and/or Adult subject to the review • Social work services across the Council and HSCP, as appropriate; NHS; Police Scotland (local) • Local Elected Members and NHS Board Members • Local communities • Scottish Government • Media • Other partner stakeholders, as appropriate
Other stakeholders for consideration	• Local MSPs and MPs • Care Inspectorate and Health Improvement Scotland • Social Care staff; public sector workers • General public • Social Work Scotland • SSSC • Office of the Public Guardian (Scotland) • Mental Welfare Commission
Potential risks	• Lack of coordination • Inconsistent messages from partners • Third-party media statements • Lack of understanding/awareness of roles and responsibilities • Off-the record briefing • Media presentation of adult or child protection issues – wider media agenda

	• Appearance of defensiveness • Public expectation of action by responsible organisations – call for people to step down
Strategy	• Be compassionate, open, available and responsive – even if there is little new information that can be shared • Hold information back by exception and only where there is precedent and/or a publicly justifiable reason to do so. Note – the reason will need to stand up legally and for example if information is requested under 'Freedom of Information' • Acknowledge any mistakes genuinely and upfront – explain circumstances consistently and clearly – confirm what action will be taken – why, by whom and when and what difference that will make • Front the review through a single spokesperson but ensure partner agencies have what they need to respond to specific questions and on a timely basis • Set the communication strategy – including the tone of response – through the APC/COG Group and deliver through the communication leads in each partner agency • Agree timetable and channels for release of information. Key findings of the Review to be published online and agreed statement through a release to media. Social media to be monitored by communications leads and co-ordinated responses agreed as appropriate through council communications. Deal with interviews on request. • Agree responsibilities for briefing target groups in advance of publication • Coordinate initial media enquiries through an agreed lead agency but route responses through communication leads in individual partner agencies.

Communications Action Plan

Requirements	Deadline	Audience	Action	Responsibility
Timetable agreed		APC COG Partner agency leads	• Communication strategy/action plan agreed by COG & APC	Lead Agency Communications (co-ordination)
Report and/or executive summary		APC COG Partner agency leads	• Full report and/or Executive Summary agreed and signed off	APC
Key messages		APC COG Partner agency leads	• Key messages from the report developed and agreed	Lead Agency Communications (co-ordination)
Spokespeople		APC COG Partner agency leads	• Lead spokesperson for the review agreed, following media training feedback	APC & COG
Public Statements		APC COG Partner agency leads	• Press statement and publication arrangements finalised and agreed • Questions and Answers – on process etc. • Background notes for Editors	Lead Agency Communications to draft and agree through Communications leads
Day of publication – internal briefings		Direct staff Family Administration	• Face-to-face briefing on key messages including findings, action	APC to upload report to Adult Protection website and

Requirements	Deadline	Audience	Action	Responsibility
		Group Leaders/Convenors All members MSPs MPs Other stakeholders as appropriate	and responsibilities, how to handle questions and timetable ahead • Provide link to report online • Provide copy of agreed media statement being issued	provide link to Communications leads Relevant services to carry out appropriate staff briefings Family liaison contact to meet with family. Communications leads to ensure their own appropriate stakeholders are provided with information
Day of publication - media		Media Public	• Report online • Intranet • Media statement • Partner websites • Social Media monitored • Interviews on request? • Media monitoring	Lead Agency Communications and Communications leads
Post publication		APC COG Partner agency leads	• Evaluation of media coverage • Report back to COG	Lead Agency Communications

Media response

Issues highlighted by the Learning Review:

Key media messages:

Potential media questions:

- Why is the Learning Review not being published in full?
- Why is the Learning Review not being published?
- Services are failing adults at risk of harm. Are vulnerable adults safe in in this area? Is the system broken?
- It seems that there is catastrophic service failure. Who is responsible? Why is no one losing their job over this?
- This Learning Review highlights recurring themes highlighted in previous reviews. Why are you not learning from past reviews?
- Staff don't appear to understand the processes and procedures they need to do their jobs properly. Is there an issue in terms of lack of training/resources? Or have staff been negligent?
- Will this happen again?

Scottish Government
Riaghaltas na h-Alba
gov.scot

© Crown copyright 2022

OGL

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit **nationalarchives.gov.uk/doc/open-government-licence/version/3** or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: **psi@nationalarchives.gsi.gov.uk**.

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

This publication is available at **www.gov.scot**

Any enquiries regarding this publication should be sent to us at

The Scottish Government
St Andrew's House
Edinburgh
EH1 3DG

ISBN: 978-1-80435-432-2 (web only)

Published by The Scottish Government, May 2022

Produced for The Scottish Government by APS Group Scotland, 21 Tennant Street, Edinburgh EH6 5NA
PPDAS1084622 (05/22)