

Spotlight on Learning Reviews

What is a Learning Review?

Learning from cases where a child or adult has died, been significantly harmed or put at risk of harm is an essential element of improving how agencies work together to appropriately support and intervene to protect children and adults. The overall purpose of a Learning Review is to bring together agencies, individuals and families to jointly learn from what has happened in order to improve systems and practice in the future.

The Scottish Government has published broadly similar sets of guidance for undertaking Learning Reviews in relation to [Adult Support and Protection](#) and [Child Protection](#). We are now using these in East Lothian and Midlothian. Click on those links to read more.

Creating the preconditions for learning

Looking at cases when something has gone wrong can be challenging. Reviewing complex situations can raise anxiety for individuals and organisations – but we know that this does not support open and effective learning. We know that blame and criticism can create defensiveness, which in turn blocks learning. Learning Reviews are not investigations or an enquiry into why a child died or was harmed. Rather, they:

- Are an opportunity for critical reflection to gain greater understanding of complex situations;
- Go beyond individual professional practice to explore what factors in the systems, processes and culture of the organisations contributed to the outcome for the child or adult;
- Focus on understanding how people see things at the time, why things happened as they did and the operating context; and
- Will include an analysis of effective practice as well as what went wrong.

How is a Learning Review conducted?

A Review Team comes together to review and assess the information and clarify what needs further exploration. Key elements of the process are a Practitioners' event and a Managers' event, which draw out the learning rather than an 'expert' Review Group identifying the learning. The Reviewer completes a report based on the learning drawn from all of this.

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What are the key features of a Learning Review?

- ✓ Inclusiveness, collective learning and staff engagement
- ✓ Support for staff is critical and should be integral to the review process so that they can participate fully in the process, reflect on practice, share knowledge and contribute to the learning as it emerges. It is essential that the Review Team and senior leaders in organisations create and support a positive shared learning culture at all stages
- ✓ A systems approach – it explores the interaction of the individual with the wider context, exploring cultural and organisational barriers, in order to understand why things developed in the way they did
- ✓ Proportionality and flexibility – it is really important to keep the process simple, notwithstanding the situations that are under review will inevitably be complex and diverse
- ✓ Timing and timeliness – it is important to avoid drift and delay in the review process, including the dissemination of the learning. A decision to consider whether to hold a Learning Review should ideally be taken within around six weeks of the initial notification. The recommended timescale for completion of a Learning Review is six to nine months. Whilst other processes, such as criminal proceedings or a Fatal Accident Inquiry, may also be running, the national guidance provides information on liaison with Police Scotland and the Crown Office to ensure that a Learning Review does not prejudice or put in jeopardy any other proceedings.

Sharing the learning from a Learning Review

We should not shy away from sharing the learning locally and nationally. It is important that we do so in a sensitive way that does not identify any individual child, adult or staff member. The new guidance encourages us to share the learning without the need to 'tell the story' of what happened. Locally, we will do this through the use of '7-minute briefings' and online briefings and incorporate the messages and learning into training courses.