



FIFE ADULT SUPPORT AND PROTECTION COMMITTEE

LEARNING REVIEW

PROTOCOL

BETWEEN

Fife Council Health & Social Care Partnership

Fife Council Housing

Police Scotland (Fife Division)

NHS FIFE

SFRS

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CHAPTER 1: Setting the Scene

1. Introduction

The purpose of this framework is to support a consistent approach to conducting Adult Support and Protection Learning Reviews and improve the dissemination and application of learning across all partner agencies. Supporting and protecting adults at risk of harm is an inter-agency and inter-disciplinary responsibility supported strategically by Fife Adult Protection Committee. This framework is for all partners.

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. Consideration should always be given to the involvement of staff in reviews and subsequent feedback to them at the conclusion of the review.

Fife Adult Support and Protection Committee should carry out Learning Reviews in certain circumstances and this framework sets out those circumstances. Other case review and legal processes may need to be considered when planning to undertake an Adult Support and Protection Learning Review [please see **Annex 2**].

This framework should be viewed as guidance to:

- assist in the protection of adults at risk of harm
- assist decisions about the effectiveness of the particular route adopted and help manage the overall process
- complement the protocols and procedures that have been approved by Fife Adult Support and Protection Committees
- help identify how processes can be managed through other suggested routes and review structures
- provide templates and flow charts to support process

2. Roles and Responsibilities

The Adult Support and Protection (Scotland) Act 2007 ('the Act') was passed by the Scottish Parliament in February 2007. 'The Act' was implemented in October 2008 and specified the powers and duties in relation to protecting adults at risk of harm. Under 'the Act', the Local Authority has a statutory duty to make inquiries about the well-being, property or financial affairs of an individual if they know or believe that the person is an adult at risk and that they might need to intervene to take protective actions. 'The Act' provides powers available to council officers to carry out investigations as deemed appropriate for the purposes of inquiry into the circumstances of an adult in order to protect them from harm.

Sections 5.1, 5.2 and 5.3 of 'the Act' place a duty on those agencies named that when they know or believe an adult is at risk of harm, they must report the facts and circumstances of the case to the Local Authority. Furthermore, the agencies named must also co-operate with inquiries made by the Local Authority in relation to adults at risk of harm.

Section 42(1) of 'the Act' states that the Local Authority has a duty to establish a multi-agency Adult Protection Committee with the following functions:

(a) to keep under review the procedures and practices of the public bodies and office-holders to which this section applies which relate to the safeguarding of adults at risk present in the council's area, including, any such procedures and practices which involve co-operation between the council and other public bodies or officeholders.

(b) to give information or advice, or make proposals, to any public body and officeholder to which this section applies on the exercise of functions which relate to the safeguarding of adults at risk present in the council's area.

(c) to make, or assist in or encourage the making of, arrangements for improving the skills and knowledge of officers or employees of the public bodies and officeholders to which this section applies who have responsibilities relating to the safeguarding of adults at risk present in the council's area.

The conduct of Learning Reviews by Fife Adult Protection Committee under these functions will help to reduce harm to adults at risk by identifying areas for improvement and sharing learning.

3. Governance

Fife Adult Support and Protection Committee is responsible for deciding whether a Learning Review is warranted using the criteria in this framework, and for agreeing the manner in which the review is conducted on behalf of the Chief Officers Group or equivalent. The Convenor of the Adult Protection Committee advises and makes a recommendation to the Chief Officers' Group when a Learning Review is required. As such, the Chief Officers' Group is the commissioner of any Learning Review with an interest in its findings and the ownership of the process and any reports generated belong to Fife Adult Support and Protection Committee.

Having considered the report, they will issue any direction or instruction as necessary and in particular, indicate:

- Their agreement, or not, with the proposals that relate to how any lessons will be incorporated and implemented within and across relevant agencies and their staff.

- Their wishes in relation to dissemination of the report, having taken account of the proposals presented by the Adult Support and Protection Committee.

4. 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 Fife 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 agencies' 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 would refer the circumstances to the Adult Support and Protection Committee for their consideration at the earliest opportunity.

Referrals can be made by any person from any agency represented on the Adult Support and Protection Committee. Each agency will agree its own route for referrals, but they should usually be made via the agency's senior officer or designated manager.

5. Definition of an Adult at risk of Harm

The Adult Support and Protection (Scotland) Act 2007 defines an 'adult at risk' as a person aged 16 years or over who:

- is unable to safeguard her/his own well-being, property, rights or other interests
- is at risk of harm **and**
- because they are affected by disability, mental disorder, illness or physical or mental infirmity are more vulnerable to being harmed than an adult who is not so affected.

The presence of a particular condition does not automatically mean an adult is an 'adult at risk'. An adult can have a disability but be able to safeguard their well-being etc.

It is important to stress that all three elements of this definition must be met. It is the whole of an adult's particular circumstances which can combine to make them more vulnerable to harm than others.

An adult is at risk of harm if:

- another person's conduct is causing (or is likely to cause) the adult to be harmed, or
- she/he is engaging (or is likely to engage) in conduct which causes (or is likely to cause) self-harm.

6. Definition of harm

S 53 of 'the Act' states harm includes all harmful conduct and, in particular, includes:

- a) Conduct which causes physical harm
- b) Conduct which causes psychological harm (for example: by causing fear, alarm or distress)
- c) Unlawful conduct which appropriates or adversely affects property, rights or
- d) interests (for example, theft, fraud, embezzlement or extortion)
- e) Conduct which causes self-harm

The Code of Practice to 'the Act' explains that the definition is not exhaustive, and no category of harm is excluded because it is not explicitly listed. In general terms, behaviours that constitute 'harm' to a person can be physical, sexual, psychological, financial, or a combination of these. The harm can be accidental or intentional, as a result of self-neglect or neglect by a carer or caused by self-harm and/or attempted suicide. Domestic abuse, gender-based violence, forced marriage, human trafficking, stalking, hate crime and 'mate crime' will also be considered as types of harm.

7. Inter-related investigations, reviews and other processes

There are a number of other processes, including criminal investigations, PIRC investigations and NHS Significant Adverse Event reviews, that could be running in parallel with a Learning Review (please see Annex 2) 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
- Ensuring that the learning identified across inter-related investigations aligns with learning and learning plans identified during the Learning Review process.

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 a criminal investigation, report of a death to the 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 there should be on-going dialogue with Police Scotland, COPFS or others to determine how far and fast the Learning Review process can proceed in certain cases. Good local liaison arrangements are important. 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, problematic alcohol and drugs use or young people in transition from children's services. On occasion complex interconnected events may require consideration of a joint Learning Review.

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.

8. Cross-authority cases

A Learning Review for Fife Adult Support and Protection Committee area may involve agencies from a different local authority, health board or police division; care home residents may be placed out of district for example. Delay in making contact with representatives from other Local Authorities should be avoided.

In the case of a potential cross-authority Learning Review, Fife Adult Support and Protection Committees should agree a mechanism for joint working, including which Adult Support and Protection Committee should take the lead, and if required joint commissioning of a lead reviewer. It will also be important that clear channels are identified for how information is shared across local authorities. This should be authorised by the Adult Support and Protection Committee Conveners and coordinated through the Adult Support and Protection Committees, with authority delegated to

Coordinators or Lead Officers. They should advise the Chief Officers' Group or equivalent. 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.

Where a dispute is not resolved and one Adult Support and Protection Committee wishes to progress, the other Adult Support and Protection Committee should make all the information that they hold on the case available to support the review. The detail of their decision not to proceed should be noted within the Learning Review.

9. Cross-UK cases

Cross-UK Significant Learning Reviews have been rare, but it is possible that adults at risk of harm and their families/carers could become involved with services across borders and a Learning Case Review involving two or more countries may be considered.

It is not possible to provide definitive guidance, as each case under consideration will be unique. However, building on the experience and learning of those Adult Support and Protection Committees who have undertaken such Learning Reviews the following points should be considered:

- Early contact with the Local Adult Safeguarding Board (England), Area Adult Protection Committees (Wales), and the equivalent in Northern Ireland to identify a link person and provide that body with a link person within Fife Adult Support and Protection Committee.
- Make available the remit of the Learning Review and request the remit of the appropriate Safeguarding Adults Board or equivalent.
- Enter into a memorandum of understanding, which should be explicit in its terms regarding access to records and staff and liaison with family members, for example.
- Consider having a member of the Safeguarding Adults Board, or its equivalent, as a member of the review team for specific meetings and tasks.
- Agree a communication strategy, which should be clear about media handling and what information may be made available in any report. It must be borne in mind that in England and Wales there is a duty to publish every Serious Case Review for public dissemination and in Northern Ireland Case Management Review (CMR) executive summaries are published. As there is no legal requirement to publish Learning Reviews in Scotland any references to data from Scotland may have to be redacted.
- Consider joint contact with the adult at risk of harm and their family/carers (or other significant persons) to make them aware of the cross-UK nature of the Learning Review and establish what arrangements will be carried out for

feedback, and for informing the family/carers of the publication of the Learning Review outcome.

10. The purpose of a Learning Review

An Adult Support and Protection Learning Review is a means for public bodies and office holders, with responsibilities relating to the support and protection of adults at risk, to learn lessons from considering the circumstances where an adult at risk has died or been significantly harmed. It is carried out by Fife Adult Support and 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 Act'.

A Learning Review should seek to:

- Understand the full circumstances of the death; or serious harm to, an adult (where parallel processes like a criminal investigation are in place, it may not be possible to gather and report full information).
- 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 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 Fife Adult Support and Protection Committee to consider what recommendations need to be made to improve the quality of services.

11. Key Features of Learning Reviews

The Key Features of a Learning review include:

- **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 structured process in order to reflect, increase understanding and identifying key learning.
- **Support for staff** – support for staff is critical and should be integral to the review process in order that they can participate fully in the process, reflect on their practice, share their knowledge and contribute to the emerging learning.
- **A systems approach** – The learning review does not stop at points when shortcomings in professional practice have been recognised. It moves on to explore the interaction of the individual with the wider context, including cultural and organisational barriers, in order to understand why things developed in the way they did. The focus is on:
 - What happened
 - How some assessments were made?
 - Understanding how people saw things at the time
 - What knowledge was drawn to makes sense of the situation, the resources available and the emotional impact of the work
 - Effective practice
 - Identification of learning points and how these will be actioned and implemented in future practice and systems
- **Proportionality and flexibility** – The situations under review will inevitably be complex and diverse and this therefore requires a streamlined, proportionate and flexible approach to ensure effective learning. This flexible approach remains grounded in the underpinning principles and values of Learning Reviews.
- **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 practice 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.

12. The overarching objectives of review are to:

- Keep under review the procedures and practices of the public bodies and officeholders required to cooperate with councils to which section 43 (3) of 'the Act' applies which relate to the safeguarding of adults at risk present in the council's area.
- Give information or advice, or make proposals, to any public body and officeholder to which section 43 (3) of 'the Act' applies on the exercise of functions which relate to the safeguarding of adults at risk present in the council's area.
- Share learning with relevant agencies and make recommendations for action.
- Consider how any recommended actions and learning will be implemented.
- Address the accountability, both of the agency/agencies and the occupational groups involved.
- Increase public confidence in public services, providing a level of assurance about how those services acted in relation to a significant case about an adult at risk of harm.

This framework supports the achievement of these 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 and consider how these might be obtained.
- Address the needs of the many individuals and agencies who may have a legitimate interest in the process and outcome.

This framework sets out:

- The criteria for identifying whether a Learning Review is required
- The procedure for undertaking a Learning Review Referral
- The process for conducting a Learning Review including reporting mechanisms and dissemination of learning tools to support the process of conducting a Learning Review

CHAPTER 2: Learning Review Referral

1. Criteria for undertaking a Learning Review

:

Fife Adult Support and Protection Committee will undertake a Learning Review in the following circumstances:

- a) Where the adult is, or was, subject to adult support and protection processes** 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) When an adult at risk of harm has not died but** is believed to have experienced serious harm 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.

3. Learning Review Referrals

A Learning Review Referral is an opportunity for Fife Adult Support and Protection Committee to consider information relating to the case, determine the course of action and recommend whether a Learning Review or other response is required. Due consideration should be given to the evidence available to suggest that the above criteria is met. It may be appropriate for partner agencies to have initial conversations to satisfy themselves that there is evidence to support the criteria being met. A Learning Review Referral should not be escalated beyond what is proportionate taking account of the severity and complexity of the case. The process and its timescales should not detract from agencies taking whatever urgent action is required to protect any other adult who may be at risk of harm.

When a case meets or appears to meet the criteria above a Learning Review Referral discussion should be undertaken. Where time limits are referred to it is important that they are adhered to. If there is difficulty with a time limit the report should record the reason for the delay. Support for staff may need to be considered.

How to refer:

The Referrer should send an Adult Support and Protection Learning Review Notification (please see Annex 2 for template) to the Adult Support and Protection Coordinator using the referral template. The Adult Support and Protection Learning Review Notification should be submitted by email within **one week** of the case coming to the attention of the agency's senior officer or designated manager. Where it has not been possible to meet this timescale, the reason should be noted on the form.

If the case is high profile or is likely to attract media attention the relevant agency adult protection lead officer, and the Adult Support and Protection Chair should be alerted by phone.

The completed Adult Support and Protection Learning Review Notification will include:

- A statement about the current position of the adult, and if they are alive, what actions have been or will be taken on their behalf.

- A brief description of the case and the basis for referral.
- Any other formal proceedings underway or completed (Annex 1).
- A summary of agency/professional involvement, including chronology.
- Contact details.

The Adult Support and Protection Learning Review Notification will not include questions to be answered by other agencies.

When an Adult Support and Protection Learning Review Notification has been received the Adult Support and Protection Coordinator will:

- Send an acknowledgment that the Notification has been received.
- Log the Notification and give it a unique numbered identifier.
- Notify all relevant agencies and include the Adult Support and Protection Learning Review Notification (Annex 3).
- Send a Request for information to allow consideration to be given to the need for an Adult Support and Protection Learning Review (Please see Annex 4 for template) and chronology (Please see Annex 5 for template) from each agency.

What agencies must do on receipt of a request for information:

- Acknowledge receipt of the Adult Support and Protection Learning Review Notification.
- Inform relevant personnel within their own agencies.
- Identify an agency representative to send single agency information to the Adult Support and Protection Coordinator using the Report template within **two weeks**. Information supplied must include a chronology and indicate the agency involvement with the adult and any other agency.

The information gathering process should include:

- A summary of involvement including background.
- An outline of key issues.
- A chronology.

- Any identified elements of good practice.
- Any identified areas for improvement.
- Details of any inter-related processes, investigations or reviews and any particular complexities (e.g. from the Procurator Fiscal, Police or any other agency, about cases where there are ongoing, or likely to be, criminal proceedings, Fatal Accident Inquiry or disciplinary proceedings) Details of any underlying or cross-cutting issues (this may involve consideration of any other agencies that should have been involved).

If agencies cannot reasonably complete the Request for information to allow consideration to be given to the need for an Adult Support and Protection Learning Review paperwork for the Adult Support and Protection Committee within the suggested times, this and the reasons for this should be recorded.

Where an agency has had no involvement they must return the Request for information report noting that there was no involvement with the service user.

Following collation of the Reports and the compilation of a multi-agency chronology, the Case Review Working Group (CRWG) will meet to take forward discussions relating to the Learning Review Referral (please see Annex6 for CRWG Terms of Reference).

The CRWG will identify the most appropriate member to liaise with other agencies where there are parallel processes taking place or the case is cross local authority or cross UK. Points of contact will be established, names recorded and the most up-to-date information from these other agencies will be gathered and shared with the CRWG to inform the decision on whether, and when, to proceed or not.

The CRWG will discuss (please see Annex 7 for Learning Review Referral Agenda) and make a decision on:

- a) Whether the adult meets the criteria as an adult at risk of harm. If the adult is considered to meet the criteria then the CRWG will;
- b) Make a decision on whether or not the case proceeds to a Learning Review or request further information from agencies to be provided as soon as possible/within an agreed time period.

A Learning Review should only be undertaken when the criteria are met, where there is potential for significant corporate learning and where a Learning Review is in the best interests of adults at risk and in the public interest.

Following consideration there are several potential outcomes available to the CRWG:

- A Learning Review should be carried out.

- A Learning Review, or a decision on this, may be deferred until the outcome of another investigation, review or process is known, if necessary.
- The CRWG may decide that no Learning Review is needed but follow-up action by one or more agencies is required if, for example, local protocols need to be reinforced. The CRWG may want to draw appropriate guidance to staff's attention or to review training or protocols around a particular theme. They may also decide to initiate local action to rectify an immediate issue or to undertake single agency action. Follow-up action should be agreed and combined in a Learning Review Referral action plan.
- Where the CRWG is satisfied there are no concerns and there is no scope for significant corporate learning or the information provided indicates that appropriate action has already been taken, they may decide to take no further action.

Whilst there may be additional agencies invited to provide additional information, the decisions relating to the criteria and Learning Review fall to the core CRWG members only. Where there is dissent between core members, the CRWG chair will make the final decision and the dissent will be noted within the recommendations to the Adult Support and Protection Committee.

The CRWG advises and makes recommendations (please see Annex 8 for Discussion Template) to the Adult Support and Protection Committee.

The Adult Support and Protection Committee advises and makes recommendations to the Case Review Oversight Group (CR-SOG). Where there is dissent between Committee members, the Convenor will make the final decisions and the dissent will be noted within the recommendations to CR-SOG.

The CR-SOG advises and makes recommendations to the Chief Officers Group on the outcome of a Learning Review Referral and any decision to proceed to a Learning Review. Where there is dissent between CR-SOG members the chair will make the recommendation going forward and this will be presented to members of the Chief Officers of Public Safety (COPS).

All decisions (including no further action) and the reasons for these decisions should be recorded by the Adult Support and Protection Committee. A record of decision-making should be compiled (please see Annex 7 for template) and Learning Review Report (please see Annex 8 for template) should be completed.

The Adult Support and Protection Committee should maintain a register of all potentially significant cases (please see Annex 10 for template) referred to it in order to evidence the decisions made; monitor the progress of the reviews undertaken; monitor and review the implementation of recommendations; and identify contextual trends (e.g. prevalence of substance misuse).

A written record of the decision should be sent to all agencies directly involved with the adult and stored appropriately. Each agency should ensure that the outcome and decisions are noted within the relevant clinical and care governance structures. If a decision is made to proceed to a Learning Review, the Adult Support and Protection Committee should advise the adult and/or family/carers of its' intentions. Notification should be sent to the Care Inspectorate, using the Learning Review Report, and, if appropriate for parallel processes, to other relevant parties (for example, Crown Office and Procurator Fiscal Service).

CHAPTER 3: Carrying out a Learning Review

1. Carrying out a Learning Review

Interdependencies

A potentially complex set of activities (see **Annex 2**) may be triggered by a significant case. It is important that local services do not interfere in or contaminate that activity, especially in relation to evidence gathering where there is, or might be, a criminal investigation – whether of staff involved in a case or a third party. The key requirement is to maintain good ongoing dialogue with the COPFS and/or Police Scotland to ascertain where they are in their considerations and agree what can be progressed in the Learning Review. Efforts should be made to minimise duplication and ensure, as far as is practicable, that the various processes are complementary albeit their purpose could be somewhat different. These inter-related processes are less likely to take place if a significant case does not involve a death. During the course of a Learning Review any evidence of criminal acts or civil negligence relating to the case which comes to the attention of the Lead Reviewer (see below) or Review Team should be reported to the Police.

Fife Adult Support and Protection Committee should seek to ensure they have a named contact in the Procurator Fiscal's office to be able to pursue such ongoing dialogue as is required to meet the objectives of each type of activity. There will also be agency-specific work that is routinely undertaken, particularly on the death of an adult at risk of harm, for example, when this occurs in hospital or is unexpected such as in the case of sudden unexpected deaths. It will be important that any Learning Review is coordinated to dovetail with such work to avoid duplication of effort and unnecessary further review.

Communication

Fife Adult Support and Protection Committee should seek to inform all those who will contribute and who have a legitimate interest in the Learning Review at each stage of the process. It may be useful to have a single point of contact and keep a log of who requests information. As each significant case will be different, the names and roles of those with an interest might vary. Throughout the process, consideration should be given as to whether there is anyone else who should be informed, or how much information should be offered to different parties on the Learning Review. It is important to be clear who needs to be aware of the review, what information they need, and when

and how this will be provided. Each Adult Protection Committee should agree with local agencies who the contact points should be and their role in the process, i.e. whether it is communication for information or decision-making.

The Lead Reviewer/s

Fife Adult Support and Protection Committee will need to consider whether a Learning Review should be led internally or externally or with some external overview. Adult Protection Committees must ensure that the Lead Reviewer and the review team, between them, have the necessary skills and competencies¹ to undertake a Learning Review. These skills will differ according to the circumstances of each case and the agreed role of the review team.

The Adult Support and Protection Committee may decide to appoint an **internal lead reviewer or two reviewers** if the circumstances of the case, based on the evidence of the Learning Review Referral, suggest that any recommendations are likely to have mainly local impact. In the case of an internal review the team would probably be drawn mainly from within the Adult Protection Committee's member agencies, but it should always consider using external expertise to provide impartial advice or comment in the form of a consultant, professional advisor or critical friend.

The Adult Protection Committee may decide to commission an **external lead reviewer** if:

- There are likely to be national as well as local recommendations.
- Local recommendations are likely to be multi-agency rather than single agency.
- The case is high profile or is likely to attract media attention.
- Councillors, MSPs or other elected members have voiced concerns about local services.
- The Adult Protection Committee is facing multiple reviews.
- The adult's family/carers or significant others have expressed concerns about the actions of the agencies.

Where an external review is commissioned, the Learning Review continues to be owned by the Adult Support and Protection Committee.

The Adult Support and Protection Committee should agree any formal contractual arrangements that may be required. They should consider which agencies will enter into the contract and ensure that individuals have professional indemnity cover. Consideration should be given to involve legal services in the drawing up of formal contracts that incorporate areas such as timescales, fees and confidentiality. Their contract should also include explicit instructions on the access to, storage of, transport

of, transmission of and disposal of sensitive personal information as required by the Data Protection Act. As the independent chair is acting on the instructions of the Adult Support and Protection Committee (representing the Chief Officer Group or equivalent) they are acting as a Data Processor and not a Data Controller for the purpose of the Learning Review and do not require to be registered with Information Commissioner's Office.

Regardless of whether the Lead Reviewer is internal or external the Adult Support and Protection Committee will wish to set out clear expectations in respect of timescales, key milestones in the process and for completion of reports.

The Review Team

The Adult Support and Protection Committee should ensure there is sufficient multi-agency representation on the review team in order to reflect the case in question. It is important to assemble a mixed team to support the Lead Reviewer so that key agencies feel confident their specialist issues are understood. The different perspectives of a mixed review team can add to the depth of enquiry. Any training or information requirements for the team should be considered. Consideration should also be given to the knowledge, skills and experience required in the review team.

The review team should be agreed, and their roles and responsibilities, including who will undertake tasks such as file reading and interviews, tasks, and how disputes will be resolved. No-one should be involved in a review if they were directly involved in the case in a professional capacity.

For any review team, it is important to establish whom the key contacts are in all the agencies involved. These could be designated Learning Review contacts who can also advise on, and broker access to, relevant practitioners and information, provide any agency information that may be relevant (protocols/guidance) and generally act as a liaison point. In addition, consideration should be given to who will make the links with relevant parties beyond the main statutory agencies. The team will also need to gather relevant evidence from a wide variety of sources and be prepared to negotiate if information is not forthcoming.

The Adult Support and Protection Committees will want to consider ensure that the Review Team has the following:

- A broad knowledge of health and social care, criminal justice and other relevant areas, such as housing.
- Recent operational experience at a senior level of health and social care or criminal justice.
- Investigation skills.
- Analytical and evaluation skills.

- Report writing skills.
- An understanding of different methodologies and why one may be more appropriate than another in particular circumstances.
- Ability to make sound judgments on information collected.
- Ability to critically analyse all factors that contributed to the learning review and the wider impacts for practice and service delivery where appropriate.
- Ability to liaise with other bodies and establish a good working relationship.
- Demonstrate sensitivity to national and local level issues.
- Appreciation of the need to be clear about the difference between a Learning Review remit and task as opposed to other ongoing proceedings relating to that case (for example, a criminal investigation).
- Where required, specialist input.

Methodology

Fife Adult Support and Protection Committee should always consider and agree the methodology to be used in undertaking the Learning Review. This may vary according to the case and agreed responsibilities of the team. Reviewers are expected to be able to use an established and evidence-based scrutiny methodology; for example, systems approach, root cause analysis² or the Social Care Institute for Excellence (SCIE) 'Learning Together' model³. For those conducting a Learning Review using this methodology, there will be no specific recommendations but findings and issues for the Adult Protection Committee to consider. The Welsh Government⁴ has developed a tiered approach. This has a multi-agency professional forum for cases with a shorter process and formal review processes.

Chronology or timeline

The Adult Support Protection Committee will wish to ensure that a multi-agency chronology or timeline of significant events and contacts is prepared (this may already have been prepared as part of the Learning Review Referral process) and circulated to agencies and professionals to check for accuracy.

Remit

Depending on the comprehensiveness of the information gathered at the Learning Review Referral stage it may be possible for the Adult Support and Protection Committee, or specially convened sub-group, to agree the remit of the Learning Review at or following the initial meeting. If there are areas that require further clarification the Adult Support and Protection Committee, or sub-group, may request that agencies undertake key tasks and report back within an agreed timeframe.

In the case of an externally led review the remit of the review and the key question(s) to be addressed should be agreed in writing by the Adult Support and Protection Committee and the External Lead Reviewer.

The clearer the remit the easier it will be to manage the expectations of those involved in contributing to the Learning Review, and the wider audience, in the outcome of the review. It is recognised that the degree of complexity and/or which people to involve might not become clear until some initial work has been undertaken, especially in the case of an external Learning Review. Consequently, the remit may need to be reviewed at a later stage. If changes are made, they should be agreed and appropriately documented by the Adult Protection Committee or sub-group.

A deadline for production of reports, which takes account of the circumstances and context of the case, should be included within the remit. Where deadlines have to be extended, for example in circumstances where other proceedings intervene, this should be recorded and a new deadline agreed by the Adult Protection Committee, or sub-group.

The Lead Reviewer (internal or external) must be briefed by the Convener of the Adult Support and Protection Committee (or person with designated responsibility). The Lead Reviewer must be given access to the initial reports and chronology prepared by agencies for the Learning Review Referral, to assist in identifying which agencies need to attend the Learning Review meetings.

The written remit of the Review should be agreed by the Adult Support and Protection Committee. It can be reviewed throughout the process, but changes must be agreed with the Adult Protection Committee. The review team should report on progress made to the Adult Protection Committee or Learning Review subgroup.

The remit should:

- Clarify roles and responsibilities across agencies.
- Set a timeframe to be covered by the review.
- Agree a timeline for conducting the review.
- Be clear and deliverable.

A review may reveal staff actions or inactions which are of sufficient seriousness that they need to be brought to the attention of the employer. The review team has a duty to do this, irrespective of the Learning Review process.

Support for staff involved in a review

During the review process staff should be informed and supported by their managers. There may be parallel but distinct processes running which staff are involved in (e.g.

disciplinary proceedings) as well as the Learning Review so sensitive handling is important. The impact on staff and the implications for human resources, regulators and others requires careful consideration.

Each organisation should have its own procedures in place for supporting staff, but the following should always be considered:

- The health and well-being of staff involved.
- Provision of personal, welfare, counselling or trauma-informed support.
- How to engage with staff, keep people informed of the process in an open and transparent way, and provide protected feedback.
- The need for legal/professional guidance and support.
- Time to prepare for discussions and interviews and for follow up and clarity about,
- How the information provided will be used.

The National Framework for Learning Review should be given to staff involved in a review, together with a copy of the local operational protocols in place in their Adult Protection Committee area to support this framework. Once the review has been completed staff involved in the case should be given a debrief on the review and the findings before the report is published. Adult Support and Protection Committees will also wish to consider what mechanism will be used to enable contributors to confirm the accuracy of what is recorded as it is drafted for the interim and/or final report.

Involvement of the adult and their family/carers

A learning review is a collective endeavour to bring together agencies, individuals, and families to learn 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 family/carers of the adult at risk should be kept informed of the various stages of the review as well as the outcomes where appropriate. There will be occasions where the family/carers could be subject to investigation or have otherwise triggered the Learning Review. In these cases, information may need to be restricted. Close collaboration with Police Scotland, the Procurator Fiscal, and any other relevant agency will be vital.

There may also be cases where families/carers are considering taking legal action against an agency or agencies that are the subject of the Learning Review.

Individual agencies should ensure that their complaints procedures are made available to the family/carer at the outset of their involvement, and throughout any Learning

Review, as deemed necessary and appropriate. This is not the responsibility of the Adult Support and Protection Committee or of the review team. Learning Review reports should include information about whether or not the adult and their family/carer were informed and involved. If not, reports should record a reason. If they were involved, reports should record the nature of the involvement and document how their views have been represented. Diversity issues should be considered and adequate support should be provided to ensure that the adult and family members/carers are able to participate.

Care should be taken about where and when an adult, or their family/carers, are interviewed, and if any special measures are needed to support this (for example, the use of advocacy or interpreter services, with particular care given to those with impaired communication). In particular if there are, or are likely to be, criminal proceedings or if there is, or likely to be a fatal accident inquiry, the review team must consult with the local Crown Office and Procurator Fiscal Service and police prior to any interviews.

It may also be useful to assign a member of staff to liaise with the adult or the family/carer throughout the review. This person should not be involved in the Learning Review process or a member of the review team. The person carrying out this liaison role should be fully aware of the sensitivities and background of the case. This person's role could include advising the family of the intention to carry out a Learning Review and making arrangements to interview the adult, family/carers or other significant adults involved. Any briefing would normally be an oral discussion.

Depending on the particular case and sensitivities, consideration should be given to arrangements for feedback to the family. This may also include how they can input into checking the accuracy of what is recorded in the interim and/or final report.

Resources

Resources should be considered when commissioning a Learning Review. It is for the Convener to negotiate with the Chief Officers' Group or equivalent to secure appropriate resources in advance. Support, advocacy and communication needs should be considered.

The Report

A Learning Review Report should seek to:

- Set out the facts on the circumstances leading to and surrounding the death/serious harm of the adult (it is acknowledged that this may be difficult if there are parallel inquiries taking place, e.g. a criminal investigation).
- Identify key learning points and how and what that learning has emerged throughout the review process.

- Examine the role of all agencies involved in providing care, support and protection services (this may be achieved by establishing a chronology of agencies' and professionals' significant events and contacts) and analyse and assess the circumstances drawing out the implications and issues.
- Explore any key practice issues and the reasons for these.
- Establish the areas for improvement and lessons to be shared, about the way in which agencies work individually and collectively to protect adults at risk of harm.
- Consider how lessons are to be acted on and what is expected to change as a result. Consider whether there are gaps in the system and whether services should be reviewed or developed to address those gaps. Consider whether specific recommendations are required.

It is important to have a degree of consistency in the structure and content of Learning Review reports. This will make it easier for people to identify and use the findings or recommendations and for read across to other reports to be made. The report should, therefore, include the areas outlined in **Annex 10**.

The Adult Support and Protection Committee should consider the necessary arrangements for correcting factual errors or misunderstandings in drafts of the report.

In agreeing the final report, whether internally or externally commissioned, the following steps apply:

- The Lead Reviewer will present the final report (and executive summary) to the Learning Review team.
- The Review team will send the final report to the Adult Support and Protection Committee Convener for presentation to the Adult Support and Protection Committee.
- The Adult Support and Protection Committee will then send the final report to the Chief Officers' Group.
- The Adult Support and Protection Convener may ask the Lead Reviewer to present the report to the Adult Support and Protection Committee or the Chief Officers' Group.
- The content and acceptance of the final report (as well as considerations regarding publication, media handling as outlined below) will be agreed between the Adult Protection Committee and Chief Officers' Group through the stepped process above.

Freedom of information and data protection

The Adult Support and Protection Committee should ensure that the review team and Lead Reviewer take account of the requirements of the Freedom of Information Act 2002 and Data Protection Act 2018 in both the conduct and reporting of the review. **Annex 11** contains an extract from a Learning Review which may be helpful in considering the report structure and content in respect of the Data Protection Act 2018. Healthcare Improvement Scotland have developed guidance on sharing information. When an independent/external lead reviewer is appointed, NHS will wish to seek Caldicott approval in respect of access to any patient files where this is required by the lead reviewer as part of the review process. This should be done as early as possible.

Arrangements should be put in place for secure storage and filing of confidential information and files. These arrangements should also include retention schedules and processes for destruction of the information when it is no longer necessary to hold. These details can be included in data sharing agreement.

Dissemination

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

The Adult Support and Protection Committee may also want to consider sharing reports with interested parties such as the Scottish Adult Support and Protection Conveners' Group and Social Work Scotland Adult Protection Practice Network. The Care Inspectorate, on behalf of Scottish Government, acts as a central collation point for all Learning Review decisions across Scotland at the point at which they are concluded. By receiving and reviewing all Learning Reviews, the Care Inspectorate can better engage with Adult Protection Committees and Chief Officers to support continuous improvement locally and to disseminate common themes to support national learning.

Publication

Whether to publish the full report or just the executive summary is a decision which should be made by the Adult Support and Protection Committee and approved by the Chief Officers' Group or equivalent. In making this decision consideration should be given to the necessity to restore public confidence, the protections within the Data Protection Act 2018 and balancing interests in terms of the right to respect for private and family life in terms of Article 8 of the European Convention of Human Rights. Where the full report is not being published, the summary should give an explanation of the redaction that has been required. See **Annex 13** for an example.

Any publication must be suitably anonymised but also clearly reflect the learning emerging from the review and the evidence for any proposed changes. If a report is not published, then the learning should be extracted from the report and published separately.

The first responsibility of the Adult Support and Protection Committee is to report to the Chief Officers Group. The Adult Support and Protection Committee has wider responsibilities and must consider the wider reporting requirements and distribution of the Report/Executive Summary. A list of potential organisations and persons to whom the Report/Executive summary can be sent is contained at **Annex 13** but it is always up to the Adult Support and Protection Committee in consultation with the Chief Officers Group or equivalent to decide this in each individual case.

It is imperative that the adult's right to privacy and the adult's right to be protected is at the forefront of all decisions and communication relating to publication of a Learning Review report.

Family/carers and/or other significant adults in the adult's life should receive a copy of any report in advance of publication except if they are subject to any criminal proceedings in respect of the case.

Publication of the report may require to be delayed until the conclusion of criminal or FAI proceedings. Where criminal or FAI proceedings are ongoing the publication of any report should always be discussed and agreed with COPFS.

Other considerations for the Adult Support and Protection Committee include the following:

- Whether an oral briefing for relevant parties in advance of publication is required. This is particularly the case where there is likely to be interest in the case amongst the wider public and may avoid misrepresentation.
- How publishing the Learning Review report will support learning.
- Whether the Learning Review report is set within the wider context of health and social care.
- Whether all parties have been informed and their views taken into account (adult, family and staff).
- Has the integrity of staff been respected and duty of care been considered.

Media handling

The media can help promote more effective prevention and intervention to protect adults at risk of harm by raising public awareness of the circumstances which can contribute to harm and what members of the community can do to mitigate these risks.

Where there is engagement with the media, the communications strategy should include a media handling plan. Most agencies will have communications officers for the agency and any protocols/handling issues should be developed in conjunction with them. Before the report is in the public domain it should be agreed who will link with

the media on behalf of Chief Officers/the Adult Support and Protection Committee, brief the relevant Communications Officer(s) and approve the wording of any quotes. No information relating to a Learning Review should be released to the press unless it has been approved by Chief Officers/Adult Protection Committee. Communication with the media should focus on learning and highlight that most adults at risk of harm **are** protected. It is important to add an element of calm and focus and not to add to any sense of alarm or confusion and the Adult Support and Protection Committee should proactively offer interviews to the media where this supports their strategic objectives e.g. of raising awareness of the process of Learning Reviews or about the role of the Adult Support and Protection Committee. Once the report on the Learning Review is published and in the public domain a high-level spokesperson, where possible, should respond to media requests.

2. Learning from Learning Reviews

The Adult Support and Protection Committee should consider how the analysis and recommendations from a Learning Review can best inform learning and practice. Types of learning that can be shared, exchanged or disseminated from Learning Review include:

- Considering the key challenges of the review and how these were, or could be, overcome.
- Reflecting on the issues identified and barriers to change, and the action that has been undertaken, or will have to be.
- Measuring the impact that a Learning Review has had capturing learning in relation to the process, output and follow-through of conducting Learning Reviews could be achieved in different ways:
 - Internal/external quality assurance to appraise the process.
 - Practice exchange/communities of expertise to share experiences, perspectives and skills.
 - Research to critically appraise/analyse the strengths and limitations of arrangements used or to draw out messages for practice, policy and research.

The Adult Support and Protection Committee will undertake a Learning Review Referral theme report on a yearly basis whether the decision was to undertake a Learning Review or not. The Adult Support and Protection Committee will determine the urgency for action planning and implementation within the learning cycle according to the significance of the issues raised. After some Learning Reviews it may be necessary for other Adult Support and Protection Committees to review their own guidance and procedures in light of the findings and recommendations. This could be facilitated through the existing groups or by specially convened meetings depending on the need for urgency. Some recommendations from reviews may have implications for a range of bodies and may need to be shared with agencies named in the Adult Support and Protection (Scotland) Act 2007, and other relevant bodies who have an interest in the circumstances of the case.

Learning Reviews are one source of information that can contribute to an agenda for learning and for practice and policy development. Other sources include the information generated through research and evaluation, inspection and audit and organisational knowledge (i.e. the understanding and awareness that exists among the staff within organisations).

Together, these can provide a map of critical issues for practice. Each also represents an opportunity to identify good practice that can be shared. Areas to consider include:

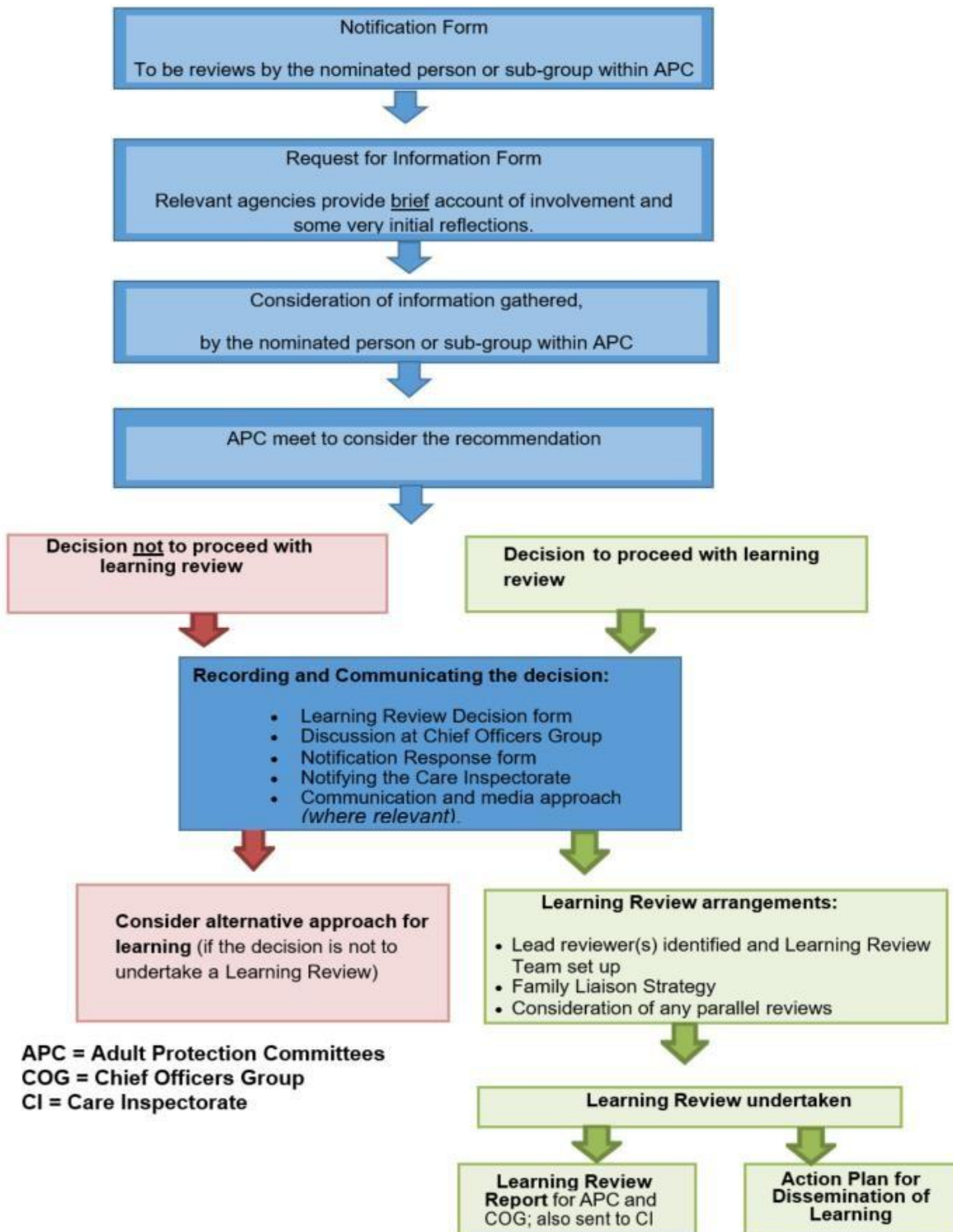
- Adult Support and Protection Committee could report on findings from their Learning Reviews in the biennial reports or within the Adult Support and Protection Committee Improvement Plan
- Brokering of practice expertise in undertaking and implementing Learning Reviews
- Active dissemination (i.e. presentation and discussion) of findings from quality.
- Assurance and research exercises through conferences (on Learning Reviews or on themes emerging from Learning Reviews), seminars and existing meetings (e.g. Scottish Adult Support and Protection Conveners Group, National Adult Support and Protection Learning and Development Network; local Adult Protection Committees; single-agency forums).
- Dissemination (i.e. circulation) of findings from quality assurance and research exercises.

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, and report nationally on the key learning points for the benefit of relevant services across Scotland and the Scottish Government.

CHAPTER 4: Annexes

Annex 1 Adult Support and Protection Learning Review Process



Annex 2

Inter-related investigations, reviews and other processes or themes 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. The police have a duty to investigate both crimes/offences and also any sudden and unexplained deaths.

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, Health and Safety Investigation, Scottish Fire and Rescue Investigation).

At the earliest possibly opportunity, where it is identified that a Learning Review may be appropriate a designated member should contact Police Scotland to confirm:

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

Crimes and Offences

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 Undertaking which may specify certain restrictions/provisions or whether they should be released pending report and summons.

Fatal Accident Inquiry

A Fatal Accident Inquiry is a court hearing which publicly 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 future 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 of 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.

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.

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 the 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 was clinically unexpected, it is described as a "sudden death". When the cause of 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 happens 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 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 providing 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 Executive⁷ 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 considers 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:

<https://www.hse.gov.uk/scotland/pdf/liaison-agreement-0617.pdf>

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 manner
- Establishing and maintaining liaison arrangements.

Healthcare Improvement Scotland

Healthcare Improvement Scotland 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.

Healthcare Improvement Scotland (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 publishes 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 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 the criteria referred to below:

<http://www.mwcscot.org.uk/good-practice/notifying-commission>

It is difficult to be prescriptive as each and every circumstance will be different. Action 1 of the Scottish Government's report '[Review of the arrangements for investigating deaths of people of patients being treated for mental disorder](#)' (December 2018) 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 had their detention suspended).

This process should take account of the effectiveness of any investigation 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 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 Office of the Public Guardian aims to ensure that these appointed proxies act in the best interests of the adult 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 Office of the Public Guardian. 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 other proxy (joint attorney) has been appointed who could investigate and safeguard the estate.

The Scottish Fire and Rescue Service (SFRS)

The Scottish Fire and Rescue Service 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 specialist fire investigation units 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 Significant Case 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 3 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 of violence or
- (ii) The adult at risk of harm has not died but** is believed to have experienced serious abuse or neglect.

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

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

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

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	

<p>Are there any immediate concerns? If yes:</p> <ul style="list-style-type: none"> • What are the immediate concerns and have these been passed to the relevant agency for consideration/ action? • What action has been taken? 	
<p>Are there any general concerns identified during this process of notification? If yes:</p> <ul style="list-style-type: none"> • What are the immediate concerns and have these been passed to the relevant agency for consideration/action? 	
<ul style="list-style-type: none"> • What action has been taken? 	
<p>Summary of the case:</p>	
<p></p>	
<p>Are other reviews, criminal investigations or other statutory proceedings underway? If so, please give details.</p>	

Name of service/agency/individuals involved with the adult, with contact details

Annex 4 Request for information to allow consideration to be given to the need for a Learning Review



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.

1. Please respond within 2 weeks, returning the completed form to amanda.law@fife.gov.uk
2. 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

Name of adult	
Date of birth	
Date of death (if applicable)	
Adult's address	

Brief details of the immediate precipitating factors leading to the referral for consideration of a Learning Review

...to be completed by the person initiating this request for information...

Summary of involvement with the adult:

--

Background history:

--

Key practice issues:

Please provide information on:

1. Recognition and assessment of Risk and need in relation to the adult
2. Information sharing in this case
3. Strategies and actions to minimise harm
4. Timely and effective action taken
5. Multi-agency responses
6. Evidence of planning and reviewing
7. Quality of record keeping
8. Appropriate use of legal measures
9. Any good practice identified
10. 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 5 Template Learning Review Referral Chronology



Multi-agency Chronology

Name		SWIFT No.	
Date of Birth		CHI No.	

Date of Event	Significant Event	Action Taken	Agency/Individual

Annex 6 Case Review Working Group TORS

Terms of reference- Fife Adult Support and Protection Case Review Working Group

To be read in conjunction with the National Guidance for Learning Review and Fife's Learning Review Protocol.

Members of the Case Review Working Group should hold the appropriate authority within their organisation to make service level decisions. They should have a detailed knowledge of process and procedures as they relate to Adult Support and Protection and a clear understanding of their service's operational practices as they align with Adult Support and Protection duties and responsibilities.

Members of the Case Review Working group must be able participate in the identification of significant and complex single and multi-agency learning and be in a position to lead, influence and embed learning throughout their service.

Membership

Service Manager – Adults West, Health & Social Care, Fife Council (Chair)	NHS – Senior manager
Adult Support and Protection Coordinator	Service Manager- Housing Services
Police Scotland	Scottish Fire and Rescue Service

Overseeing the support and protection of adults at risk is an inter-agency and inter-disciplinary responsibility of the Adult Support and Protection Committee (ASPC). The ASPC has three explicit key functions which drive their statutory responsibilities:

1. To keep under review the procedures and practices of the agencies represented who have a responsibility for the safeguarding of adults at risk in Fife.
2. To give advice, information and make proposals in order to safeguard adults at risk in Fife.
3. To make, or assist in or encourage the making of, arrangements for improving the skills of officers or employees of the agencies represented.

Fife ASPC promotes continuous improvement through rigorous self-evaluation, including identification and consideration of cases where corporate learning opportunities may exist.

Initial decision making in respect of this area of responsibility is delegated to the Case Review Working Group. This group report any recommendations to the ASPC for discussion and agreement, who then report to Chief Officers Public Safety Group.

Where relevant, the Case Review Working Group and/or the ASPC will ensure learning from local and national reviews, and Learning Reviews undertaken elsewhere, are documented and shared widely for the purpose of corporate learning.

Any of the circumstances below could suggest that a Learning Review may be required. A Learning Review Referral Discussion should first determine whether a Learning Review is merited. The detail and level of review will depend on the individual case and circumstances. A review should not be escalated beyond what is proportionate having taken account of the severity and complexity of the case.

A Learning Review is the process undertaken:

1) When an 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 or
 - The death is by suicide, or accidental death.
 - The death is by an alleged murder, culpable homicide, reckless conduct, or act of violence.
- (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 Support and Protection committee determines there may be learning to be gained through conducting a Learning Review.

Learning Reviews are seen in the context of a culture of continuous improvement and will focus on reflection and learning and reflection on practice and the systems within which practice operates.

The ASPC is responsible for deciding whether a Learning Review is warranted and for agreeing the manner in which the review is conducted. This decision is based on

recommendations from the Case Review Working Group, following their Learning Review Referral discussion.

Purpose

- To oversee the application of the Fife ASPC Learning Review Protocol.
- To fully consider any Learning Review notifications and progress these as required. This will include the provision of Request for Information Reports by single agencies/services, consideration of this information leading to clear recommendations for the ASPC, including reasons for these.
- To provide inter-agency involvement in any Learning Review as required during the review process and outlined in local guidance.
- To provide oversight of Learning Review management during the review process.
- To consider Learning Review report findings and make recommendations to the ASPC.
- To provide inter-agency involvement in any other case reviews where these are agreed as part of the Learning Review process.
- To ensure any business changes or corporate lessons learned through both Learning Review and any other case reviews are identified, recorded and actioned as required on either a single or multi agency basis. This includes identified good practice.

and

To ensure Fife Adult Support and Protection Learning Review Protocol is:

- Fit for purpose.
- Understood by stakeholders.
- Evaluated to determine impact of compliance and effect.

Context

The Working Group will work to current legislation and the agreed National Guidance for Adult Protection Committees for Learning Review.

Leadership and Membership

Membership will consist of at least one representative from each of the key agencies of Health and Social Care, Housing, NHS Fife, Police Scotland, SFRS and the APC Co-ordinator. Other representatives from agencies/services may be invited to attend where this will support the consideration of specific cases.

Process

The Working Group will follow the process for consideration of cases as outlined in the local protocol.

Quorum The group shall be considered quorate if a minimum of 4 core members are present. The nominated deputy will chair the meeting where required. A member of the Adult Support and Protection Support Team will provide administrative support.

Meeting Frequency

The group will meet as required unless otherwise directed by its Chair or the ASPC.

Resources

Resources available to the Case Review Working Group will include:

- The time and expertise of its members.
- Any approved share of the annual ASPC budget.
- Additional resources if required will be considered by COPS.
- The ASPC Support Team will provide administrative support for the Working Group.

Decision making and recommendations to the ASPC

Decisions relating to all aspects of CRWG business, in particular the progression of Learning Review, will fall to the Core Group members only (as noted in membership above). Whilst other partners may be invited to share information, they will not have remit to offer a view on decisions.

Where there is a split decision between Core Group Members in relation to key business matters, e.g., the 3-point Adult Support and Protection Criteria being met or the progression of Learning Review, the Chair of the group will have the final decision and this will be taken to ASPC for approval.

Accountability

Updates on Learning Review Referrals and Learning Reviews are reported to the Case Review Strategic Oversight Group which was formed in 2016. This latter group also has an overview of similar work being undertaken through Fife Child Protection Committee (CPC) and Multi-agency Public Protection Arrangements (MAPPA). The Adult Support and Protection Case Review Group is accountable to the ASPC and through this to Fife Chief Officer's Public Safety Group.

Annex 7 Template Learning Review Referral Discussion Agenda

1 Welcome and Apologies

2 Purpose of the Learning Review Referral Discussion today

- Consider information relating to the case under an umbrella of continuous learning and improvement
- Determine next course of action to support our ongoing learning and improvement (this could be an action plan or request for further details)
- Consider what our recommendation will be to ASPC (this may be delayed to another mtg due to parallel processes)

Before further discussion takes place, if the person is still alive, confirm they are safe and consider any implications for other adults who need to be kept safe also

3 Parallel Processes: Were there any parallel processes that require to be considered alongside this Learning Review Referral?

- Is there an outcome?
- Is there learning that requires to be included in our action planning?
- Consider witness contamination.
- Consider any duplication of information collation and if this could be avoided.
- Do we require to delay a decision until the outcome of the parallel process?
- Do we need to feed anything back to the other process to ensure the loop is concluded?

4 Trigger Report

- As the criteria has been met (the death of an adult at risk of harm) the case has been progressed to this group to consider.
- Police have reviewed the circumstances and will present
- Areas of concern noted are questions, not areas of practice learning. This isn't an investigative forum as such, but a place to discuss learning around practice

5 Multi agency Chronology

- Elements of good practice identified
- Identified areas of improvement
- Any agencies that should have been involved but were not?
- Interrelated processes: Identify who will keep this meeting updated on the process to allow final decisions to be made

6 Decision

- Do we have any gaps in information that we would like filled?
- Actions identified for ongoing learning or progression

7 Decision to hold a Learning Review

- Discuss potential outcomes from the National Guidance for Adult Protection Committees

8 Close

Annex 8 Learning Review Referral Discussion Record



Case Review Working Group
Record of discussions relating to Learning Review Referral
DATE

Discussion from meeting date:
Discussion from meeting date:

Annex 9 Adult Learning Review Process: Care Inspectorate Electronic Decision Notification Form

The electronic notification form is to be completed at the point when a decision has been made to conduct a learning review, or to detail the reasons for not proceeding. This word version is to assist in preparing the response. Learning review decision notifications should be submitted here: [learning review decision notification](#).

A notification decision form is to be completed for all adults considered under the National Guidance for Adult Protection Committees Undertaking Learning reviews introduced on 26th May 2022.

For completion by representative of Adult Protection Committee or mandated sub-group

Section 1

1.1	Date of notification
1.2	Name of the person submitting notification
1.3	Position
1.4	Email address
1.5	Telephone number
1.6	Adult Protection Committee area

Section 2: Adult's information

Note – only redacted information with no identifiable information

2.1	Adult identifier (For example: Adult D)
2.2	Gender of adult
2.3	Age of adult when Learning Review referral was made
2.4	Primary type of harm <i>Select one from pick list</i>

2.5	Any other applicable type of harm <i>Select all that apply from pick list</i>
2.6	What is/was the adult's ethnicity?
2.7	Primary case type <i>Select one from pick list</i>
2.8	Primary location of harm <i>Select one from pick list</i>
2.9	Has the adult died?
2.9.1	If yes, please advise on date of death
2.10	Outline what is/was the nature of the adult's situation <i>Relevant background information including key risks and supports</i>
2.11	Was the adult referred under Adult Support and Protection (Scotland) Act 2007 during the time period being considered?
2.12	Was the adult supported under Adult Support and Protection (Scotland) Act 2007 during the time period being considered? <i>Support includes inquiry, investigation, case conference and protection planning</i>
2.12.1	If yes, please provide further details <i>This should include information about stages of the process and application of the three-point test/criteria</i>
2.13	Were there concerns related to the adult's decision-making capacity?
2.13.1	If yes, please provide further details

2.14	Was the adult subject to Adults with Incapacity (Scotland) Act 2000 or the Mental Health (Care & Treatment) (Scotland) Act 2003 during the time period being considered?
2.14.1	If yes, please provide further details
2.15	Did the adult have an unpaid carer?
2.16	During the time period considered did the adult receive support that included a commissioned service?
2.16.1	Please select all type of services that apply

Section 3 – Decision making process

3.1	Date APC received the notification form for case to be considered for Learning Review
3.2	What are the locally agreed timescales for carrying out a Learning Review? (From referral to Learning Review decision)
3.3	What was the membership of the review group? <i>Name, organisation, and designation</i>
3.4	Date of review group meeting
3.5	Options considered by review group <i>This may be in relation to immediate actions, or recommendations that precede any further case review processes.</i>
3.6	Review group's recommendation and rationale to proceed or not to a Learning Review <i>Please provide a brief summary (perhaps in bullet point) of the recommendations, and supporting rationale, made by the Review Group to the Adult Protection Committee</i> <i>If a process other than a Learning Review is being pursued but meets the criteria for a Learning Review, please remember to forward a copy of this report to the Care Inspectorate and complete the outcome notification form</i>
3.7	Date of review group's recommendation

3.8	Date Adult Protection Committee notified of review group's recommendation
3.9	Note of discussion by Adult Protection Committee <i>Please provide a brief summary (perhaps in bullet point) of the discussion & resultant recommendation of the Adult Protection Committee regarding the findings of the review groups recommendations regarding a Learning Review, actions to be taken as an outcome, and recommendations to the Chief Officers Group</i>
3.10	Adult Protection Committee's decision(s) and rationale
3.11	Date of Adult Protection Committee Decision(s)
3.12	Note of any comments by /discussion with chief officers <i>Please provide a brief summary (perhaps in bullet point) of the discussion & resultant decision of the Chief Officer's Group regarding the findings of the Learning Review, and actions to be taken as an outcome – including whether there will be a full Learning Review.</i>
3.13	Date of chief officers' final decision
3.14	If not proceeding to a Learning Review, any improvement actions identified and arrangements for oversight and implementation

Annex 10 Template Register of all Potentially Significant Cases



OFFICIAL SENSITIVE: POLICE AND PARTNERS

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Significant Case Reviews/ICR

The following table provides an update to COPS on the progress of Action Plans from Significant Case Reviews and Initial Case Reviews which have been completed in the three business areas. The intention is that this will be updated quarterly and added to as Case Reviews are completed.

Case Review Name	Date Action Plan Agreed	Number of recommendations/ findings Number of actions agreed	Number of actions completed within agreed timescales	Number of outstanding actions	Number of actions not completed within agreed timescales	Comments
MAPPA Case Reviews						
Adult Protection Case Reviews						
Child Protection Case Reviews						

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OFFICIAL SENSITIVE: POLICE AND PARTNERS

Annex 11 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 health and/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 agency involvement. 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, the interventions 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 multiagency 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 12 Data Protection and Reports

It should be noted this information related to a Significant Case Review rather than a Learning Review but may be useful when considering Data Protection and Learning Reviews.

The following is an extract from a previous Significant Case Review completed in September 2013 and may be useful in considering the report structure and content: 'This document contains the conclusions and recommendations of the Significant Case Review relating to D. In the interests of transparency, every effort has been made to disclose as much of the Significant Case Review as is lawfully possible. The only editing prior to disclosure is the redaction of personal data, disclosure of which cannot be justified under the Data Protection Act 1998 (now 2018) ("the DPA"). Although there has been a criminal trial and extensive media coverage of this case, and a significant amount of both personal data and sensitive personal data is, as a result of this, publicly available, disclosure of the personal data contained in this report must still comply with the DPA. This means that even though some of the redacted information may already be publicly available, or it may be considered to be in the public interest to disclose, it cannot automatically be disclosed, as the DPA contains certain conditions which must first be met. The process of redacting the Significant Case Review has involved careful consideration of:

- The need for transparency and the overall purpose of the Significant Case Review in the identification of any lessons learned
- The public interest in disclosure

Considering whether information is sensitive personal data, (for example, because it is information about a person's physical or mental health or condition, his/her sexual life, or the commission or alleged commission of an offence) and whether its inclusion in the Significant Case Review complies with the Data Protection Act 1998 (now 2018).

Balancing interests in terms of the right to respect for private and family life in terms of Article 8 of the European Convention on Human Rights, meaning that any information contained in the report relating to D himself and other people whose history was closely linked to D can only be released if it is lawful, necessary and proportionate to do so.

Following this, the review panel concluded that in the unique circumstances of this case, it would not be appropriate to release the main body of the report. The narrative of the report could not be redacted so as to remove all information carrying an identification risk or the possibility of causing harm to third parties, and it was felt that removing all such information would lead to the report being at best meaningless and at worst misleading.

The conclusions and recommendations have been included but with certain text (generally containing biographical details) redacted for the reasons set out above.

Any redactions are clearly marked with the word “[Redacted]”. Some minor grammatical changes have been made (not flagged) to maintain consistency of language following some redactions.

Annex 13 Dissemination/Publication: Interested Parties

Those with responsibility for local service delivery and review probably will include:

- Staff involved in the review
- The local Adult Protection Committee
- Chief Officers: Chief Executive of Local Authority/Chief Executive of Health Board/ Police Scotland representative
- Director of Social Work/Chief Social Work Officer/Senior Managers in the Police and Health Service
- Mental Welfare Commission
- Crown Office and Procurator Fiscal Service
- Inspectorates – Care Inspectorate, HM Inspectorate of Constabulary
- Health Improvement Scotland
- Professional regulators, for example, Scottish Social Services Council
- Voluntary organisations and independent providers, where they are involved in the case
- Those with wider interests in the Significant Case Review report could include:
 - Family/Carers and/or significant others of adult involved
 - Local Councillors/Health Board Chairs/Representatives of Police Scotland
 - Local Authority, Health Board and Police press officers
 - Other Adult Protection Committees
 - Professional representative bodies
 - Legal representatives
 - Unions

Other key interests are likely to be:

- The general public
- Elected members, e.g. MSPs, MPs and Councillors
- The media

Annex 14 Consultation Record

**Adult Support and Protection Committee
Protocol/Procedure Consultation Record
Learning Review Protocol
Police, NHS, Fife Health and Social Care Partnership, SRFS
July 22**

Consultation Type	Date	Practitioners Invited	Practitioners who responded
Case Review Working Group – draft document sent for review	16.8.22		
ASPC	24.8.22		