**National Guidance**

for Child Protection Committees

Undertaking Learning Reviews:

Resources

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Learning Review – Information for Families and Carers

**Insert relevant CPC logo**

Protecting children and young people is the responsibility of several different organisations such as Social Work, Health, Education, Police and others who support children and families.

In each local authority area, there is a Child Protection Committee which is made up of a group of people who work for these organisations. Child Protection Committees make sure organisations and the local community work together to plan, carry out and improve the way the child protection process works.

**What is a Learning Review?**

**When is it needed?**

When a child dies or is seriously harmed, or when or when a child was at risk of death or serious harm, the local Child Protection Committee must decide whether or not to look further into what happened.

**Why does the Child Protection Committee do this?**

To understand if there are any lessons to learn about the support offered to you and your family. The Committee looks at how people have worked together to support you and your family: for example, social workers, GPs, teachers, health visitors, police etc. This is called a ‘Learning Review.’

**What happens during a Learning Review?**

A person called a Reviewer will speak to family members, professionals and other people who know/knew your child/ren to learn more about what happened and to suggest how to make things better in the future.

The Reviewer will be helped by a small group of people from other organisations. This group is called the ‘Review Team’. Both the Reviewer and the Review Team will get information from all the organisations that have worked with you and your family. This will mean sharing information and records that they have about your child/ren and family. This information will only be shared with the Review Team and will remain confidential.

**Support for You**

1. A member of the Review Team will contact you and be your link person. He or she will offer support and communicate with you during the review. This person is able to let you know what to expect, how the process is going and answer any questions you may have.
2. You can also have other people to support you during this Learning Review process such as a friend, family member, support worker or advocacy service.
3. Some families who have gone through the same Learning Review process have told us the kind of information that helped them. Here are some of their questions and typical answers. Please remember that each situation is different but some of these **questions and answers** might help you.

**Can someone discuss this leaflet with me as I find it easier to talk with someone?**

Yes, of course that is a great idea. We want to help you.

A member of the review team will be in contact with you so that this can take place.

**Can someone write down key information that I need for the next stage so I do not forget it or get confused?**

Your link person will think that’s a great idea to have notes if that will help you – perhaps they might even suggest a small notebook is handy where all your information can be kept together. The note taker could be a friend, family member supporting you, an advocate or another member of the review team. This will be your choice.

**What does the Review do that is different to the other services already involved?**

The Review is different. It is looking at the actions and responses from all the services involved and so that these services can learn how to improve their practice

**How can the Learning Review help me and my family?**

It will give you an opportunity to tell what happened from your point of view and how that felt.

**How do I know what is happening or what is going to happen next?**

The member of the review team that is helping you will keep you updated so you know what is happening.

**Who are the people involved?**

The member of the review team who is helping you will help you find out about the different jobs and tasks that people have in the Review.

**What information from me will the Reviewer and Review Team use?**

This is a good question. It may be that they do not use all the information that you share with them. The Reviewer or Chair will plan with you how they will use your information. You can ask about who will be able to see this.

**How will I hear about what the Review decides?**

Speak to the member of the review team who is supporting you to find out how you will hear about the learning and outcomes of the Review. They can provide more information.

**What if there is media interest? How do I handle media interest?**

Sometimes, there may be newspaper or media interest in the outcome of a Review. The person supporting you can help you with any arrangements for dealing with this situation if this happens. The important thing is to take it a day at a time.

**How long will the Learning Review take?**

It usually takes six to nine months from the start of Learning Review to the final report. Sometimes it can take much longer and the person supporting you will speak to you about this if this happens.

**Contact us**

We understand this is a very difficult time for you and your family.

We hope that this leaflet has helped you and your family to understand more about the Learning Review. Of course, each child / family is different and you may have other questions you would like to ask us or you may want to talk further about the Review. If there is anything else you would like to discuss this please contact us as follows:

Insert relevant contact details……………………………………………………………….

………………………………………………………………………………………………….

………………………………………………………………………………………………….

Thank you

The ideas from families were taken from research, if you would like to learn more about this please see the reference below.

Morris, K., Brandon, M. and Tudor, P. (2012) A Study of Family Involvement in Case Reviews: Messages for Policy and Practice BASPCAN

Example of a Learning Review Process

(covers the stages between the first meeting of the Review Team and the beginning of dissemination)

**First Review Team meeting**

Practicalities including discussing the principles and ways of working, clarifying roles and functions; identifying Practitioner Event participants and Senior Manager event participants and their preparation;

Sense making of the situation;

First pass at issues and questions to explore;

Arrangements for collating further information (if gaps identified);

Set dates and venues for Review Team Meetings, and Practitioner & Senior Manager events;

Verifying that the Care Inspectorate was notified of the decision to proceed to a Learning Review.

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**Second Review Team meeting**

Confirming tasks done

Checking on the implementation of the Family Liaison Strategy;

Checking on the preparation for the Practitioner & Senior Manager events (confirmations; information and support for practitioners attending)

Further exploration of the emerging issues and reflections.

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**Engaging with family members**

(according to the Family Liaison Strategy)

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**Practitioner event**

Jointly discussing the story of involvement, identifying and analysing significant events;

Identifying learning;

Identifying effective practice;

Thinking about possible strategies for improving practice and systems, including possible recommendations.

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**Post practitioner event**

Writing up learning points and circulate to participants to check for accuracy/agreement

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**Senior Managers** **event**

Discussing the outline of the situation, the challenges and what worked well and why, the changes needed and the strategies for improvement, together with the emerging recommendations.

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**Draft report**

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**Third Review Team meeting**

Discussion of draft report

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**Fourth Review Team meeting**

(**NB:** a 4th meeting might not be necessary. If things are straightforward there is a possibility all of this can be done at the third panel meeting);

Finalising report;

Outline action plan.

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**Feedback to family**

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**Presentation/dissemination to CPC and COG;**

**CPC submit completed report to the Care Inspectorate**

Example Learning Review Report

***XXXXXX* Child Protection Committee**

**Learning Review**

**Child M**

Insert date report was completed

The purpose of this exemplar is to illustrate what a completed Learning Review report might look like. It is a work of fiction but based on a number of real scenarios.

This review is set in a pre-COVID-19 world.

1. **Introduction**
   1. On 03/10/2020 the father of Child M, called an ambulance to the home address because Child M was not breathing. Father was caring for Child M, his mother and sibling were out. Child M was taken to hospital where he was pronounced dead on arrival. The results of the subsequent post-mortem showed Child M had suffered several injuries which were considered to be non-accidental. Child M was 5 months old when he died.
   2. Since his birth the family of Child M had been receiving intensive support from Health and Social Work Services. Both Child M and his older sister were on the Child Protection Register under the category of neglect.
   3. A Learning Review Notification[[1]](#footnote-1) was submitted to *xxxxx* Child Protection Committee and, after requesting further information[[2]](#footnote-2) the decision was made to undertake a Learning Review as this situation did meet the criteria, specifically:

**When a child has died or has sustained significant harm or risk of significant harm** as defined in the [National Guidance for Child Protection in Scotland.](https://www.gov.scot/isbn/9781802011500)

**and** there is additional learning to be gained from a review being held that may inform improvements in the protection of children and young people

**and one or more** of the following apply:

* Abuse or neglect is known or suspected to be a factor in the child’s death or the sustaining of or risk of significant harm
* The child is on, or has been on, the Child Protection Register (CPR) or a sibling is or was on the CPR or was a care experienced child (i.e. looked after, or receiving aftercare or continuing care from the local authority). This is regardless of whether or not abuse or neglect is known or suspected to be a factor in the child’s death or sustaining of significant harm, unless it is absolutely clear to the Child Protection Committee that the child having been on the CPR or being care experienced has no bearing on the case
* The child’s death is by suicide, alleged murder, culpable homicide, reckless conduct, or act of violence
  1. The time frame for the review was from the birth of his older sibling until the death of Child M, a period of some 17 months. However, the Review Team also had access to some historical information relating to mother’s childhood.

1. **The process of the Review**
   1. In accordance with the guidance[[3]](#footnote-3) this Learning Review adopted a systemic approach. Such an approach goes beyond individual or professional practice to explore underlying systemic elements, the links with organisational factors and the wider context. A key feature of this approach is to bring together agencies and practitioners in a collective endeavour to reflect and learn from what has happened in order to improve practice for the future. The focus is on accountability not culpability, on learning and not blame.
   2. A Case Review Team was convened to steer the process. It was chaired by the Lead Nurse, Child Protection and made up of representatives from:

* Health Services
* Social Work Services
* Police Scotland

The Review Team and the review process were supported by an Administrator.

* 1. The Review Team began the learning process by identifying significant issues and clarifying the questions and areas to explore. They also identified the participants to be invited to the practitioner/first-line manager event and the Senior Manager event, briefed them on the process, helped them with preparation and supported them throughout. Participants were asked to reflect on their involvement with Child M and his family thinking specifically about:
* Assessments
* Decision making
* Actions
* Interactions with other professionals and services
* Areas of effective practice
* Areas where there could have been some improvements
  1. The Practitioner Learning Event was held on (insert date)from 9.30 until 4.00 and was facilitated by the Reviewer. There were 14 participants from:
* Paediatrics
* Midwifery
* Health Visiting
* GP Surgery
* Social Work
* Police Scotland

The Review Team Chair was also in attendance and the Review Team Administrator took notes of the session to aid the compilation of this report.

* 1. Each participant described their involvement with the family, highlighting the actions they took and the reasons underpinning them as well as their assessments of the situation at the time. This was done as chronologically as possible. After each input there was an opportunity to ask clarifying questions, engage in discussion and begin to identify key issues and learning points. Once everyone had contributed they moved into small groups for further reflection on the emerging learning and to think about some possible actions and recommendations.
  2. The following day there was a Learning Event for Senior Managers to bring a strategic perspective to the Review. This was a half-day session and was attended by representatives from:
* Children and Family Services including Children’s Services Managers, Chief Social Work Officer and Lead Service Manager
* GP Clinical Lead
* Paediatrics
* Director of Nursing, Midwifery and Allied Health Professionals

As with the Practitioner Event, the Review Team Chair also attended and again the Administrator took notes of the session to aid the compilation of this report.

* 1. Participants reflected on Child M’s situation, identified emerging themes; looked at what worked well and why; explored challenges and missed opportunities and considered any changes that were needed as a result of the learning from this review.
  2. During the course of this review the Reviewer and Review Team chair also met with Child M’s parents to ascertain their views.

1. **The circumstances that lead to the Learning Review**

**Family composition**

|  |  |  |
| --- | --- | --- |
| **Relationship** | **Date of Birth** | **Ethnicity** |
| Child M | 01/05/2020 | White Scottish |
| Sibling Child B | 02/06/2019 | White Scottish |
| Mother | 10/10/2000 | White Scottish |
| Father | 15/07/1998 | White Scottish |
| Maternal Grandfather | 26/03/1975 | White Scottish |
| Maternal Uncle | 04/09/1995 | White Scottish |

**Background**

* 1. At the time of Child Bs birth the family were living with maternal grandfather and maternal uncle. There were no concerns about the care of Child B.
  2. There was some historical information available about mother. As a child she lived with her father and 2 older brothers, her mother having left when she was 2. At the age of 8 her name was placed on the Child Protection Register under the category of neglect.
  3. During her pregnancy with Child M mother attended all ante-natal appointments and there were no concerns until March 2020 when poor home conditions were highlighted. At this point the family had moved into their own home.
  4. Child M was born on 01/05/2020. Throughout his short life there were concerns about his health, his weight loss and the conditions within the home and he had four admissions to hospital. The first, at 12 days old, was instigated by the Health Visitor who, on her Primary Birth visit, observed that he was unwell, had lost weight, was suffering from oral thrush and had what looked like flea bites on his legs, (the family had a pet dog). Child M was diagnosed with gastroenteritis and treated and discharged. Two days later he was brought to the emergency department by mother’s cousin who was babysitting and who reported he was vomiting after feeds. Child M was admitted to the ward.
  5. In the meantime the Health Visitor had made a child protection referral and an IRD took place on 14/05/2021. It was agreed that when Child M was ready for discharge it should be with his parents but to the maternal grandfather’s home so that their house could be thoroughly cleaned. For the next few weeks things seemed to improve and Child M was feeding well and gaining weight.
  6. At a Child Protection Case Conference on 07/06/2020 Child M’s name was placed on the Child Protection Register under the category of neglect. The Child Protection Plan included the involvement of a Family Support Worker.
  7. On 12/06/2021 Child M was admitted to hospital for a third time because of coughing episodes resulting in vomiting. (Both parents were heavy smokers.) Mother was reluctant to remain at the hospital and so Child M was discharged 3 days later with open access to the ward if needed.
  8. For the next 3 months the Social Worker, Health Visitor and Family Support Worker provided intensive support to the family and there were regular Core Group Meetings which one or both parents attended. Home conditions remained a concern, there were some improvements but they tended to be short-lived.
  9. On 05/08/2020 Child M was brought to the Hospital Emergency Department by mother who was concerned that he might have epilepsy as she had observed his eyes rolling and he was not responding. He was discharged later that day.
  10. Child M’s health seemed to improve after this but concerns then centred on Father’s mental health. He described feeling depressed being anxious about money and having suicidal thoughts. He was prescribed anti-depressants.
  11. A Review Child Protection Case Conference was held on 06/09/2020 and registration continued under the category of neglect.
  12. On 03/10/2020 Child M died.

1. **Practice and Organisation Learning**
   1. Some families are able to parent a first child to an acceptable standard but struggle when they have a second child:

In this situation no concerns were noted with regard to the parenting of the older sibling. However, the family were living with maternal grandfather and maternal uncle for the first few months of Child B’s life. By the time Child M was born they were in their own home and therefore any support they had previously had with managing a home and caring for a baby was reduced. Furthermore, they then had two Children under 2 years of age. When exploring concerns and assessing risk to a child professionals need to be mindful of the impact of changes in circumstances and the increasing complexity in parenting more than one child.

* 1. The importance of describing and clarifying conditions within a home in order to assess the impact of environment on babies and young children and whether or not it is acceptable:

In this situation home conditions were sometimes described as cluttered, sometimes as acceptable and at other times as unacceptable, with rapid deterioration being noted. It is also important, when working with families living in areas of deprivation that professionals do not become inured to this and therefore work with different thresholds of ‘good enough’. The use of Neglect Tools can help to prevent such cultural relativism.

* 1. For assessment and planning to be meaningful and robust it needs to be a multi-agency activity, using a range of tools to collect, collate and analyse information, to formulate effective interventive plans and to measure change:

There were a lot of concerns about Child M and a lot of information about the family, but it was not always brought together. For instance, hospital staff had some pertinent information about parenting capacity having observed both mother and father interacting with Child M. If this had been shared at the time it would have helped to build a more holistic picture of what was happening.

The use of assessment tools such as The Graded Care Profile[[4]](#footnote-4) would have greatly helped to measure the quality of care and identify what needed to change and how that change might be realised. The use of chronologies would have also helped to build an understanding of the situation over time and to identify patterns of concern.

* 1. The impact of adverse childhood experiences and parental mental health on parenting capacity:

In this situation mother had herself been a neglected child and father had some mental health problems. It is important for professionals to gain an understanding of how these issues might impact on parenting capacity and the lived experiences of children in order to provide resources to build, increase and improve parenting ability.

* 1. In recording it is important that professionals distinguish between what they have directly observed and what has been reported to them:

Here there were examples of parental reporting of Baby M feeding well when to the professionals he appeared pale and listless and was losing weight.

* 1. Some families may have the potential to change but lack the motivation to do so:

There were some improvements in home conditions and parenting when the parents were strongly urged to make changes by the professionals involved. These improvements were usually observed on **planned** visits by the Health Visitor or the Social Worker or the Family Support Worker. However, opportunistic visits by professionals revealed that this progress was not sustained and often conditions had deteriorated.

The professionals involved felt increasingly ’stuck’ as the situation did not improve. This raises the question of what interventions are effective in situations of neglect and how can parents be motivated to make those changes.

* 1. The importance of distinguishing between a family’s attendance at meetings and their engagement with the change process:

The parents gave the appearance of complying with child protection plans and processes. They attended Child Protection Case Conferences and Core Group meetings where the concerns of professionals were clearly expressed and minuted. However, they were either unable to take them on board or did not see the point of making sustained changes.

1. **Effective practice**
   1. In this situation there were many examples of good communication and inter-agency working including:
      1. Liaison and information sharing between Midwifery and the Health Visiting service was good and resulted in a timely referral to Children’s Social Work Services.
      2. The Social Worker, Family Support Worker and Health Visitor worked very collaboratively. They co-ordinated their visits, shared information, ensured there was a mixture of planned and opportunistic contacts with the family and gave consistent messages about the need for change and the nature of the change required. They worked hard to try to improve the situation and to protect Child M.
2. **Suggested strategies for improving practice and systems**
   1. It is suggested that the CPC set up a development programme on the theme of neglect focussing on:

* Assessment tools including Graded Care Profiles and the use of chronologies
* The assessment of parenting capacity and the impact of adverse childhood experiences and mental health issues
* Identifying interventive strategies for effecting positive change
  1. In this situation the professionals worked hard to support and help this family, but improvements were minimal and short-lived. It is suggested, therefore, that, in addition to supervision within their own team/agency, professionals have access to joint, facilitated cross-service reflective sessions to review situations that seem ‘stuck’ and to think about how to change and move things on in order to protect children.
  2. A review of the template for Child Protection Plans to build in:
* Overarching aims
* Specific objectives
* Clarification of indicators of genuine progress
* Realistic timescales
  1. Ensure Acute Services are aware of child protection concerns and Child Protection Plans through:
* Attendance at IRD meetings and Child Protection Case conferences as appropriate
* Access to the Child Protection Register
* Ensuring they are in ‘communication loop’

|  |  |
| --- | --- |
| Signed and dated by: |  |
| Reviewer(s): |  |
| Review Team Chair: |  |
| Date: |  |

Example Learning Review Action Plan Template

**Strategies for improving practice and systems**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Strategy 1:** | | | | |
| **Action**  **(how we intend to do it)** | **Timescale** | **Responsible lead** | **Performance measure**  **(how well are we doing?)** | **Analysis of performance**  **(are we making a difference?)** |
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| --- | --- | --- | --- | --- |
| **Strategy 2:** | | | | |
| **Action**  **(how we intend to do it)** | **Timescale** | **Responsible lead** | **Performance measure**  **(how well are we doing?)** | **Analysis of performance**  **(are we making a difference?)** |
|  |  |  |  |  |
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| **Strategy 3:** | | | | |
| **Action**  **(how we intend to do it)** | **Timescale** | **Responsible lead** | **Performance measure**  **(how well are we doing?)** | **Analysis of performance**  **(are we making a difference?)** |
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| --- | --- | --- | --- | --- |
| **Strategy 4:** | | | | |
| **Action**  **(how we intend to do it)** | **Timescale** | **Responsible lead** | **Performance measure**  **(how well are we doing?)** | **Analysis of performance**  **(are we making a difference?)** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Example Seven Minute Briefing Template

**Background**

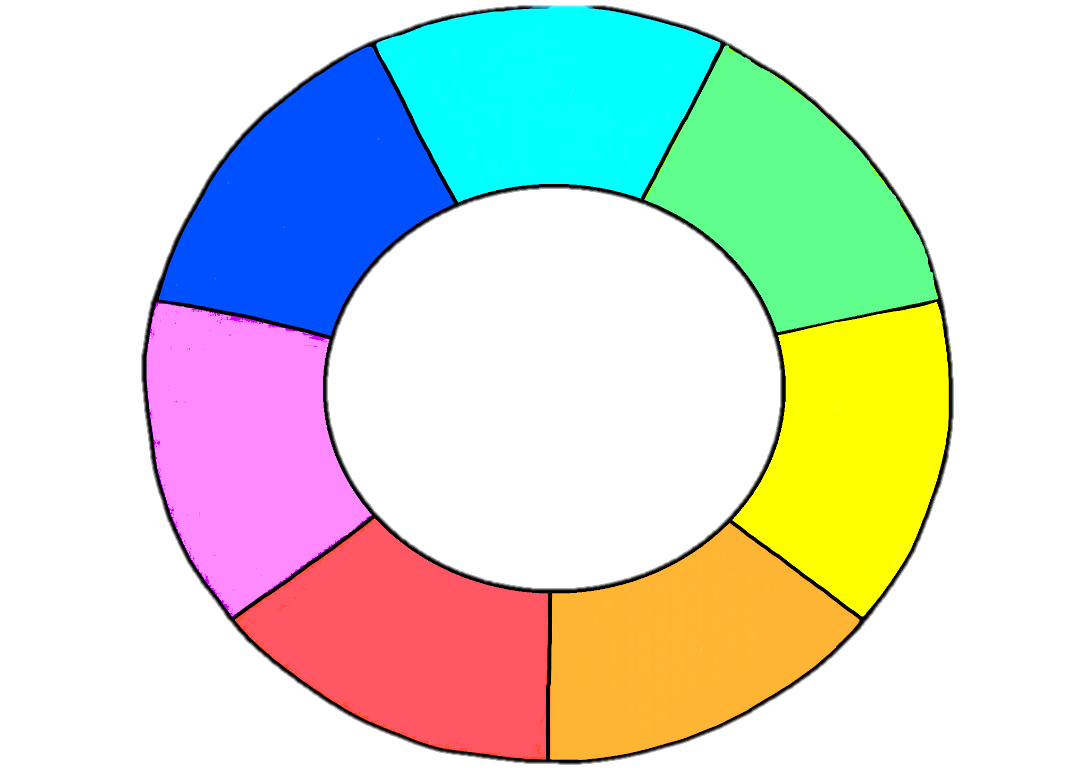
**Context**

**Identified Themes**

**Learning and Actions *(*cont.)**

**Identified Themes *(cont.)***

**Identified Themes *(cont.)***

****

**LEARNING**

**REVIEW**

**Learning and Actions**

Driving The Change: Improvement and Implementation Resources

The change process that starts during a Learning Review cannot stop once an action plan has been agreed, or the findings disseminated. The end of a Learning Review should also mark a shift of focus towards how to best drive the required change.

Various approaches, such as those informed by the Model for Improvement or implementation science, could prove valuable in guiding the process of embedding learning and driving the change identified through a Learning Review. More information on these approaches can be found by exploring the resources below.

**Improvement methodology resources**

The [Model for Improvement](http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementHowtoImprove.aspx) is a tool that could be used for **accelerating improvement** of outcomes and processes. The model moves through four stages to identify aims, establish measures, create change ideas and test changes using the ‘Plan-Do-Study-Act’ cycle.

* Institute for Healthcare Improvement (IHI), [How to improve](http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx);
* West of England Academic Health Science Network (AHSN), [Quality Improvement (QI) tools](http://www.weahsn.net/toolkits-and-resources/quality-improvement-tools-2/);
* Social Care Institute for Excellence SCIE, [Quality improvement in health and social care](http://www.scie.org.uk/e-learning/quality-improvement) (free e-learning course);
* Associates in Process Improvement (API), [Reading Lists](http://www.apiweb.org/index.php/resources/api-reading-list) (relevant literature on improving quality).

**Specific to Scotland:**

* [Children and Young People Improvement Collaborative (CYPIC)](https://www.cypic.co.uk/);
* Health Care Improvement Scotland, [I-Hub](https://ihub.scot/);
* NHS Education for Scotland, [Quality Improvement Zone (QI Zone)](https://learn.nes.nhs.scot/741/quality-improvement-zone);
* Education Scotland, [National Improvement Hub](https://education.gov.scot/improvement/);
* Scottish Government, [Model for Improvement](https://www.gov.scot/publications/three-step-improvement-framework-scotlands-public-services/);
* [Improvement Service (IS)](https://www.improvementservice.org.uk/);
* Care Inspectorate, [the HUB](https://hub.careinspectorate.com/how-we-support-improvement/starting-your-improvement-journey/);
* Centre for Excellence for Children's Care and Protection CELCIS, [Quality Improvement programme: Permanence and Care Excellence (PACE)](https://www.celcis.org/our-work/key-areas/permanence/pace-permanence-and-care-excellence-programme/pace-quality-improvement-homepage).

**Implementation science resources**

Implementation science is focused on addressing the gap between evidence, policy and practice. ‘Active Implementation’ is one of the theories of implementation and provides a set of [six frameworks](https://www.activeimplementation.org/frameworks/) that can be used to guide **complex systems change**.

* [Active Implementation Research Network(AIRN)](http://www.activeimplementation.org);
* [National Implementation Research Network](https://nirn.fpg.unc.edu/national-implementation-research-network);
* [Global Implementation Society (GIS)](https://globalimplementation.org/);
* [UK Implementation Society (UK-IS)](http://www.ukimplementation.org.uk).

**Specific to Scotland:**

* NHS Education for Scotland, [Early Intervention Framework](https://earlyinterventionframework.nhs.scot/): provides a database of evidence-based prevention and early intervention approaches designed to improve the mental health and wellbeing of children and young people; the [implementation science](https://earlyinterventionframework.nhs.scot/background-information/implementing-for-success/) underpins the development of the tool;
* Education Scotland, [National Improvement Hub](https://education.gov.scot/improvement/self-evaluation/using-implementation-science-to-support-the-implementation-of-interventions-in-real-world-contexts/);
* Centre for Excellence for Children's Care and Protection CELCIS, [Active Implementation: making a meaningful difference](https://www.celcis.org/about-us/our-approach-implementing-change).

Example Media Communications Plan

Prepared on behalf of the ………………………… CPC/Chief Officers Group Date last updated: ……………….

|  |  |
| --- | --- |
| **Title** | **Learning Review – X** |
| **Lead** | Chief Officers Group Y |
| **Initial preparation date** | DD/MM/YY |
| **Lead partners and key stakeholders** | * A Council * An NHS board * A CPC * Police Scotland * SCRA * Scottish Government * Care Inspectorate * The Crown Office * CPCScotland |
| **Main communications contacts** | * Council * NHS * Police Scotland * Scottish Government * Care Inspectorate * Crown Office * CPCScotland |
| **Context** | Brief Description of the subject matter of the Learning Review together with key points. |
| **Aims** | * To reassure the local community * To provide a coordinated response to questions and concerns raised internally across all agencies and externally with the public * To deliver accurate information about the case, including roles and responsibilities and action taken * To ensure that public confidence in the member agencies is appropriately supported * To deliver a human and compassionate message about the tragic incident |
| **Communications outcomes** | * Balanced media reporting of the facts and key messages * Ensure internal audiences including elected members and members of health boards are aware of the facts and key messages and the actions that are being taken within their own organisation, as appropriate * Reporting of any action that has been taken or will be taken, as appropriate * Tone of compassion, openness, transparency and willingness to learn if there are improvements to be made |
| **Target audiences** | * Direct family * Social work, Justice SW Service and NHS, Police Scotland (local) * Local Elected Members and NHS Board Members * Local communities * Scottish Government * Media * Other partner stakeholders as appropriate |
| **Other stakeholders** | * Local MSPs and MPs * Care Inspectorate and Healthcare Improvement Scotland * The professions and public sector workers * General public * Social Work Scotland * CPCScotland |
| **Potential risks** | * Lack of coordination * Inconsistent messages from partners * Third-party media statements * Lack of understanding/awareness of roles and responsibilities * Off-the record briefing * Media presentation of child protection issues – wider media agenda * Appearance of defensiveness * Public expectation of action by responsible organisations – call for people to step down |
| **Strategy** | * Be compassionate, open, available and responsive - even if there is little new information that can be shared * Hold information back by exception and only where there is precedent and/or a publicly justifiable reason to do so. Note - the reason will need to stand up legally and for example if information is requested under ‘Freedom of Information’ * Acknowledge any mistakes genuinely and upfront - explain circumstances consistently and clearly – confirm what action will be taken – why, by whom and when and what difference that will make * Front the review through a single spokesperson but ensure partner agencies have what they need to respond to specific questions and on a timely basis * Set the communication strategy – including the tone of response - through the CPC/COG Group and deliver through the communication leads in each partner agency * Agree timetable and channels for release of information. Key findings of the Review to be published online and agreed statement through a release to media. Social media to be monitored by communications leads and co-ordinated responses agreed as appropriate through council communications. Deal with interviews on request * Agree responsibilities for briefing target groups in advance of publication * Coordinate initial media enquiries through an agreed lead agency but route responses through communications leads in individual partner agencies. |

**Communications action plan**

| **Requirements** | **Deadline** | **Audience** | | **Action** | **Responsibility** |
| --- | --- | --- | --- | --- | --- |
| **Timetable agreed** |  | | CPC  COG  Partner agency leads | * Communication strategy/action plan agreed by COG | Lead Agency Communications (co-ordination) |
| **Report and/or executive summary** |  | | CPC  COG  Partner agency leads | * Full report and or Executive Summary agreed and signed off | COG |
| **Key messages** |  | | CPC  COG  Partner agency leads | * Key messages from the report developed and agreed by COG | Lead Agency Communications (co-ordination) |
| **Spokespeople** |  | | CPC  COG  Partner agency leads | * Lead spokesperson for the review agreed by COG following media training feedback | COG |
| **Public Statements** |  | | CPC  COG  Partner agency leads | * Press statement and publication arrangements finalised and agreed * Questions and Answers – on process etc. * Background notes for Editors | Lead Agency Communications to draft and agree through Communications leads |
| **Day of publication – internal briefings** |  | | Direct staff  Family  Foster Carers  Administration  Group Leaders/Conveners  All members  MSPs  MPs  Other stakeholders as appropriate | * Face-to-face briefing on key messages including findings, action and responsibilities, how to handle questions and timetable ahead * Provide link to report online * Provide copy of agreed media statement being issued | CPC to upload report to Child Protection website and provide link to Communications leads  Relevant services to carry out appropriate staff briefings  Family liaison contact to meet with family.  Communications leads to ensure their own appropriate stakeholders are provided with information |
| **Day of publication - media** |  | | Media  Public | * Report online * Intranet * Media statement * Partner websites * Social Media monitored * Interviews on request? * Media monitoring | Lead Agency Communications and Communications leads |
| **Post publication** |  | | CPC  COG  Partner agency leads | * Evaluation of media coverage * Report back to COG | Lead Agency Communications |

**Appendix 1**

**Media response**

**Issues highlighted by the Learning Review:**

**Key media messages:**

**Potential media questions:**

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

**Appendix 2**

**Draft press statement**

**Date:** tbc

**Key findings of the Review**

Independent Chair of XXXXX Child Protection Committee commented:

**Link to summary report online**

**Notes to Editors**

1. Scottish Government (2021) National Guidance for Child Protection Committees: Undertaking Learning Reviews Annex 1.1 [↑](#footnote-ref-1)
2. Scottish Government (2021) National Guidance for Child Protection Committees: Undertaking Learning Reviews Annex 1.2 [↑](#footnote-ref-2)
3. Scottish Government (2021) National Guidance for Child Protection Committees: Undertaking Learning Reviews [↑](#footnote-ref-3)
4. The Graded Care Profile was created by Paediatricians Drs Poinay and Srivastave and was developed to help professionals measure the quality of care being given to children where there are concerns they may be being neglected. [↑](#footnote-ref-4)