Learning reviews for children and adults in Scotland
Summary report 2025

Publication date: July 2025

Contents

1. Introduction

The Care Inspectorate acts as the central collation point for all learning review notifications and completed reports. Learning review notifications support information gathering to inform the committee's decision about whether or not to initiate a learning review. The committee then submits the notification and decision to the Care Inspectorate as the central collation point for learning review notifications and reports. We provide quality assurance observations on all submitted learning review reports.

The overall purpose of a learning review is to bring together relevant agencies, individuals, and families to learn from what happened. This supports improvement and develops systems and practices to help keep people safe. Learning reviews for children and young people are conducted under the National learning review guidance for child protection committees undertaking learning reviews. These learning reviews are underpinned by the rights set out in the United Nations Convention on the Rights of the Child (UNCRC). Adult protection committees carry out learning reviews in line with their duties under section 42(1) of the Adult Support and Protection (Scotland) Act 2007 and the principles and values laid out in the National learning review guidance for adult protection committees undertaking learning reviews.

For the first time, we have combined our child and adult learning review summary reports to provide a joint national overview of learning review activity. Data in this report is drawn from learning review notifications from 19 adult protection committees (APCs) and 15 child protection committees (CPCs). As part of our refreshed approach, we intend to publish a report with a broader quality assurance focus next year.

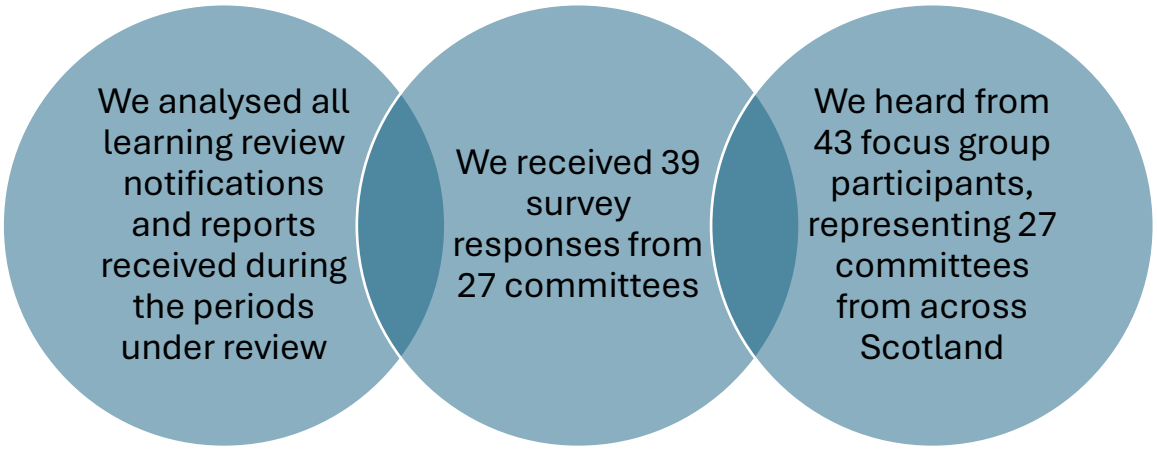
The Care Inspectorate is also responsible for collating all notifications of deaths of looked after children and care experienced young people receiving continuing care or aftercare support in Scotland. In addition to our quality assurance role for learning reviews, we have a lead responsibility for providing quality assurance feedback to partnerships where a local authority has undertaken a review in line with the Looked After Children (Scotland) Regulations 2009 (as amended). We are aiming to explore the links with this, and the learning review activity in our next report.

The data presented in relation to learning review notifications and reports refers to all of those submitted in the current reporting periods. Until 1 April 2025, the reporting periods for adult and child learning reviews were not aligned. Future joint annual learning review data reports will cover the period of one fiscal year.

Where percentages are used, these are calculated to the nearest number and may not total 100%.

We would like to thank the adult, child, and public protection committees (the committees) across Scotland for their valuable contributions to this report.

2. Report evidence base



The data for children and young people in this report covers the fiscal year 2024/25. The data for adults covers the reporting period from 1 December 2023 to 31 March 2025. Where relevant, we have included trend information drawn from previous years' data.

During the reporting periods, fifteen learning review reports were submitted to the Care Inspectorate for children and young people and thirteen for adults.

Forty-three people attended the focus groups and 39 people completed targeted surveys, representing 27 committees from across Scotland.

The terms that we use in this report

Where we have relied on figures, we have tried to standardise the terms of quantity so that 'a few' means up to 19%; 'some' means 20% up to 39%; 'just under half' means 40% up to 49%; 'just over half' means 50% up to 59%; 'most' means 60% up to 79%; 'almost all' means 80% up to 99%; and 'all' means 100%.

3. Key messages

- The number of learning review notifications for adults has risen significantly; however, this has not translated into a comparable increase in those proceeding to a learning review.
- The number of learning review notifications for children and young people has fallen, as has the number proceeding to review.
- At times, committees undertake an alternative form of review, although learning review criteria is met. The Care Inspectorate is now receiving reports following these reviews for children and adults.
- The Care Inspectorate is not always made aware when learning review reports are published. While this is not mandatory, it limits our ability to provide full analysis and learning for the sector.
- Self-neglect is a notable form of harm within adult learning reviews, while the neglect of children and young people continues to be a prominent type of harm identified in learning reviews for children.
- Most adult learning reviews were initiated due to the death of an adult.
- Once a decision has been made to undertake a learning review, the process should be completed within a timeframe of six to nine months. Committees were not consistently able to meet these timescales outlined in the national learning review guidance for both children and adults.
- The identification and appointment of lead reviewers with the relevant skills, knowledge, capacity and autonomy is challenging for some child and adult protection committees.
- Care experienced people under the age of 26 appear to be underrepresented in the learning review process. The Care Inspectorate will look at this in more detail in the coming year to better understand commissioning and reporting practices.

4. Children and young people

Learning review notification data analysis

Thirty-four learning review notifications were received from 15 child protection committees concerning 42 children and young people. Nine notifications involving 13 children and young people proceeded to a learning review. In the previous reporting year, there were 53 notifications for 79 children and young people. Twenty-three of those notifications for 49 children proceeded to a learning review.

Of the 13 children and young people across the nine notifications proceeding to learning review, the gender of seven was recorded as female and six as male. Thirteen of the children and young people who did not proceed to learning review were recorded as female, and 16 were recorded as male.

In two notifications from separate committees, the learning review criteria was met, and the Care Inspectorate was notified of intent to proceed with an alternative type of review. In line with the national learning review guidance, when this occurs, child protection committees should submit anonymised completed reports or minutes that record learning and recommendations to the Care Inspectorate. Six alternative review reports in respect of six children and young people were submitted to the Care Inspectorate during 2024/25. Four of these children and young people died. Three of the six reports were received as learning review notifications in the reporting year 2023/34 and one in 2022/23. The remaining two were submitted as notifications in 2024/25, and alternative reviews were concluded in the same year.

A few children and young people subject of a learning review notification had a recorded disability. Of the thirteen children and young people proceeding to a learning review, two had a recorded disability.

Age profile

Table 1 illustrates that children under the age of five years were most likely to be the subject of a learning review notification. Just under half of notifications which proceeded to a learning review related to children under the age of five years. This age group also represented just under half of notifications, which did not proceed.

More than one-third of review notifications, which were proceeding to a learning review, were for children aged 11-15 years.

Children and young people age (years)	Number of people proceeding to learning review	Number of people not proceeding to learning review
Under 1	2	8
1 - 4	4	6
5 - 10	1	2
11 - 15	5	5
16 -17	1	1
18	0	2
Over 19	0	5

Table 1: Age range.

Ethnicity

The percentage of people in Scotland with a minority ethnic background increased from 8.2% in 2011 to 12.9% in 2022. This was a larger increase than over the previous decade (from 4.5% to 8.2%)[1]. Considering Scotland's ethnic diversity, we may expect to see more people from minority ethnic backgrounds subject to learning review notifications.

Children and young people		
Ethnicity	**Number proceeding**	**Number not Proceeding**
White Scottish	6	21
Other white British	0	3
Mixed Ethnicity	3	1
Not Disclosed	3	3
Not known	1	1

Table 2: Ethnicity

The ethnicity of children and young people was recorded as white Scottish in just under half of those proceeding to learning review and in most of those not proceeding.

Type of harm

Notifications were received regarding 19 children and young people who experienced non-fatal incidents. Four notifications involving multiple children and young people proceeded to a learning review.

Table 3 displays the types of harm identified in notifications when the child had not died. No children or young people were recorded to be at risk of harm from themselves or others, or as a result of their own mental ill-health. Multiple harms

[1] Scotland's Census 2022 - Ethnic group, national identity, language and religion

were recorded in some notifications. Neglect remained the most prevalent type of harm recorded for children. Individual harms were not recorded when multiple children and young people were included in a single notification.

Type of Harm	Number of notifications [2]
Neglect	21
Physical abuse	11
Emotional abuse	5
Sexual abuse	3
Child sexual exploitation	1

Table 3: types of harm recorded in notifications when the child or young person had not died.

Other risks or adversities were identified in notifications but were not specifically recorded as types of harm. These included parental mental ill-health, domestic abuse, parental criminality, and parental drug use.

Children and young people who died

Notifications were received for 23 children and young people who died. Four proceeded to a learning review. Suicide was the most common cause of death recorded in all notifications for children and young people who died. As investigations were ongoing for a small number of children and young people at the point of notification, the cause of their deaths was not known (table 4).

Although seven notifications were submitted for young people aged 18 and over who died, no learning reviews under the children's guidance proceeded for this age group. The deaths of five of these young people were drug-related. One young person completed suicide, and one death was unascertained pending further investigation. Four young people were noted to be the subject of an alternative form of review in addition to the learning review notification process. These included drug-related death reviews and reflective reviews. All the young people were in receipt of, or eligible for, throughcare and aftercare services. One young person was in a continuing care placement.

Cause of death (children and young people)	Number of notifications proceeding	Number of notifications not proceeding
Suicide	2	5
Sudden unexplained death in infancy/childhood	1	4
Alleged murder	1	-
Accidental death	-	1
Drug related	-	3
Not known (awaiting post-mortem or outcome of other investigations)	-	4
Medical condition	-	2

Table 4: Cause of death (children and young people)

[2] Multiple harms were recorded in some notifications.

Deaths of care experienced children and young people (1 April 2023 to 31 March 2025)

Local authorities must notify Scottish Ministers and the Care Inspectorate of the death of a looked after child within 24 hours, as per Regulation 6 of The Looked After Children (Scotland) Regulations 2009 (as amended). Revised death of a looked after child guidance was published on 6 February 2024 to provide greater clarity and better support review practice.

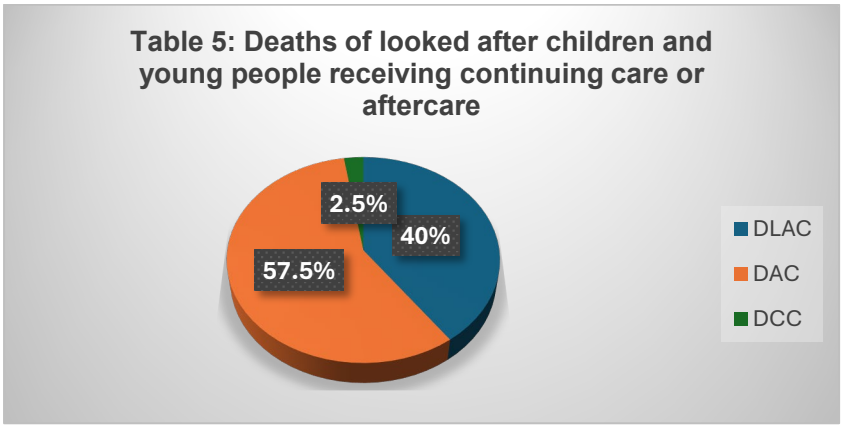
The local child death review group, and where appropriate the child protection committee and chief officers' group, should agree the review approach. A proportionate review of the child or young person's circumstances must be undertaken and, wherever possible, there should only be one multi-agency review. Reviews submitted to the Care Inspectorate in relation to the deaths of looked after children have increasingly placed a deeper emphasis on multi-agency reflective learning. We encourage partnerships to always consider a learning review when the child or young person who died was care experienced. This approach provides a comprehensive framework which supports multi-agency learning.

Details of notification requirements can be found on the Care Inspectorate website.

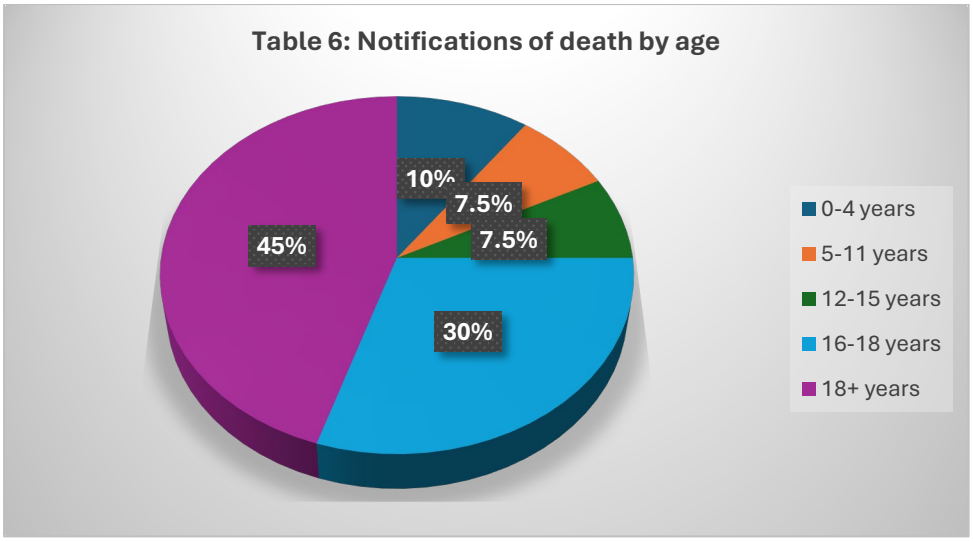
Following the introduction of the National Hub for reviewing and learning from the deaths of children and young people, a core dataset is required upon completion of any review. More information about the work of the National Hub and the core review dataset can be found here.

Notifications

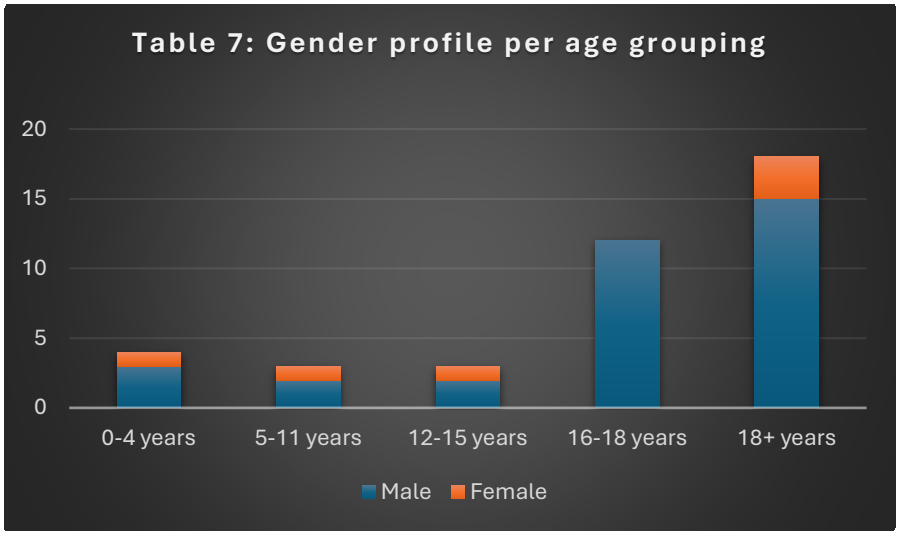
From 1 April 2023 to 31 March 2025, the Care Inspectorate was notified of the deaths of 40 looked after children and young people receiving continuing care or aftercare support.



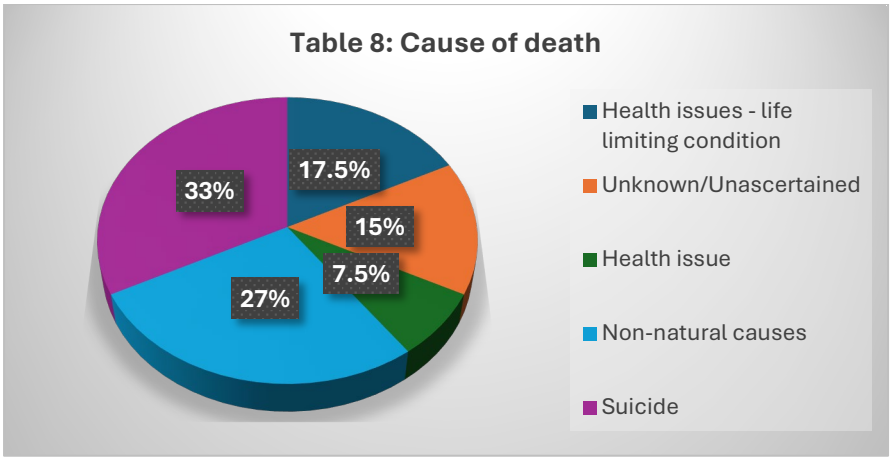
The notifications received related to 16 deaths of looked after children, one young person receiving continuing care, and 23 young people receiving aftercare support.



The age range was between 5 months and 25 years. The majority of notifications of deaths of looked after children and young people receiving continuing care or aftercare support were in relation to young people aged 16+ (75%).



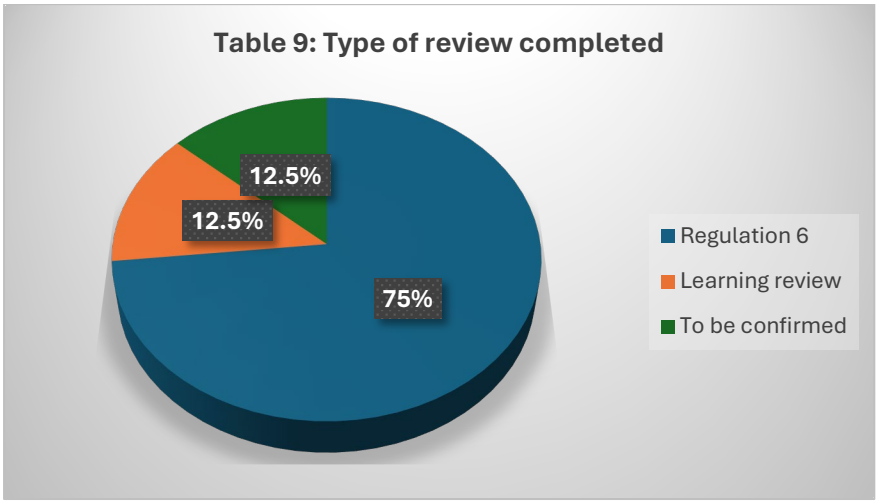
The representation of males was higher than females across all ages. In total there were 34 males (85%) and six females (15%).



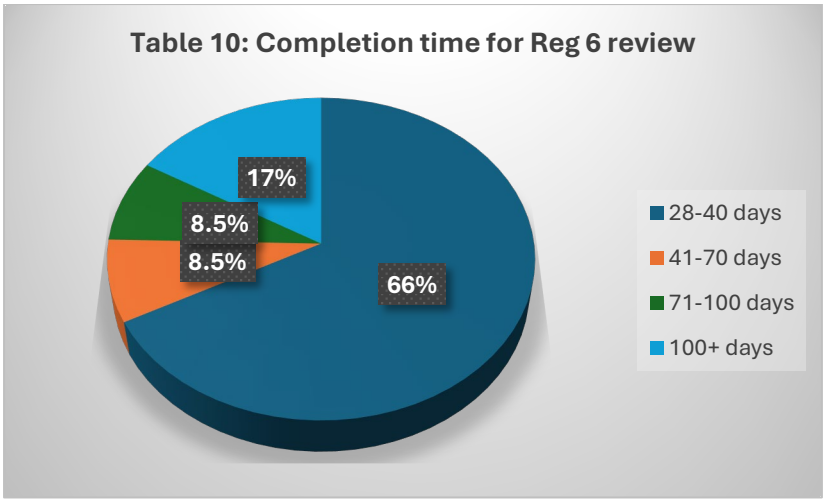
Almost one quarter of deaths (25%) (10) that were notified related directly to children and young people with health-related concerns. This reflected life-limiting conditions (17.5%), or illness developed at a point in their life (7.5%).

Reviews of deaths of looked after children

From 1 April 2023 to 31 March 2025, the Care Inspectorate received notice of 16 deaths of looked after children.



Most reviews (12) were completed under Regulation 6 of The Looked After Children (Scotland) Regulations 2009 (as amended). In two instances, the type of review was yet to be confirmed. A learning review proceeded following two notifications relating to the death of a looked after child.



The range of completion time for a review under Regulation 6 of the Looked After Children (Scotland) Regulations, 2009 (as amended) was between 28 and 143 days. Two-thirds (8) were completed between 28 and 40 days.

Trend data

Between 2015 and 2020, notification data for children and young people was recorded in calendar years. In 2021, we began to record the data in fiscal years. Table 11 includes data during the period of transition from initial case reviews (ICRs) and significant case reviews (SCRs) to learning reviews. The learning review guidance was published on 2 September 2021. ICRs therefore continued to be reported from 1 April to 2 September 2021.

In last year's data report for children and young people, we reported that the number of learning review notifications was distinctly higher than for the average number of notifications over the previous eight reporting years. There was also a higher number of learning review notifications that were not proceeding than in previous years.

There was a decrease in the number of learning review notifications and the number of children and young people subject to learning review notifications in 2024/25. Although the figures for alternative reviews appear to be increasing, this has only been reported on during the last reporting year, and so numbers have risen from zero to three.

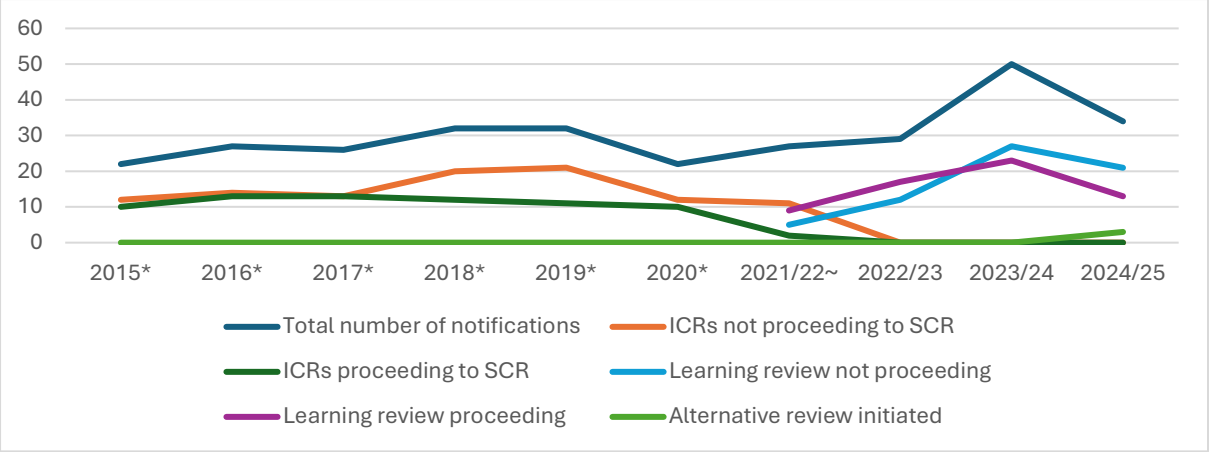


Table 11: Annual data - notifications proceeding and not proceeding.

*Calendar year

~Implementation of the National learning review guidance for Child Protection Committees Undertaking Learning Reviews

There has been a decrease in the number of learning review notifications for children and young people and in the number of those proceeding to learning review.

Learning review reports

Fifteen learning review reports were submitted for children and young people, and thirteen for adults. A few learning reviews for children and young people related to more than one person, either due to them being subject to the same episode of harm or experiencing similar types of harm to others.

All 15 learning review reports for children and young people contained multi-agency recommendations, findings, or strategies for improving practice and systems, while some also contained those aimed at single agencies. The number of these ranged from five to 27. Seven reports contained more than 11.

The most common recommendations, findings, or strategies for improving practice and systems are reflected in Table 12.

Theme of recommendations, findings or strategies for improving practice and systems	Frequency identified in learning review reports
Pre-birth and post-birth planning	4
Neglect	3
Mental ill-health and emotional wellbeing of adolescents	4
GIRFEC	7
Information sharing and professional communication	11
Transitions	6
Professional cultures and attitudes	6
Thresholds for intervention	11
Quality of assessment and analysis of risk	13
Parenting capacity	9
Non-engagement	10
Other	5

Table 12: Frequency of recommendations, findings or strategies for improving practice and systems.

Other recommendations, findings or strategies for improving practice and systems included the development of services for care leavers; improving and understanding the role of the Scottish Children's Reporter Administration and the children's hearing system; ensuring the voices of children are heard; improving the management of new referrals, assessments and case closures within social work; and improving the visibility of home-schooled children.

Recurring issues

Ten of the 15 reports for children and young people identified practitioner difficulties in engaging with parents or carers. Some young people did not find it easy to engage with services and attend appointments as they moved into adulthood, while others were difficult to maintain contact with. It was particularly challenging to maintain meaningful contact with some fathers.

The application of the Getting it Right for Every Child (GIRFEC) policy expectation continued to be a challenge. This was evident in seven of the 15 learning review reports we received. In some situations, there was confusion among professionals about how to raise a concern about a child. Crucially, some staff did not understand their responsibilities, or those of others. Children and young people and their families were not always involved in informing the plan aimed to support them.

Issues in relation to information sharing and communication between professionals featured in 11 reports. Information was not always shared timeously. Where a child

had siblings, the needs of and risks to them were not always considered. In some instances, adequate information was not shared between children and adult services, meaning that assessments were incomplete. IT systems were seen as a barrier to accessing relevant information and to enable the effective sharing of information by staff when these did not work effectively or when access was not available when needed.

The quality of assessment and analysis of risk was identified as an area for improvement in 13 of the learning review reports received. Some learning reviews identified links to information not being shared effectively between services. The circumstances of parents were not fully known or investigated in some instances.

The committee members we heard from did not believe additional guidance was required to enable staff to better support young people transitioning to adult services. However, there was an identified need within learning reviews for an improved approach to coordinating pathway plans, to help identify need and address risk. *Transitions for care experienced young people: A thematic review*, published in November 2024 highlighted the importance of the quality of plans and to agreeing a shared understanding of their purpose.

The identification and response to neglect was an area of concern in some of reports submitted, compared with most reports in the previous reporting year. Reports noted uncertainties in how to escalate concerns, when and to whom.

Areas of effective practice

Effective practice was recorded in 12 of the 15 learning review reports for children and young people. These included the flexibility of support to children, young people and their families, and the support provided to staff. Areas of effective practice were not routinely highlighted in detail and did not regularly feature within recommendations and strategies for improving practice.

Parental adversities

The national guidance recognises that families and others involved in learning reviews may have been impacted by, or experienced trauma. Although parental trauma was not routinely referenced in notifications and reports, adversities experienced by parents or carers were recorded.

Parental mental ill-health was noted in some of the notifications and reports received. This primarily impacted on the mother's level of care provided to her child or children. Parental alcohol misuse was recorded in a few notifications and reports, however, the impact on the child or children was not always clear. Where parental alcohol use was identified, most child or children were also impacted by domestic abuse.

Parental drug misuse was highlighted as impacting upon the child or children) in some notifications and reports. Mental ill-health issues were also recorded for just over half of these parents. Examples of the impact of parental substance misuse included the risks to some children and young people due to the parent(s), associates, presence of drugs within the household, neglect, and the parent's reduced capabilities to provide safe care for their children.

Domestic abuse concerns were recorded in most of the notifications and reports received. However, the impact of domestic abuse on the child or children was not explored fully in most of these. Where the impact was explored, this included child or children being exposed to incidents of domestic violence or having to leave their home as a parent fled domestic abuse. Domestic abuse was noted to impact on child or children emotional wellbeing, causing a high state of distress.

Parents' own adverse childhood experiences were recorded in a few notifications and reports. There was little consideration of the impact on their own child or children.

5. Adults

Learning review notification data analysis

Seventy learning review notifications were received from 19 committees for adults during the reporting period. Most notifications demonstrated well informed decision making and most decisions about whether to proceed or not were made within 42 days, in keeping with national learning review guidance.

Although the reporting period for adult reviews covers a 16-month period, the number of notifications has more than doubled between the two reporting periods. The proportion proceeding increased from some to just over half.

Of the 70 notifications received, just over half proceeded to a learning review. Two main factors for cases proceeding to learning review included adults being referred under adult support and protection and issues around their decision-making capacity.

Three learning review notifications for multiple adults were each proceeding to a thematic learning review. The themes included adults who all stayed in the same residential resource; mothers who had completed suicide and whose children were either removed or likely to be removed from their care; and deaths of adults in emergency accommodation. No reports from these learning reviews were received as of 31 March 2025. The learning will be included in future national overview reports.

The gender in just over half of all notifications proceeding for adults was recorded as male. The rest were recorded as female. For those proceeding to learning review, the primary reason for involvement with services was mental ill-health. Harm to the adult occurred within their own home in most notifications received for those proceeding to review.

The most prominent type of harm identified in all notifications remained self-neglect. Most notifications received related to the death of the adult.

Not all adult protection committees sent learning review notifications to the Care Inspectorate when a learning review was being considered. Most adult protection committees submitted at least one notification in the 16-month reporting period. This reduced to just under half when calculated as a 12-month average.

Age profile

The highest number of learning review notifications was for those between the ages of 34-44. Those aged 65 and over accounted for just under one-third of those proceeding.

The largest age group where notifications were not proceeding was between 75 and 84 years. There was a relatively even spread between those aged 34 and 64.

Adults age (years)	Number of people proceeding to learning review	Number of people not proceeding to learning review
16 -17	1	0
18-24	1	1
25-34	6	2
34-44	9	6
45-54	4	6
55-64	4	6
65-74	8	2
75-84	2	9
85-95	2	1

Table 13: Age range.

Ethnicity

Overall, ethnicity was described as white Scottish in most notifications, with a few people's ethnicity unknown or unrecorded.

Adults		
Ethnicity	**Number proceeding**	**Number not Proceeding**
White Scottish	27	22
Unrecorded/Not known	5	5
Pakistani	1	0
Scottish	3	0
White other British	1	2
White Irish	0	3
Polish	0	1

Table 14: Ethnicity

Type of harm

The most prevalent type of harm for adults proceeding to learning review was self-neglect, with neglect and self-harm being the other main categories. The secondary type of harm for adults was physical harm, seen in just over a quarter of cases. Not all notifications recorded a secondary type of harm (Table 15).

The primary type of harm for adult learning review notifications, where a learning review was not proceeding, was self-neglect in one-third of cases. Self-neglect also accounted for a similar proportion of cases in those notifications proceeding and those not proceeding.

Overall, self-neglect, neglect and self-harm were the most prevalent harm types in the notifications received. This reflects the position in the previous reporting period.

The primary reasons for not proceeding to a learning review included unmet criteria, referral to other agencies, lack of new multi-agency learning, and ongoing improvement actions.

Type of Harm	Number proceeding	Number not proceeding
Physical	3	8
Neglect	6	2
Self-neglect	13	11
Financial	2	1
Psychological	3	-
Self-harm	5	3
Institutional	3	3
Multiple	2	-
Domestic violence	-	2
Substance use	-	1
Fire fatality	-	2

Table 15: Primary type of harm - adult not proceeding to learning review.

Primary case types

Of those adult cases proceeding to learning review, some experienced mental ill-health, problematic alcohol use and/or substance use.

Primary case type	Number of notifications proceeding
Physical Disability/health	7
Frail Older	4
Alcohol/substance use	9
Mental Health	11
Learning Disability	3
Homelessness	1
Dementia/Cognitive Impairment	1
Multiple case types	1

Table 16: Primary case type (adults proceeding)

Location of harm

Where a learning review proceeded, most adults were harmed in their own homes. This was also the case for those that did not proceed. A few adults were harmed in

an institutional or supported setting, such as a hospital, prison, sheltered or supported housing, or care home. A small number were harmed in homeless accommodation or other types of private accommodation.

Adults who died

Most notifications for adults related to someone who died. The cause of death was not always clear at the point of submission, and we have therefore reported on the case and harm type. The most prominent type of harm for those who died was recorded as self-neglect.

The case, or service type for some of those who died was alcohol and substance use, with a few categorised as mental health and a few frail older people.

Case/Service Type	Number of all notifications (proceeding and not proceeding)
Alcohol or substance misuse	14
Dementia or cognitive impairment	1
Frail older person	9
Learning disability	4
Mental health	10
Physical disability	6
Multiple	2
Other	5

Table 17: Case or service type for adults who died (proceeding and not proceeding)

Trend data

Reporting periods have changed for adult learning review activity. Table 18 shows the yearly average of learning review notifications, learning reviews, and alternative reviews undertaken during the last three reporting periods. The number of notifications is markedly higher in the most recent period.

	2019 to 2022 – Average per year	2022 to 2023 Average per year	2023 to 2025 Average per year
Notifications	31	27	53
Proceeding to learning review	6	9	10
Alternative review	5	7	5

Table 18: Average annual learning review data (adults)

Although there has been a marked increase in the number of learning review notifications for adults, this has not translated into a comparable increase in those proceeding to a learning review.

Learning review reports

Thirteen learning review reports were submitted for adults. The following key areas emerged through our analysis of the reports received and with partnerships involved in our focus group discussions.

Recommendations and strategies for improving practice in adult reviews mainly focused upon issues such as the need for service or committee design and structure and improved training. A few recommendations or strategies for improving practice had national relevance.

Other recommendations or strategies for improving practice for adults in relation to case recording, effectively reviewing records and other information sources to support decision making, professional curiosity, and accessing specialist areas of practice, such as alcohol and drugs. Others related to multi-agency working, information sharing, knowledge of legislation, staff supervision, systems and strategic management.

Recurring issues

The most frequently referenced practice issues highlighted in adult learning reviews were single and multi-agency communication and information sharing; knowledge of adult support and protection, including recognising and responding to risk; and the consistency and accuracy of recording. These were commonly linked to the need for enhanced multi-agency working and training to increase understanding around roles and responsibilities. This included supporting staff to better recognise harm, and the impact of substance use within the adult support and protection context.

Areas of effective practice

Areas of effective practice noted in adult learning reviews related to proactive multi-agency working, information sharing and the quality of involvement from general practitioners and some other health staff. Positively, more committees were involving those adults with lived experience in reviews, although almost all survey respondents agreed that this proved challenging.

6. Shared characteristics: children, young people and adults

Methodological approach

The methodological approach and style varied across children and adult learning review reports. A range of formats were used to present recommendations and strategies for improving practice and systems.

Involving parents, carers and/or significant family members was positively considered in the majority of learning reviews for children, young people and adults. Family members informed the scope and terms of reference of a small number of learning reviews. When family members were not involved in learning reviews, the reasons for decisions were clearly recorded in most cases.

While consideration was given to involving some young people subject to a review they ultimately did not input to the learning review process directly.

Governance

The national guidance for both children and adults notes that all learning reviews must adopt a systemic, proportionate and flexible approach. Even when the learning review criteria was met, some committees chose to undertake alternative forms of review rather than conducting a learning review in accordance with the guidance. A clearer understanding is required about why another form of review is at times preferred over a learning review.

Some committees experienced instances where external reviewers were unable to produce a quality report for them within the timescales required. There was a general consensus among focus group participants that greater consistency is required in the commissioning of learning reviews and that it can take considerable time to find the right lead reviewer. Securing an external reviewer often relied upon using existing networks and established working relationships.

Most focus group members valued having externally commissioned lead reviewers, as they felt that they offered objectivity, critical challenge and independent validation. A small number of committees used internal lead reviewers. This approach reduced the financial burden, time delays, and upskilled staff in lead roles. However, internal reviewers were not generally seen to be as autonomous as an external reviewer.

Timeliness

The national guidance for both children and adults suggests lengthy review processes should be avoided. Optimum learning arises when significant events are identified as early as possible, relevant to the context of practice. Once a decision has been made to undertake an adult or child learning review, it should be completed within a timeframe of six-to-nine months.

The length of time to completion for children and young people varied from under six months to more than 24 months. Just over half of reviews were concluded within 18 months.

We found the average time taken to complete an adult learning review was 23 months (within an overall range of seven to 35 months), falling significantly out with the suggested timescales within national guidance.

Reasons for delays were not always acknowledged or recorded in learning review reports. Commonly recorded reasons for delays included changes or absences of key personnel, operational pressures, legal processes, complexity, and difficulties commissioning skilled and experienced external reviewers.

Publication of learning review reports

The national learning review guidance for children and for adults both state that the Chief Officer Group, informed by a recommendation by the committee, will decide if and when to publish the report. If a report is not published, then the learning should be extracted from the report and published separately.

The Care Inspectorate is not always made aware when all learning review reports are published, and this is not a mandatory reporting requirement. The learning review knowledge hub continues to hold published learning review reports and relevant research, and this facility will continue to be developed.

7. Key considerations

Data

As most reviews are not published, sharing learning across Scotland to best effect is limited and is therefore a key consideration for the sector. During the reporting period there was no formal mechanism for national recommendations to be taken forward and addressed. The joint national child protection and adult support and protection learning review group was reformed in 2024 and has the potential to address this. The group now receives quarterly learning review data from the Care Inspectorate, which provides oversight of emerging issues and process risks. The group should use this to drive strategies for improving practice and recommendations of both local and national relevance.

The Care Inspectorate continues to improve its internal process to capture and report on data with an increased frequency in order to support learning. We will continue to engage with the sector at the child protection and adult support and protection learning review group on the potential applications of the data we capture and frequency of reporting. This will ensure our work is impactful, timely and improvement-focussed.

Supporting improvement.

The Care Inspectorate is committed to continuous improvement in its role and responsibilities for learning reviews.

Fewer notifications were submitted under the national guidance for people below the age of 25 than for any other age group. Although we encourage partnerships to always consider a learning review when the child or young person who died was care experienced, only a small number of those aged 18-26 became the subject of a learning review. We will continue to encourage partnerships to always consider a learning review, supporting the principle of one proportionate multi-agency review within the framework of the national guidance. Although many of these young adults were the subject of alternative forms of review, further work is required to understand why this cohort appears to be underrepresented in the learning review process.

The inconsistent approach to the publication of reviews, or the learning from them, inhibits national learning. This has the potential to be improved with the further development of the learning review knowledge hub, providing improved accessibility to resources for committees.

We continue to use quality markers, aligned with the national learning review guidance, to provide observations on learning review reports. Recent research and analysis we undertook identified ways we will enhance our existing approach to quality assurance.

In line with the direction of the national public protection leadership group (NPPLG), we will continue to enhance an appreciative public protection approach to our work.

This aims to help continue to foster a culture of learning. In the coming year, we will consult with the sector in reviewing the Care Inspectorate's code of practice for the review of learning reviews and how we strengthen our focus on improvement.

Lead Reviewers

The Care Inspectorate supports the provision of external assurance and will work as part of the joint national child and adult learning review group to consider ways of addressing identified areas of concern. The National Child and Adult Learning review Group has taken the initial step of developing a national list of external reviewers. While not offering any level of endorsement, it is a starting point. Committees should still undertake due diligence to ensure that the external reviewer can meet their requirements.

8. Conclusion

This is the first annual joint report, which includes data from child and adult learning reviews. It provides an overview of national learning review data to support partnerships to improve their local learning review processes. Many of the themes emerging from the learning review reports and notifications reflect those seen in previous national overview reports.

At times, child and adult protection committees undertake alternative forms of review to a learning review. When the learning review criteria are met, the learning, or reports, from these reviews should be submitted to the Care Inspectorate in accordance with the national guidance. As the numbers of these reports increase, we will include a thematic overview in future quarterly reports to the child protection and adult protection learning review group and annual data reports. This will broaden our ability to identify themes, aspects of good practice and learning opportunities to share nationally.

Along with the Centre for Excellence for Children's Care and Protection (CELCIS) the Care Inspectorate continues to facilitate the learning review knowledge hub, sharing learning with national reach. It is anticipated that during 2025/26, this will extend to include learning reviews for adults, supported by the Institute for Research and Innovation in Social Services (IRISS). We will continue to draw from research and data to inform how we can meaningfully support partnerships to improve how learning reviews are undertaken and how learning is implemented and sustained.

The Care Inspectorate continues to provide quarterly updates to Child Protection Committees Scotland and to Adult Protection Conveners, including a section on the most recent learning review data. The timing of the next full analytical report will be kept under review and will be largely dependent on the number of completed learning review reports and alternative review reports received.