ECPC LRCP25.1 – Young Person H

Multi-Agency Reflective Discussion Executive Learning Summary

August 2025

Introduction

Young Person H, aged 20, was a care experienced person accessing continuing care.

One evening, Young Person H left home and travelled to the city, where they were in contact with numerous friends and acquaintances. Some contacted public services concerned for Young Person H's safety and wellbeing. As a result, several professionals across different agencies had involvement with Young Person H on that evening and into the early hours of the following day.

Sadly, despite these contacts, Young Person H completed suicide the following morning whilst still in the community.

As Young Person H was in receipt of continuing care and had completed suicide, the situation met the criteria for a Learning Review notification, as detailed in National Guidance for Child Protection Committees Undertaking Learning Review in Scotland (2021- updated 2024) .

The Reflective Discussion process has involved Young Person H's foster family being informed of the learning process and the outcomes.

The Executive Learning Summary offers an overview of the Reflective Discussion process undertaken and outlines:

- The circumstances leading to the death of Young Person H
- Practice learning and suggested strategies for improvement
- Examples of effective practice.

Sharing Personal Data

Edinburgh CPC has given due consideration to the extent to which personal data can be shared in any Executive Learning Summary being placed in the public domain. The report has been anonymised, insofar as is possible, and includes only information that can be lawfully shared. Any disclosure of personal data must comply with the Data Protection Act 2018 and the General Data Protection Regulations (2018): Article 8 of the European Convention on Human Rights (the right to respect for private and family life) and must have acted in accordance with these requirements.

The Executive Learning Summary is a limited version of the full report.

Circumstances that led to the Reflective Discussion

Young Person H's early life was impacted by substantial adversity. From one year old, they were known to child protection services and this early involvement continued until they were three years old, at which point they became Looked After and Accommodated. A Permanence Order was later sought by the local authority. This Permanence Order shared parenting responsibilities between the local authority and the long-term foster carer.

Young Person H and another family member were cared for by the same permanent foster carers throughout the remainder of their childhood. Sadly, the family did experience the death, through ill-health, of one of the foster parents who had been an important role model in Young Person H's life. This is reported to have changed the dynamics in the family home and impacted their emotional well-being, leading to increased instances of substance use by Young Person H. Despite this, Young Person H did look to be progressing with their life and plans, having been employed in different sectors and preparing to attend university.

At the time of their death, Young Person H was in receipt of Aftercare and allocated to a Throughcare Aftercare worker but was largely independent and autonomous. Their foster carer also received support from a fostering Social Worker.

Practice Learning

1. Visits to Looked After Children

The same social worker remained allocated to Young Person H for some time, despite a move into a management role. This was intended to minimise disruptions to the young person.

Whilst Looked After and Accommodated, Young Person H should have been visited by their social worker a minimum of 12 weekly, by virtue of their permanent care experience. This is to maintain contact and provide them with support (City of Edinburgh Council, Children's Social Work Practice Standards).

However, home visits, discussion with and the express views of the young person did not often take place and were not always recorded. It was acknowledged that the social worker didn't have a strong, supportive relationship with Young Person H, despite long-term involvement.

City of Edinburgh Council has carried out extensive work on Children's Services Practice Standards since this time.

Suggested Strategy: City of Edinburgh Council Children's Services may wish to review how allocation decisions are taken and the use of Supervision to ensure scrutiny and best practice.

2. Looked After Reviews and Continuing Care Reviews

Statutory Guidance dictates that all care experienced young people should have a care plan that is reviewed regularly (s.5 and s.44 Scottish Government (2009) The Looked After Children (Scotland) Regulations). For children and young people who are subject to a Permanence Order, the Looked After and Accommodated Children Procedure for City of Edinburgh Council (2022) advises that reviews should be held 'at least annually.'

While these reviews did take place, chaired by a Reviewing Officer independent of the day-to-day case management, the meetings were not often representative of the multi-agency group of staff who could have been in the team around the child. The representatives at the meetings were usually from the foster care, social work and school. Care Experienced Nurse were rarely informed of the meetings, let alone invited.

The Looked After and Accommodated Children Procedure for City of Edinburgh Council (2022) advises that 'the social worker will identify all those professionals/other adults who should be invited to the review' and 'There is a requirement that all professional staff attending the review will submit a report on their involvement with the child, and in particular any views and wishes the child may have expressed.' In Young Person H's case, this meant that crucial information that could have been shared with or from colleagues in NHS was not considered.

A scheduling sheet system is used locally for such meetings with various prompts for the Lead Professional to consider appropriate and proportionate invites. This has already been updated to ensure the Care Experienced Nurse Practitioner Mailbox is always informed of Looked After Reviews and can contact the Reviewing Officer or Lead Professional for further information where required.

The Reflective Discussion also highlighted that the review process can work better for young people when they have a relationship with a Reviewing Officer, that has been built up over time through the Looked After Review periods. Practitioners commented that this process has improved over recent years in Edinburgh, where Reviewing Officer's now offer opportunities to meet a child or young person out-with their Looked After Reviews, which makes it possible to plan the review meeting in-line with the child or young person's needs, wherever possible. It was recognised Young Person H had a consistent Reviewing Officer for many years who had then moved on to retirement. Over the last few years, their annual Looked After Review Meetings were supported by several different Reviewing Officers who they had not developed a relationship with. With the exception of appearing off-camera during one remote Looked After Review, Young Person H had elected not to attend their Reviews.

Suggested Strategy: Edinburgh should consider reviewing guidance on multi-disciplinary involvement in Looked After and Continuing Care Reviews, as part of City of Edinburgh Council's Looked After Procedures.

Edinburgh may wish to explore measures for considering whether a child's Looked After Review meeting is quorate, so that the meeting can effectively explore all parts of their lives and care planning with the professionals who are present. It is recognised that this requires to be balanced with respecting the views of a developing child; recording their views; and any subsequent decision-making around attendance at meetings in their social work records.

Edinburgh should attempt to maintain consistent Reviewing Officer relationships whenever possible to aid the quality of the Looked After Review process.

The Reflective Discussion was not able to hear fully about the Continuing Care and Pathway Plan Review process for young people reviewed by Throughcare Aftercare but any learning from the Looked After Review process may transfer over to the elder age-group.

3. Voice of the Child

As noted earlier, Young Person H did not appear to have a direct relationship with their social worker and so it was difficult to include their express views and opinions in the review meetings. Reflective Discussion participants noted that these were accurately represented in meetings by the professionals from Education, with whom Young Person H had a trusting and supportive relationship. However, it should be noted that there was very little evidence in the case recordings of the young person's voice and experiences.

There were instances where Reflective Discussion practitioners recollected express views of the young person around the privacy of their own information and how this had informed how professionals shared or withheld this information in reports, meetings, or informally with the foster carer. However, Young Person H's views and professional decision-making around this did not appear to be included explicitly in case records.

Further, the Reviewing Officer was not aware of some of the mental health and substance use challenges the young person was facing. This may have hindered them from planning the review meeting and update of the care plan in a way that allowed for full decision making or exploration of supports that could have been valuable.

Participants reflected that there were often tensions in managing the young person's right to privacy and information they had shared alongside the needs of their caregiver, and the wider helping team. This area of practice has also been explored in the Learning Review Report of Young Person D (April 2024), which explored challenges in working with hard-to-reach young adults.

Whilst the views and privacy of a young person are important, the foster carer held joint parental rights and responsibilities. Further, corporate parenting responsibility were not always upheld by withholding key information from the team around the young person.

Suggested Strategies: Edinburgh may wish to consider developing a restricted section to paperwork for Looked After Reviews, so that all relevant parties have the information they require and can save this to their individual systems.

Edinburgh may also consider offering an opportunity for a young person to be able to speak to professionals without the foster carer present and for decisions or supports to be reflected in the care plan in a way that still respects a young person's privacy.

Edinburgh's workforce may wish to consider how they develop their practice in working with young people to share relevant information with their caregivers and professionals who support them directly, while continuing to respect their privacy.

4. Change of Circumstances and understanding change and trauma

A Change of Circumstances process is used locally for Looked After children and young people (as detailed on the Children's Practice Team webpages). Reflective Discussion participants confirmed that the level of day-to-day information sharing on changes to the young person's circumstances was very limited. This was evidenced in the multi-agency chronology where only one Change of Circumstances proforma was noted by NHS Lothian in March 2020, despite Young Person H leaving school, moving home, and experiencing the death of a permanent carer during this time. The Change of Circumstances proforma is the main vehicle by which other key partners in the team around the child are notified about formal changes for a young person. Although, in many cases, there is also good informal communication and information sharing out-with this, sometimes things can be missed.

Suggested Strategy: Edinburgh may wish to review the Change of Circumstances form and guidance for Looked After Children, especially reflecting on corporate parenting responsibilities and the child-centred changes of circumstances that might be considered significant to the lived experience of a child.

5. Health reliance on Lead Professional

The multi-agency chronology and discussion at the reflective event, demonstrated that there had been a handful of occasions where Young Person H had contact with an Emergency Department or another health service. It was recognised that single-agency information sharing within health services can often depend on whether the contact has been within the same Health Board. Young Person H was latterly resident in another Health Board area and information would not routinely have been passed back to the NHS Lothian Care Experienced Nurses. It was identified that this may leave a gap in offering young people access to local services aligned to their circumstances.

There are other occasions when a Care Experienced Nurse would, on receiving health contact or information, reach out to the social worker, as lead professional to ascertain any further involvement. The Reflective Discuss heard that Health staff are often reliant on the Lead Professional's view as to whether they make contact with the Young Person or their carer directly and values and thresholds across services may be different.

Suggested Strategy: Edinburgh's health services should consider when it is appropriate to make direct contact with a young person or their carer, following the notification of a hospital attendance or other medical intervention, rather than rely solely on contact with the Lead Professional.

6. Working across Local Authority areas

It is not always clear whether the local authority or health board area that a Looked After young person is resident in are made aware that of the care experienced young person who is the responsibility of another local authority.

Suggested Strategy: Edinburgh should consider whether Looked After children moving to a new area should have details shared with the new local authority to ensure that any input from public protection or emergency services is flagged with their Lead Professional in Edinburgh. This could be recorded on the local recording system to ensure that the other area share information in line with corporate parenting responsibilities.

7. Records of Out of Hours calls and screening

The Reflective Discussion for Young Person H brought up some discrepancy about whether a call from the carer to Out of Hours Social Work was logged when Young Person H left their home distressed on the evening before their death. At the time of the review, there was no official log of this call.

On further retrospective investigation, it was established that the foster carer did call Emergency Social Work Service in the early hours of the morning asking for advice on what he should do regarding messages received from friends of Young Person H regarding their physical (intoxicated) and mental wellbeing (having suffered a relationship breakdown). These messages also indicated that Young Person H was threatening to kill themselves. The call handler advised the carer that, given the nature of the messages received, the carer should contact Police Scotland.

This was not recorded on the social work records system, as given the nature of the concerns raised, immediate contact with Emergency Services was deemed the most appropriate route. An operational manager for Out of Hours Social Work has reflected that, while this may be the case, the information should have been recorded within social work records systems, so the social worker on shift could have screened it and decided whether to contact the foster carer for support. This would also have meant that day-staff allocated to Young Person H would have been aware of the circumstances on their return to work and may have been able to offer the family immediate support.

Learning from this circumstance has led to a change in practice in that all out of hours' staff will now record all calls on the social work records system, where the call relates to an individual (child or adult) who is already known to social work. This action likely takes care of the suggested strategy below.

Suggested Strategy: Edinburgh should consider reviewing Out of Hours Social Work screening processes to ensure that any concerns pertaining to a child is recorded, screened and a multi-agency approach is undertaken in the absence of the social worker. This would ensure a foster carer felt listened to, supported and assured of a clear process of information sharing with the young person's team involved.

8. Emergency Mental Health Assessment for 16+

The Reflective Discussion explored the process by which Police make a referral to Mental Health Assessment Service (MHAS) for individuals they encounter who they deem to be in mental distress. For all under 18s, the Police are required to take young people to MHAS for an in-person mental health assessment. Whereas over 18s are initially assessed over the phone.

At the time of Young Person H's distress and contact with Police Scotland, a telephone assessment with MHAS took place, following which Young Person H was conveyed by Police to the house of a friend. However, the telephone assessment was not documented on TRAK due to clinical pressures/demands, which has made it difficult to analyse this action in retrospect.

Health professionals also noted that a Care Experienced Flag is present on an individual's TRAK record until the age of 18. This means that during Young Person H's involvement with the Mental Health Assessment Service (MHAS) in October 2024, it is likely that they would not have been aware of his care experience.

It should be noted within this practice learning point that the Reflective Discussion was attended by a Senior Manager from CAMHS, rather than the MHAS service, who were not represented.

Suggested strategy: Edinburgh services may wish to consider a change of protocol in considering that all care experienced young people up to the age of 26 should be conveyed to MHAS for an in-person mental health assessment.

Edinburgh Health services may wish to consider increasing the use of the care experienced flag system on TRAK for individuals to the age of 26.

9. Police Systems

Both British Transport Police and Police Scotland were involved in the final incident that led to a Learning Review Notification. The Reflective Discussion heard that the organisations use two distinct systems to record their enquiries. In Young Person H's case, this led to further distress and confusion for the foster family who, at a time of grief, had visits from different Police services who did not appear to have the most up-to-date information. At one point this resulted in the foster carer having to inform a further set of Police Officers who attended the home, that Young Person H was no longer missing, as he was deceased.

Suggested strategy: Police Scotland and British Transport Police to consider how they could align systems or improve information sharing to prevent against further re-traumatisation to a family.

Effective Practice

1. Education

During the period under review, Young Person H was experiencing Covid-19 isolation, and the foster family were going through the shock and grief of losing an adult carer. The school pupil support lead and school counsellor acted as safe adults who offered Young Person H containment and emotional support. This was especially true as Young Person H was described as subdued and did not have a close relationship with their social worker, despite an enduring

involvement. It is important that the young person had safety; trust; choice; collaboration; and empowerment, in line with trauma-informed practice. Young Person H seems to have received a trauma-informed, responsive and adaptable approach from the helping team at the school.

This would be a good practice example for education to build into child protection training for education and youth work staff.

2. Family Based Care

The reflective discussion heard that Young Person H's foster carer received a high level of sensitive and supportive contact with their Family Based Care social workers. Fostering social workers had a good understanding of the young person's day-to-day life and how this was being managed and supported by the carer. They were attempting advice and support on maintaining connection and meaningful conversations, which both individuals in the family found challenging.

3. Care Experienced Nurse Practitioners

NHS Lothian have expectations under CEL 16 (2009) arrangements to offer care experienced children and young people an annual health review.

As part of the Reflective Discussion, Care Experienced Nurse Practitioner's shared the updated Standard Operating Procedure for Transitions and Nursing Care when a young person has their final LAAC Review. While communication between the Care Experienced Nurse Practitioner team and social workers, as Lead Professionals, is greatly improved and benefits fuller consideration of the health and wellbeing needs of young care experienced people as they reach transition to adulthood, it would be useful for the wider workforce to be aware of the process.

Edinburgh should consider how Lead Professionals and other members of the team around the child are made aware of NHS Lothian's Standard Operating Procedure through guidance and procedure.

Conclusion

The Reflective Discussion of a young, care experienced adult who was in distress to the point of completing suicide, raised again the importance of planned and structured transitions to adulthood for young people involved in our services. It was also identified that these processes are greatly supported by genuine and enduring working relationships with a range of staff across the workforce.

It is recognised that considering the death of a young care experienced person by suicide was painful and distressing and, while every effort was made to provide a trauma-informed and respectful experience, the Edinburgh Child Protection Committee thank all the practitioners who took part in the event and shared their views and experiences so honestly.

These have been recorded in the above account and carefully considered against national and local expectations, leading to the practice learning points shared for local and national consideration.

Signed and dated by:	
Reviewer:	Adele Ferguson & Laura Brown
Date:	15/08/2025