Child Protection Committee

Combined Learning Review Executive Summary

Young Person A & Young Person D

May 2025

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[1] Introduction

This combined executive summary has been published by North Lanarkshire's Child Protection Committee following two learning reviews that were undertaken into the deaths of two young people who had previously been provided with care and protection from the multi-agency partnership within North Lanarkshire.

The learning reviews were undertaken with a focus on system role and function in accordance with the National Guidance for child protection committees undertaking learning reviews (2021). The focus was not solely on individual or professional practice but rather explored underlying systemic elements, the links with organisational factors and the wider context. The aim of the reviews was to inform recommendations of systems learning and improvements which would ultimately translate into improved experiences and outcomes for the children, families and young people supported by them.

The combined summary covers a high-level overview of the reasons and circumstances that resulted in a learning review being undertaken, the process of the review, and the learning and recommendations for systems improvement.

Section eight of this report details a range of improvement actions which have been implemented or are currently in progress which will go some way towards addressing the learning points and recommendations identified.

[2] Circumstances leading to review

Young person A was remanded in HMYOI Polmont in 2023 after early life experiences of parental substance misuse and domestic abuse followed by a very short period of time in a North Lanarkshire children's house in Oct/Nov 2017. There were concerns regarding mental health issues and substance misuse and following release from Polmont in 2023, he died from a drug overdose a few months later. He was 17 years old.

Young person D experienced significant trauma throughout his childhood and lived in kinship care for a significant proportion of his life. This young person moved back to live with his mother at the age of 17 but there were further concerns about mental health issues and substance misuse. Frequent changes of accommodation were experienced before D's death in 2023, reportedly as a result of a drugs overdose. He was 20 years old.

[3] Process of the learning reviews

Both reviews were overseen by case review teams, chaired by the Child Protection Committee (CPC) chair and with internal lead reviewers from North Lanarkshire Council. Review group members included representation from Social Work (Children & Families, Adults and Justice), Health (Nursing, Public Protection and Community Mental Health), SCRA, Police, and Addictions as well as the co-ordinator from the CPC. Consultation was also undertaken with housing, education, children's house staff, primary care GP services and CAHMS as well as another local authority area where one of the young people had resided for periods of time over a number of years.

Reflective practitioner events were utilised to ensure that learning was gathered in the context of practitioner knowledge and experience at the time.

Both families were approached to provide information about the review process and offer to contribute to the review reflections. One young person's mother chose to take this up and was able to provide her own perspective of the key events in her son's life experiences.

[4] Brief historical context

Both young people's early life experiences were impacted by loss of critical relationships. Young person A was cared for alternately by his father and then his mother and moves would often happen due to a breakdown in the relationship with the parent he was living with at the time. Young person A experienced an affluent lifestyle during his early years, however this changed when his father lost his job when A was around 7 years old. Young person A was also exposed to adverse parental experiences including parental substance misuse and domestic abuse. When A's relationship with his father broke down as a young adult, he spent a period of four weeks living in a children's house towards the end of 2017 before briefly living with his sister, until this relationship also fractured.

As both young people moved through adolescence, they had limited and fractured levels of care and support. For young person A, his adolescence was characterised by volatility in his relationships with his parents with a recurring pattern of crisis which led to enhanced supports from agencies. This led to some periods of stability which were quickly followed by further crises when support was withdrawn.

Over the last three years of his life, young person A was subject to continued episodes of poor mental health, suicidal ideation and use of substances to the point of overdose. There were also concerns about domestic violence and young person A was known to police for often low-level offending. He continued to accrue charges and was remanded in HMYOI Polmont for a period in 2023. He was liberated but continued to struggle with substance misuse despite supports provided by justice services, Barnardo's and appointments provided by addiction services. A few months after this Young person A died from a drug overdose.

Young person D did not have any contact with his father for the duration of his childhood and was also removed from the care of his mother when he was only a few years old. This resulted in fractured relationships with his siblings, especially his sister who was cared for elsewhere. For a great deal of his childhood, young person D's mother was largely absent from his life having experienced a period in prison and a move away to England. Young person D's relationship with his maternal grandmother, who had cared for him since he was very young, broke down when he was 17, and he initially stayed with another aunt before moving to live with his mother who lived in another local authority area. This period of time was characterised by frequent moves between his mother, his girlfriend's home, and homeless accommodation. At one point young person D described to police his isolation and lack of family support. As a young adult young person D's maternal grandmother was diagnosed with terminal cancer and died before he was able to make contact with her again.

For young person D, his experience of later adolescence was characterised by the lack of stability in somewhere to call home and a lack of consistency in supportive relationships, especially when he left North Lanarkshire and moved between other local authority areas where his care leaver status was invisible. As a result, there was no indication of young person D accessing support in regard to his mental health and wellbeing or drug misuse until April 2022 where he opened up to police about his struggles with homelessness, addiction and poor mental health. At this point young person D's status as a care leaver was identified and this initiated a more integrated period of support for him, although this was not consistent across all services. Young Person D continued to move between accommodation providers due to his volatile behaviour towards staff, police charges and his use of drugs. Young person D was also subject to charges in relation to domestic abuse and received support from justice services. He was referred to addiction services however it was considered that his needs would best be supported through the community mental health team. Young person D was offered an appointment but failed to attend. In 2023 young person D was made subject to a further CPO but died shortly after, reportedly as a result of a drugs overdose.

[5] Analysis of Interventions

Early Trauma – Young person A faced many challenges in his early childhood, however there was limited evidence that partners recognised his early experiences and losses or considered the impact of trauma on his presentation as a young adult. This in turn impacted on his capacity to accept support and professionals' ability to engage with him. There was evidence that consideration had been given to A's mental health and wellbeing, with referrals made to CAMHS. However, there was limited evidence of attempts to integrate any work achieved within CAMHS into the assessment or plan for intervention by school nursing.

Young person D's early years were characterised by adverse childhood experiences, including parental poor mental health, substance use, parental separation and loss, and fractured family relationships. There was no working relationship with D's mum throughout his childhood to provide opportunities for family mediation, restorative and reparative work. When children are placed in kinship care arrangements, there is a need to consider navigation of complex family dynamics to support lifelong connections with important people as the child grows and develops.

Many young people engage in alcohol or substance use to cope with past and present trauma, which can escalate to more serious substance misuse and addiction. The accessibility and responsiveness of mental health and addiction services in a trauma responsive manner is critical given the complex presentations of young people and often finite opportunities to initiate engagement. Mental health, addiction services and GPs need to work collaboratively to carefully consider how best to engage and effectively support young people in recognition of their trauma, presentation and potential barriers to engagement.

Assessment of Risk – Many concerns were noted for young person A and considerable information held within both universal and targeted services. However, there was little evidence that relevant information was brought together or shared in a way that could be used to inform an assessment of risks or a plan to meet his needs. His exposure to parental domestic violence was not risk assessed. There was no up-to-date chronology of significant events that would have helped to build an understanding of the situation over time and to identify patterns of concern and suggest potential interventions to reduce risk. A health needs assessment was completed, however there was no sustained input around his emotional health and well-being. Discharge from CAHMS due to non-engagement evidenced a lack of consideration of the impact of trauma on young person A's mental health.

Planning & Review - A formal review of the child's plan would have ensured a more holistic approach to intervention for young person A and supported staff to consider and evaluate the effectiveness of care planning and for the plan to be shared with relevant partners. Follow up on referrals made to CAMHS and health assessments during A's school years often took too long to progress. Adult mental health services reacted and responded to referrals but there was little recognition or focus on the need for safety planning. Emergency Department staff who saw A on numerous occasions and police colleagues who had similar contact did consider interventions to address wider issues but dealt with each presentation as a single event. A had stabilised while remanded in Polmont and was keen to engage with services on his liberation. It would have been helpful if a pre-liberation planning meeting could have taken place however he appeared at court from remand and was released by the Sheriff. Therefore, professionals involved with A were not immediately aware of his liberation.

For Young Person D there were no records of care plan review meetings being organised by social work between 2008 and early 2010. Other meetings are noted when the children's plans were reviewed, mainly through the Children's Hearing. Coinciding with the formalising of Kinship Care and associated local procedures being implemented, 6 monthly Kinship Care Reviews were also evident from early 2010.

At the time of D being placed in the care of his maternal grandmother, there is limited documentation around D's health needs in the records. Formalisation of kinship care placements mean that a health needs assessment would now be completed in these circumstances. There was a missed opportunity to secure D and his sister by a Residence Order and remove them from the Children's Hearing system. It was recognised that the monitoring of permanence plans via Kinship Care were not previously as rigorous as other placement types, and the formalising of Kinship Care has resulted in the alignment of procedures and monitoring with all other routes to permanence.

Information Sharing - As A transitioned into adult services, hospital staff held pertinent information about his emotional health and wellbeing, and police held information about his drug misuse. However, this was considered on an individual basis rather than shared in a multi-agency forum which meant a holistic assessment of his current needs and formal assessment of future risks was missing. Information within mental health systems were often paper-based and therefore did not follow the individual or make it easy for staff to make a holistic consideration of needs. When D accessed homeless accommodation, better analysis of information and ensuring all agencies recognised key information, such as care leaver status would have initiated earlier review mechanisms in housing and should have instigated pathway planning for him. This would have supported a more robust and co-ordinated approach to the support received in the months prior to him being made subject to a Community Payback Order.

Information sharing and multi-agency chronologies are critical to ensuring a shared understanding of background, and vulnerability and risk factors. This is critical to the assessment and planning of supports and interventions by a single or multi-agency response. The chronology for a child will support insight to help predict potential future challenges in adolescence and must support future planned interventions and support needs.

Support in Transitions - The absence of any discharge or care plan review resulted in no support plan for young person D when he moved to reside with his mother, and the other local authority were unaware that he was there or his care leaver status. There should always be a discharge review as part of Pathway Planning that considers all needs, including if they are moving to another local authority area. If a care leaver is discharged from care and moving to another local authority, consent should be sought to notify social work in that area in the event of that young person coming in to contact with services there. **Further discussion with legal services after completion of this report has highlighted that even if consent has not been given, public task exemption should apply and the local authority that*

the young person resides in should be aware of their presence in order to fulfil their duty of care towards them.

It is unclear if young person D was aware of his full rights and entitlement to support as a care leaver at the time or to reconnect should he need support later. Although there had been alignment between kinship care assessments and the reviews of plans, at the time of D's placement ending, the team had not implemented discharge reviews for kinship care.

A young person's age should not be the determining factor of the level of support they receive, this should be determined by robust assessment and planning with the care leaver taking account of their views. There needs to be recognition of the service transitions between children's and adult services which may coincide and need to be navigated seamlessly for a successful transition for a young person.

[6] Learning and Improvement

Area for improvement 1. Assessment of need, planning and joint working

The reviews found:

- Where there are escalating concerns about a child, young person or family's needs, staff need to be confident in using the GIRFEC staged pathway to bring the right people together. Multi-agency planning meetings must involve young people and their families in developing clear plans for intervention.
- Practitioners need to strengthen their understanding of the appropriate use of legal measures and the role of the Reporter.
- Children's planning reviews need to be more consistent to ensure robust decision making and tracking of progress to secure permanence within an appropriate timeframe to meet their needs.

Area for improvement 2. How transitions in education are supported

The reviews found:

- There was an identified gap between health support accessed as a young person via school and health support available as an adult.

Area for Improvement 3. Providing seamless transitions between children's and adult services

The reviews found:

- Consideration of broader E-messaging marker for care experience (there is now a care experience marker on social work systems across housing, revenues and benefits systems to prevent young people being charged council tax).

- Transition and safety planning should recognise the impact of parental domestic abuse in childhood on early adult relationships.
- All young people transitioning out of care should have a Care Experienced Young Persons Discharge Review that should conclude with a My Future Plan (Pathway Plan) to identify aspirations and support needs.
- Throughcare and aftercare preparation should recognise potential for increased risk and vulnerability and ensure care leavers are aware of their rights and entitlements.
- There must be clear routes for care leavers to reconnect and ensure access to supports and services that identify and recognise care leaver status and respond in a trauma informed manner.
- All young people known to services under 21 should have a pre-liberation planning meeting to ensure that there are measures in place to mitigate risk as this is a critical time for young people (now embedded in practice since April 2023).
- Cultural change is required in how young adults are seen, heard and understood. Training for council officers and other key partner agencies on Throughcare/Aftercare responsibilities and contextual/transitional safeguarding approaches. Appropriate support received should be determined by robust assessment and planning, rather than specific age.

Area for Improvement 4: Maintaining Support and family relationships.

The reviews found:

- Support services must be able to navigate family tensions while supporting young people. There must be the option of future reparative work between children and families where possible, regardless of where they are being cared for.
- Carers must be supported to navigate the challenges of teenage years to help prevent breakdown of placements. Chronologies to be used to help consider potential future challenges in adolescence and support required.

Area for Improvement 5: Co-ordinated multi-agency response.

The reviews found:

- Where there are concerns about a young person's mental health and use of substances, mental health, addiction services and GPs need to work collaboratively with young people through a "no wrong door" approach.
- Information sharing and multi-agency chronologies should be a key tool in assessment and planning support through ensuring a shared understanding of background, and vulnerability and risk factors.

- Joint, facilitated cross-service reflective supervision sessions should be used to review situations that seem 'stuck' and to consider how to overcome these difficulties.
- Neither of these young people benefitted from coherent multi-agency planning where all partners were clear about their responsibilities. Consideration should be given to a protocol for young people frequently presenting to agencies such as health and police due to trauma and crisis.
- Review of Police Scotland protocol around sharing of information about chaotic, high risk young people with other services. Police concerns should be comprehensively considered by adult social work services involving liaison with other key agencies as appropriate.

[7] Effective practice

There was effective practice during specific time periods when individual professionals demonstrated a consistent and persistent approach to supporting young person A. An addictions staff nurse recognised that due to trauma and life experiences A may not respond to written correspondence and as such reached out via telephone. As a result, they were able to begin to build a tentative relationship which allowed A to participate in an addictions assessment where he was able to share significant information about previous trauma.

Barnardo's focus on relationship-based practice saw young person A re-allocated to his previous worker. This ensured that he had positive supports immediately prior to his death. This worker had met A's sister previously and as such was able to link with her and A's partner in her attempts to provide support. The worker also linked appropriately with housing and social work staff around her concerns for A immediately prior to his death.

Secondary school pastoral notes were extensive, and it was clear that the intention was to identify and offer all available supports to A. The support worker from Intensive Services (Youth Bridges) was able to build an effective relationship with A. This allowed him to identify strengths, needs and risks and to seek interventions to address these. This was a supportive relationship for A in the weeks prior to his death. The worker also worked in partnership with housing, addictions and Barnardo's ensuring information was shared in a timely manner.

At the point of A's admission to custody, there was an automatic referral to Youth Bridges who were in communication with Polmont and ensured that his support needs were discussed from the first meeting the week after admission

Emergency Department staff who saw young person A on numerous occasions and police colleagues who had similar contact did consider interventions to address wider issues however the impact of support was limited as each presentation was dealt with as a single event.

The learning review for young person D identified that overall, the multi-agency assessment, risk assessment, intervention, planning, reviews and management arrangements supported the rationale for decision making throughout. In many respects multi agency working appears to have been effective in this case.

Good communication and joint working was identified between health and social work services during D's early years. Supportive interventions were planned and provided.

When young person D was moved to the care of his grandmother, she was supported financially in accordance with the local authority link carers scheme.

Child protection key processes were compliant with procedures and timescales with good family and agency involvement and appropriate consideration of legal measures.

The learning review concluded that agencies were trauma responsive to young person D during his childhood. It was apparent that young person D's behaviour and presentation was a response to some of his early childhood experiences. His grandmother, the school and social work responded to this in a supportive way with a good level of success throughout his childhood.

The police recognised and responded holistically to D's presentation and vulnerabilities by appropriately linking him with housing, mental health services and social work, this served to reconnect D at a crucial point with local services.

[8] Improvements made since the time of the reviews

Assessment of Risk - The reforming of the role of the school nurse with a renewed focus on Emotional Health and Wellbeing means that young people in a similar situation to young person A would now remain active on a school nursing caseload. The revised school nursing role has been implemented across NLC since September 2017 and the number of school nurses in post has doubled since 2017. There have been several practice and policy changes and progress made in implementing GIRFEC which would have possibly meant that young person A's case was managed in a very different way. The cluster model would have potentially led to early intervention and as such it is vital that health staff have a role to play in Cluster meetings.

Planning and Review - The changes in exclusion policy, commitment to inclusion and implementation of Virtual School in North Lanarkshire now offers additional supports to young people in A's situation. While A was in custody, it was already agreed practice that planning meetings would take place for all 16- and 17-year-olds in preparation for leaving custody. From April 2023 this also became practice for the 18 to 21 age group. It is recognised that following the formalising of Kinship Care placements and alignment with looked after and accommodated regulations for formal care placements, a Health Needs

Assessment would be completed at the outset of the placement, and this would be reviewed at subsequent Kinship Care Reviews.

Information Sharing - With the implementation of the well-being application and empowering clusters model, the review team believed that information would now be shared across agencies more readily and appropriate interventions sought. A care experience marker is now in place on social work systems across housing, revenues and benefits systems to prevent young people being charged council tax. A joint housing and social work operations group also now meets fortnightly to plan for the accommodation of care experienced young people.

Maintaining Family Relationships – The Lifelong Links service now addresses the identified gap in supporting young people to reconnect with family members and significant adults whom they may have lost contact with through their care experience. This enhances reparative work between children and families where they are or have been cared for away from their family and helps to create sustainable relationships in adulthood.

Transitions - It has been confirmed that discharge reviews now routinely take place at the end of all kinship care placements.

After Care Support – there has been a partnership focus on increasing and strengthening after care support for care experienced young people, with a particular focus on providing more predictable and intensive support for young people returning for help. The multiagency support is centred around the 'after care hub' comprising social work and housing support, Life Long Links, specialist counselling service and the throughcare and after care nurses.

There was an identified gap between health support accessed as a young person via school and health support available as an adult. In response to the gap in service, the North University Health and Social Care Partnership established a Throughcare and Aftercare Health Team to provide caring and compassionate interventions to young people with care experience who are transitioning towards adulthood. Care is specifically focused on health interventions that can maximise improvements in short- and longer-term outcomes for the young people identified. The Throughcare and Aftercare Health Team has been noted to have a significant impact in this area although committed funding is only temporary. The Throughcare and aftercare Hub ensures that there are now clear routes for care leavers to reconnect and ensure access to supports and services.

Role of the Reporter – 'Robust Referrals' training is now in place and offered on a multiagency basis.

[9] Next Steps

A short life working group has been established to consider the improvement actions and how these can best translate into actions that target practice change where required. These

improvement actions will be reviewed through the combined Child Protection Committee and Improving Children's Services' Continuous Improvement Group, which will consider how best to implement and measure meaningful improvement.