Department for Education

‘You really are on your own’:

A study of the early deaths of young people who were in care

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Content warning

This publication covers sensitive and potentially distressing topics, including death, suicide, self-harm, and the experiences of care-experienced young people who have come to harm.

We recognise that these issues may affect people personally or professionally.

Please take care of your wellbeing and step away if needed.

We encourage you to speak with someone about how you are feeling and to access support if you need it. Support is available from organisations such as:

- **Mind**
- **Samaritans**
- **NHS**

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Foreword from Ashley John-Baptiste

It is a national tragedy that so many care-experienced young people are dying so early in life and that, resultantly, a report like this is required.

I have substantial lived experience of the care system. Yet despite this, nothing could have prepared me for the heartbreaking stories we have encountered.

These young lives ended far too soon.

Although we have heard about young people who were in devastating situations – we have also come to learn how loved and missed they are by those who knew them.

Their lives truly mattered.

As we lay out the scope of our work, it's important that we firstly pay our deepest condolences to every care-experienced young person who suffered an early death, to their loved ones and to the staff who supported them.

1. Introduction

In 2023, the government introduced an expectation on local authorities to report deaths of care leavers[1] through the Child Safeguarding Incident Notification System[2]. On reading these notifications every fortnight, the Minister for Children and Families, Josh MacAlister MP, commissioned an independent review to better understand the shockingly high number of early deaths in the care-experienced community.

This report describes the findings from an analysis of young people, ages 18 to 24, who had previously been in care and who suffered early deaths[3]. It includes an overview of the data we looked at and also an exploration of the individual circumstances of a small number of young people.

The review aims to shine a light on the lives of the young people who died, with the intention of understanding them and providing the basis for a national conversation about what we need to do to better prevent the early deaths of care-experienced young people going forward. These are deaths of some of our most vulnerable young people in the country. It is our responsibility to children in care and young care-experienced adults to ensure they have the additional support to help them deal with the adversity they have faced.

In summary, we have heard about young people at the height of vulnerability who were isolated and often very lonely. On reaching 18, they faced a dramatic drop in support and received inconsistent and, at times, inadequate help from both children's and adults' services. They were alone, with no safety net and with catastrophic consequences.

This is not the case for all care-experienced young people, and we would argue for a more tailored level of support for those who need it most. It is likely that one key ingredient to those who make more progress on leaving care is the presence of at

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[1] Throughout this report where we use the term 'care leavers' we understand this to mean young people entitled to leaving care support as outlined in Chapter 2 of statutory guidance, The Children Act 1989 guidance and regulations, Volume 3. We also use the term care-experienced throughout this report, as we know young people often prefer this term to care leaver. For the purposes of this report, the two terms are used interchangeably.

[2] Statutory guidance, Working Together to Safeguard Children, states that local authorities should notify the Secretary of State for Education of the death of a care leaver up to and including the age of 24 via the Child Safeguarding Incident Notification System. However, this is not mandated in legislation.

[3] The review looked at all notifications of the deaths of care leavers age 18 to 24 made to the Department for Education (DfE) from January to December 2025. The review also looked at a subset of notifications of the deaths of looked after children and care leavers age 16 and 17 made to DfE over the same period where abuse or neglect was not a factor in the incident and, therefore, was not in scope of the work of the national Child Safeguarding Practice Review Panel.

least one adult who they can trust and who will support and guide them through the transition into adulthood.

2. How the review was undertaken

The report is based on evidence from two strands of work: firstly, an overview of the whole group looking at cause of death and individual characteristics; and secondly, for a small group of young people, in-depth conversations with staff who worked with them. Where possible, we also spoke to family and friends of the young person.

We selected these conversations with the aim of representing notable patterns and themes that stood out amongst the group and talking to a range of local authorities in relation to geography, Ofsted ratings, rural and metropolitan areas.

The senior leaders in the local authorities we spoke to were transparent and open to learning from the review, but we received a mixed response in relation to preparedness. In some places the staff we spoke to demonstrated in-depth knowledge about the young person, empathy, care and commitment. In others they appeared to know very little about the young person and seemed sketchy about the detail of the work they had done.

We were struck by one local authority who, despite having multiple young care-experienced people who died in 2025, were particularly hard to engage with. The staff we spoke to seemed noticeably unprepared and were unwilling to answer a question about what services were doing to address and reflect on the deaths of their young people.

We spoke to, or made approaches to potentially speak to, professionals from the following 18 local authorities, 16 of which were specifically regarding young people from the wider group we considered:

- Barnet
- Birmingham
- Blackburn with Darwen
- Bournemouth, Christchurch and Poole
- Camden
- Devon
- Durham
- Hackney
- Havering
- Hertfordshire
- Kent
- Merton
- North Northamptonshire
- Solihull
- Stockton-on-Tees
- Suffolk

- West Berkshire
- West Sussex

We also held roundtable discussions with young people with care experience, loved ones of young people who had died, government departments, and charities and interested organisations. Their contributions were invaluable. A list of participants is available in **Appendix A**.

3. Overview of those who died, notified to DfE in 2025

Appendix B provides more granular detail of the characteristics of the group.

Outlined below are some headlines from the data. Estimates presented aim to offer an indicative comparison with the general population, however due to differences in data collection and reporting, a like-for-like comparison is not possible[4].

- In 2025 (Jan to Dec) the DfE received 112 notifications of deaths of care leavers in England, age 18 to 24[5]. Given that in 2025 there were 86,620 care leavers at ages 18 to 24[6], this translates to an estimated death rate of approximately 130 per 100,000 care leavers[7]. This is about three to four times higher than the death rate in the general population[8]. Of that group 42% were female (47) and 58% were male (65).

- More death notifications were made to DfE for care leavers at age 18 compared to all other ages in the 18 to 24-year-old range, with one fifth occurring at age 18, and a further 30% across ages 19 and 20 combined.

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[4] Due to differences in how the relevant available datasets are collected, as well as the available age ranges and timeframes and the completeness of the care leaver death notifications data (see footnote 5), it is not possible to make a direct like-for-like comparison. The datasets used for the care leaver death rate estimates and comparisons to rates of the general population presented in this section are:
a) care leaver death notifications data – as reported through the Child Safeguarding Incident Notification System (CSINS);
b) care leaver population data – as received through the annual SSDA903 data collection; and
c) mortality statistics for the general population – as published on nomis from ONS.

[5] There may be some deaths of care leavers that were not notified to DfE – while in statutory guidance, this notification is not mandatory, and for care leavers at ages 21 to 24 where local authorities may no longer be in contact, they may not be aware of a care leaver's death so unable to make the notification. Notifications may, therefore, represent an undercount of actual care leaver deaths.

[6] Based on the latest annual SSDA903 data publication for the year ending 31 March 2025, there were 86,620 care leavers at ages 18 to 24. The timeframe of this data does not align with the timeframe of the care leaver death notifications considered in this review, which was from 1 January to 31 December 2025.

[7] This estimate is rounded to the nearest 5 per 100,000 care leavers; it should be treated with caution and may entail substantive margin of error.

[8] For the general population, the latest (2024) ONS mortality statistics show the death rate at ages 15 to 19 as 24.17 per 100,000 and the rate at ages 20-24 as 35.05 per 100,000. ONS mortality data sourced from Nomis - Query Tool - Mortality statistics - underlying cause, sex and age This data is not provided at individual ages, but age ranges, with groupings at 15 to 19 and 20 to 24.

- 68% of those care leavers who died for whom notifications were made were White, 12% Black, 12% mixed ethnicity, and 3% Asian[9], which broadly corresponds with the care leaver population with slight over representation of Black and mixed ethnicity[10].

- 36% of the care leavers likely died[11] by taking their own lives (40 young people, 24 female and 16 male). The suicide rate for this group is potentially five times higher than that of the general population[12]. Females were significantly over-represented in suicide rates, potentially 15 times higher than that of the female rate for the general population[13].

- Of the 2025 group, four deaths related to knife crime, seven involved road traffic accidents and eight involved young people who were known to have had diabetes[14].

These figures align with a body of research consistently demonstrating the disproportionately poor outcomes for care-experienced young people.

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[9] White includes White British and other White background; Black includes Black British, African, Caribbean and other Black background; mixed ethnicity includes White & Black African, White & Black Caribbean, and other Mixed background; Asian includes British Asian, Pakistani, and other Asian background.

[10] In 2025 in England, based on the annual SSDA903 data collection, of care leavers ages 18 to 21 53% were White, 15% were Black, African, Caribbean or Black British, 10% were Asian or British Asian, 8% were of mixed ethnicity or multiple ethnic groups, and 14% were of other ethnic groups. The timeframes between the SSDA903 data and care leaver death CSINS data are not completely aligned, since the SSDA90s data relate to the year ending 31 March 2025, and the care leaver death CSINS data looks at the timeframe of 1 January to 31 December 2025.The department does not publish data on the ethnicity of care leavers ages 22-25.

[11] Care leaver death notifications often do not identify the cause of death but provide characteristics relating to the death and background information on the young person's circumstances. In some instances, the cause of death may be identified as "unknown" or "uncertain", but the characteristics and circumstances described suggest a likely cause. Incident information, including characteristics, is based on what the local authority has reported at that time of notification.

[12] For the general population, the latest (2024) ONS mortality statistics show the rate of death caused by intentional self-harm is at ages 15-19 as 5.18 per 100,000 and the rate at ages 20-24 as 8.67 per 100,000.

[13] For the general population, the latest (2024) ONS mortality statistics show the rate of death caused by intentional self-harm for females at ages 15-19 as 3.35 per 100,000 and the rate at ages 20-24 as 4.86 per 100,000.

[14] The number of death notification for care leavers who had diabetes were identified by searching across all fields of the notification form, as 'diabetes' is not an available incident 'characteristics' option. It is, therefore, not possible to provide a definitive figure for this group, and the available data may underrepresent the actual number of young people notified who had diabetes.

- A study on the association of childhood out-of-home care with all-cause mortality, led by Dr Emily T. Murray of University College London and published in 2020, found that adults who had been in care as children were more likely to die prematurely, especially from unnatural causes, and have not shared in the general improvements in life expectancy seen over time[15].
- A further study published in 2021 on the lifelong health and wellbeing trajectories of people who have been in care led by University College London professor Amanda Sacker described the evidence about the scale of inequalities and their consistency over time as "robust". It found that outcomes for care-experienced people differed depending on the type of care placement they had, with those cared for by relatives having the best outcomes across health, socioeconomic circumstances, family life and living arrangements, those who had been in residential care having the poorest outcomes, and those in foster care having outcomes between the two[16].

While these are only two examples from the wider evidence demonstrating the significant disparity in outcomes for care-experienced people, the conclusions are clear and consistent. The challenge now is to look beyond the statistics to understand young people's experiences of leaving care, and the support, practice and gaps in provision that have the greatest influence on their outcomes.

[15] Murray ET, Lacey R, Maughan B, Sacker A. Association of childhood out-of-home care status with all-cause mortality up to 42-years later: Office of National Statistics Longitudinal Study. BMC Public Health. 2020 May 20;20(1):735. doi: 10.1186/s12889-020-08867-3. PMID: 32434479; PMCID: PMC7238620.

[16] Sacker, Amanda & Murray, Emily & Lacey, Rebecca & Maughan, Barbara. (2021). The lifelong health and wellbeing trajectories of people who have been in care: findings from the Looked-after Children Grown up Project The LACGro Project. 10.13140/RG.2.2.14371.58403.

4. Themes and patterns from those who died

When looking at the cause of death and circumstances of the young people who had died, we found similarities between subsets of young people. We have described in this section some of those emerging patterns and, based on our in-depth conversations, offered a fuller picture of some of the young people, their circumstances, their lives and their stories.

Before looking at the patterns and themes emerging from our work, it is worth noting that **more deaths occurred at age 18 than at any other age within the 18 to 24 year-old range**. Whilst numeric data based on the care leaver notifications should be considered with caution due to the limitations in reporting and completeness[17], this is strongly suggestive of the stark challenges and pressures faced by 18-year-olds when they leave care.

The majority of those young people were living on their own in either semi-independent or independent accommodation, and some experienced periods of homelessness. After the intense attention and monitoring that they received when in care, living independently can be both desirable and daunting. Young people who are leaving care are often very keen to live by themselves and professionals working with them may also believe that this is the best option. These are young people who are likely to have experienced abuse, rejection and trauma. They may have had difficulty in maintaining relationships or experienced many different homes during their time in care. They may wish to be independent, to be left alone to live their lives in the way that they want, and to be more in control. With that freedom, can come isolation and loneliness. It is a fine balance, and without stable and strong relationships, the sense of being alone can be overwhelming. As one young person we spoke to said ***"Readiness is not dependent on age. Support needs to be needs-based, not age-based."***

4.1 Young people in custody in adult prisons

Of those who died and were notified to DfE in 2025, six young people were living in adult prisons and had died as a result of drug overdose or suicide. The prison service recognises that going to an adult prison at age 18, being in custody for the first time and being care-experienced are all high risk factors. For young people who are not

[17] There may be some deaths of care leavers that were not notified to DfE – while in statutory guidance, this notification is not mandatory, and for care leavers at ages 21 to 24 where local authorities may no longer be in contact, they may not be aware of a care leaver's death so unable to make the notification. Notifications may, therefore, represent an undercount of actual care leaver deaths.

emotionally robust, being in such a regulated environment and having to spend so much time alone in their cells can be devastating.

Care experience and care leaver status are not recorded in the deaths in custody data. As a result, it's hard to know how disproportionately represented care leavers are in custody deaths. Ministry of Justice officials have reported that care leavers are disproportionately more likely to self-harm in custody. Currently, prison staff and offender managers rely on prisoners to self-identify their care experience – not everyone will want to disclose that, and disclosure rates, while improving, remain significantly below what research indicates they should be.

Also, young people who have been in care need to consent to the prison alerting their local authority to the fact that they are in custody. A problem here is, many young people do not understand what they are consenting to. Thus some care leavers are likely to be in custody without the knowledge of their local authorities. Without this awareness, local authorities cannot support their young people in custody. Visits from leaving care personal advisers (PAs)[18] can often be crucial to tackling isolation but due to shortages of staff in the prison, these visits are often cancelled at short notice. We heard of one local authority who had a specific post, named a custody coordinator, whose role was to ensure there was good communication with the prison, and that care leavers received special attention and visits from local authority staff.

In Michael's story, he was identified as at high risk of self-harm and suicide and vulnerable to exploitation but nevertheless received a custodial sentence. We ask, is there an argument for sensitivity and special consideration to be given to care leavers when making sentencing decisions?

Michael

Michael is an anonymised name.

It is hard to sum up the extent of trauma, rejection and hardship that Michael faced in his short life. He was of white British origin, the eldest of seven children all of whom came into care when Michael was six years old. The children had suffered

[18] A 'personal adviser' (PA) is a role that must be appointed by the responsible local authority for each young person entitled to particular leaving care support (including eligible children, relevant children and former relevant children). The functions of the PA role are defined in regulations (The Care Leavers (England) Regulations 2010) and include: to provide advice (including practical advice), support and to coordinate the provision of services, acting as the care leaver's main point of contact with the responsible authority, and helping the authority to implement and review their pathway plan as they transition to adulthood.

neglect and severe sexual abuse and been made to undertake sexual acts between each other. Some of the siblings were placed together but for both safeguarding reasons and on therapeutic advice, with the exception of two of them who were twins, they were separated. Throughout his childhood, Michael found this separation very hard to bear. Soon after Michael and his siblings came into care, their father took his own life while in prison. During his teenage years, Michael appeared increasingly interested in and fascinated by his father's life and experiences.

For the first four years of being in care, Michael received reparative work to help him deal with his past trauma, including intensive therapy. He was living with the same nurturing foster carer throughout that time, who provided a safe space and allowed him to have the experiences that a seven-year-old should enjoy – to be a little child. Very sadly this foster carer became very unwell herself and could no longer care for Michael or remain as a foster carer. This was a devastating rejection for Michael and as a young pre-teen he then went on to a series of over 10 foster placements before he reached 18, some for a period of a year or 2, which were positive but which ended due to circumstances outside of Michael's control. By age 17 he had not found the sense of belonging and stability which he desperately needed.

Michael was described by those who worked with him as funny and engaging, and they spoke about how they enjoyed his company. He was said to be '*a lovely lad, a bit of a joker even at primary school*'. He was personable and polite but guarded about his feelings. Underneath this light veneer, he was very vulnerable and had low self-esteem – the narrative he told himself throughout his childhood was that he was '*a bad child who didn't deserve to be loved*'. Those who worked with him recognised this vulnerability and, as he moved into late teenage years, they were very concerned about him being exploited by others who would take advantage of him.

Michael was not without aspirations and talked about wanting to be a carpenter. He loved fishing and talked of living in a remote place in a caravan where he could be free.

When Michael was 17, he was moved from his foster placement into semi-independent accommodation outside his locality. He was frequently reported as missing and was known to be taking drugs. He got involved in low level offending, shoplifting and burglaries. He experienced homelessness during this time and was staying at addresses unknown to those who were working with him. During this period he spent about six months living with his aunt with whom he became very attached. Towards the end of his time with her, he became more erratic, smashing up furniture and being aggressive to the family. Her children were scared of him, and although she said he could no longer live with her, she remained involved in his life and showed her commitment to him in different ways.

In the months leading up to his 18th birthday, Michael became more involved in criminal activity and was known to be associating with drug dealers. He looked thin, unkempt and his clothes were dirty. There was always a strong smell of cannabis around him. He wasn't responding to attempts to meet with him and there were concerns about his loneliness.

In early 2025, following charges of theft and criminal damage, he was given a suspended sentence and then bail conditions, which he frequently breached. In early February he was taken into police custody following a dramatic scene when he climbed onto the roof of his accommodation and the police closed the street while they gave chase and eventually brought him down. In court, having broken the conditions of his previous suspended sentence, he was sent to an adult prison – at just over age 18, his first time in custody, and with knowledge of his heightened vulnerability as a care leaver. Before being transferred to prison, while still in a police cell, he attempted to use his jumper as a ligature and was also seen banging his head against the wall.

Somehow, none of the information about Michael's heightened vulnerability as a care leaver was passed on to the receiving adult prison, and when he arrived, no special arrangements were made in response to his extreme vulnerability. Michael had several significant risk factors: it was his first time in prison, he said he had anxiety and depression, he was a young prisoner and was a care leaver. The prison failed to recognise how Michael's various vulnerabilities, when considered together, increased his risk of suicide and self-harm. In his short time in prison, Michael was observed to be very agitated, shouting, repeatedly pressing the emergency bell in his cell. After a fight with his cell mate, as a punishment he was initially placed in a segregation unit, a very isolated place to be. However, having been assessed by a nurse, he was deemed not medically fit to be located in the segregation unit. During this assessment Michael kept his eyes closed, saying he "didn't want people to know what he was thinking". He was moved to a healthcare inpatient department, but there was no further assessment of his mental health before he was moved back, approximately 24 hours later, to a single cell on a main residential prison wing. As a disciplinary sanction for poor behaviour, Michael lost a number of privileges, including reduced time out of cell and access to a television. There was no evidence that prison staff considered how his age and vulnerabilities might affect his ability to cope with these restrictions.

Despite his probation officer passing on information about Michael's vulnerability, his communication difficulties, the likelihood of him being exploited and his paranoid tendencies when taking cannabis, Michael wasn't treated with any special considerations. In late February, two weeks after being sent to prison, Michael was found dead in his cell with a ligature around his neck.

4.2 Young women who had experienced the removal of their own children

Six of the young care-experienced women had experienced their own children being removed through a court order and had chosen to take their own lives. In recent years there has been a growing awareness of the vulnerability and needs of these women. They are young women who have not only lost a child or children whom they have deeply loved but also experienced intense shame about the judgement that they were unable to look after their children. A Barnardo's study[19] of young parents with care experience found that many of the women they spoke to had felt scared and judged instead of the pregnancy being seen as a time of excitement and celebration. These numbers only emphasise our responsibility to: firstly, do everything possible to support young women to keep their children; and secondly, if that is not possible, then help such women deal with the enormous loss when a decision is made that they are not able to parent their children safely.

Janey

Janey is an anonymised name.

Janey was a lively young woman who was well liked by those who worked with her and loved by her older sister and her friends, as well as her former foster carer. Her heritage was White British. She was described as bubbly, and strong willed – her friend said that 'spirited' was a good word for her, and her sister said, "*You always knew she was in the room*". Alongside her devotion to her children, she had aspirations to eventually gain full-time employment.

Janey took her life in early 2025, at the age of 24 years, when her three children were nearing the end of long care proceedings where the final care plan[20] presented to court was that the children should be adopted. She left each of her children a letter for them to have as adults. In these letters she said how sorry she was and how she missed cuddling them. She told them of how she had tried to change so that she could keep them, and how she would always be with them. Her sister spoke of Janey's huge pride and her shame and said she knew Janey would not survive without her beloved boys.

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[19] Care-experienced Parents Unite for Change, Barnardo's 2022

[20] A care plan under the Children Act 1989 is a written document prepared by the local authority that sets out how a child's needs will be met while they are in care, including where they will live, how their health and education will be supported, their contact with family, and the long-term plan for their future.

Janey came into care when she was 15 years old having been rejected by her mother, who had put her on a train to go and live with her older sister. Her sister described her as very sad at this time and told us how Janey had attempted to take her own life during those initial months away from her home. She spent some time in hospital following her suicide attempt and continued to struggle with her own mental health for the years to follow. She suffered from anxiety and depression and received help from both child and adult mental health services.

Before reaching 18 years old, Janey lived with a foster carer whom social workers and family said was just a fabulous person. She encouraged Janey's talents in singing and, as the foster carer owned a horse, Janey spent time at the stables which she loved. Janey became very attached to her foster carer, and foster brother, and felt that she replaced the mother who had rejected her, calling her 'Mum'. Janey did very well while in her care and kept in touch with her after turning 18 years. The workers and her sister reflected that if there had been a formal role for the foster carer in her adult life, things might have been different.

Janey was in a long-term relationship with the father of her children, and they presented a united front when advocating for the children in settings such as school or in meetings with children's social work services about their care. They were committed to each other, but it was a volatile relationship with violence between them. This violence along with concerns about neglect and drug use were the reasons why care proceedings were taken and the children removed. Janey worked very hard during the long care proceedings to improve the state of the home and was drug-free for long periods, but after an attempt at rehabilitation, there was evidence of further violence and the plan was that the children should be permanently removed from her care. Her sister said that she had always said that if she lost the boys, she would end her own life.

When reflecting on what might have been different, the staff we spoke to felt that more could have been done to bring in her former foster carer or help to repair links with her sister, to support her in the care of her children. Her sister said that with help Janey could have become a better parent and spoke of how children's services tell you what has to change, but don't actually help you to make that change. She spoke of needing a step-by-step guide to help you develop yourself as a parent. Her sister also felt that Janey worked so hard to keep her children and change herself and her home, but it was the violence from the children's father that led to permanent separation from the children.

Both the workers and her sister and friend felt that there were no services available to help Janey deal with the enormous loss of her children. In the end she took her own life within a few weeks of being told that the final care plan was that the

children would be permanently removed from her care. It was just too much for her to bear.

4.3 Suicides of young people going through transgender transitions

Three young people were experiencing or had experienced transgender transitions and taken their own lives. We heard about the impact of dealing with transition or difficulties with one's gender identity and how one young person felt that he just didn't fit in today's world.

Nicky

Nicky is an anonymised name.

Nicky was described as an articulate and able young person who was mature, insightful and thoughtful about his circumstances. His heritage was White British. He lived in supported accommodation at the time of his death when he was 19 years old. He was described by one care worker as '*a beautiful soul*', but he had few friends and lived a lonely life. Central to his loneliness was his diagnoses of gender dysphoria and of autism, which increased his sense of not being accepted.

Nicky was born female but said that from a very young age he felt that he was male. This feeling of being in the wrong body dominated his life, and he spoke frequently of a feeling that he had to fight to be recognised as male. According to one worker who supported him, his happiest moments were, "a particular weekend spent with his mum and getting his testosterone". Nicky was active on Discord, an online chat platform, which may have alleviated his loneliness to some extent. His sister shared the note that Nicky left following his death in which he said that he didn't feel compatible with society and felt '*so so lonely*'. He said he had '*dreams of having a stable job, a cat and maybe even friends*'.

As a teenager, Nicky had experienced poor mental health and had attempted suicide by swallowing batteries and spent some time in a mental health facility. At one point during this period he was sectioned following an incident where he was perceived to threaten a staff member, who he alleged had bullied him and not taken his gender dysphoria seriously. He also experienced a 'deprivation of liberty' placement where four staff were assigned to care for him, which he found very oppressive. As a young adult, he said he hated to be watched and understandably was said to have developed resentment against all services following these

restrictive placements. The workers spoke of how Nicky felt he was always fighting for recognition.

There wasn't good co-ordination between children's and adults' services for Nicky, and according to a member of staff involved in the operation of Nicky's supported living accommodation, adult services didn't attend crisis or multi-disciplinary meetings about Nicky. As a result, the supported living manager made a formal complaint about adult services.

Nicky's sister described him as her everything. They grew up together and shared some very difficult experiences as younger children. She spoke of the fact that he had tried to buy poison from the dark web, and it had been intercepted at customs and then again by the police a second time. He tried a third time and was successful in receiving the poison in the post, which he eventually used to take his own life. Nicky's sister questioned if more could have been done by those who worked with him, to prevent him receiving the poison. It's true that those who worked with Nicky knew of his suicidal intentions and that he had tried again to order poison from the dark web.

4.4 Young people seeking asylum

Across the leaving care population, 30% of 19 to 21-year-olds are young people who came to the UK seeking asylum[21]. Of those we looked at, ages 18 to 24 whose deaths were notified in 2025, 11 had been children separated from their family and seeking asylum. Some who were waiting for a decision or had received a negative decision regarding their immigration status had taken their own lives.

We heard of the impact of negative age assessments on young people. In one instance, a young man who had been known to the leaving care service for two years was living in his own place, attending college and receiving support. After two years in the UK, he was assessed as being 23 years old, was moved out of his flat the next day and placed in a hotel, not in his local community. He was found collapsed in a field a few weeks later, with the cause of death unknown but suspected to be an overdose.

Abraha's story epitomises the level of trauma experienced in having to leave war-torn countries and the incredibly harrowing and perilous journeys those young people have made in order get here. The need for very specialist help in dealing with their past and the impact on their emotional wellbeing is not always recognised. The focus of work is often to find accommodation and support separated children with the process of

[21] Explore our statistics and data - Explore education statistics - GOV.UK

seeking asylum and refugee status. Alongside this practical work, it is vitally important to attend to the huge impact of leaving family and undergoing a terrifying journey to reach the UK.

Abraha

Abraha is an anonymised name.

Abraha arrived in the UK in March 2021 at the age of 17. He had been travelling through Africa and Europe for seven years, having left Eritrea at a very young age, around 10 years old.

Abraha was a likeable young man with a good sense of humour. He was passionate about football and gaming, and known for his love of food. As a member of the Orthodox Christian Church he had a reputation for acts of kindness and, at times, went above and beyond to help others in need.

Not much is known about why he left Eritrea, but he is said to have left with his uncle. The very few details that are known about his journey tell a horrendous tale of exploitation, beatings and rape in Libya, and experiences which would be extremely hard to deal with as a child, most likely on his own and without the support of a trusted adult. It is not known how long he remained with his uncle during those traumatic years. His family in Eritrea and his sister who has since settled in the UK, heard nothing from him during the years he was travelling.

Abraha received support from Children's Services, including provision of accommodation, initially foster care and then as an adult in semi-independent accommodation. He had a reasonably trusted relationship with his social worker who was able to make some progress in assisting Abraha into college and encouraging him to access medical help to treat his Hepatitis B condition - treatment that he was reluctant to receive for a number of years. He was said to have had a good relationship with his probation officer, but she left for another job. Staff who worked with Abraha said he was guarded in talking about his past, and his family, to the extent that despite knowing him for over four years, they only discovered that he had a sister in the UK after he had died. Professionals believed Abraha had very few family connections due to him reporting that his parents had passed. Following his death the police located his sister, who was named as his next of kin. His sister shared that they had remained in contact over the years. She also confirmed that both of his parents were alive in Eritrea and lovingly arranged for him to be returned home, where he was laid to rest surrounded by his family and community in accordance with their Orthodox Christian faith.

One practitioner said that Abraha, "*wanted to be in a place of safety*". He had support from his Church community, a small circle of friends, and also at different times accessed help from voluntary sector charities such as the Da'aro Project and Off the Record. Despite this support, Abraha suffered from depression and there were concerns about his mental health. He had a conviction for cannabis possession and also for common assault and criminal damage following an incident at a venue where Abraha had been gambling. Abraha admitted he had a gambling addiction and was trying to work on this.

Abraha was given refugee status in July 2023, which provided him with some sense of security. He moved to supported accommodation in the summer of 2025 and appeared happier with his new place, although the provider we spoke to said he hardly knew Abraha. Workers commented on his mood during this period, saying it was notable in that he was happier than he had been in previous years. His aspiration was to work, secure a tenancy and be financially secure, but he had never actually found employment during his short years of adulthood.

Abraha was found in his bathroom having hanged himself in December 2025, a week before his birthday. His friends had been with him the evening before and they had arranged to meet again the next afternoon. They alerted the staff in the supported accommodation when he didn't respond to their calls, and the member of staff found him. Abraha did not leave a note or give specific reasons for ending his life. His social worker had noticed during the preceding autumn months that he was more difficult to reach and had not wanted contact with children's services.

The people who worked with Abraha shared a number of reflections and things they wish they had done differently as well as identifying service gaps. Firstly, in relation to his mental health and depression, while therapeutic services were offered, his social worker reflected that referring him through the GP route might have led to him accessing specialist adult mental health provision. Children's services staff noted that Abraha would not have met the criteria for adult mental health services. They commented that it was very difficult to find adult services that would match those provided to children, with one practitioner saying, "*everybody tried to find services for Abraha to fill the gaps of children's social care*".

Abraha made limited use of the counselling and support voluntary agency services on offer, but didn't receive specialist help in relation to the journey he had made to get to the UK. It is hard to imagine just how frightening and traumatic it must have been for a child in his early teens to deal with abuse, uncertainty and separation from the security of family during those years when he was making his way to the UK. We have to question how well equipped leaving care services are in dealing with such extreme trauma and also how they might access adult services pathways to support him as a young adult.

After he died, staff who worked with Abraha were shocked to find that he had a sister in the UK who he saw regularly. They had no knowledge of this and they believe he had been coached by those who arranged his travel to not talk about family either here in the UK, or back in Eritrea. It was notable that the police were able to locate his sister within 24 hours, and staff lamented that they wished they had known more about his family and the support his older sister might have provided had they been able to have regular contact with her.

4.5 Young people murdered

Three of the young people were murdered, including one young woman killed by her partner, and two young men who died from stab wounds. Kieron's story highlights how random this can seem and yet, based on the group we reviewed, it appears that deaths from homicide may be over-represented among those who have left care.

Kieron

Kieron is an anonymised name with special meaning for his family.

Kieron was deeply loved by his family and was described by those who worked with him as friendly, polite and able to ask for help and support when he needed to. "*There was always hope with him*", reflected one worker who supported him. He was of mixed heritage, Black Caribbean and White.

Such was the love and fondness held for Kieron that his funeral bustled with local authority staff, friends and family from all chapters of his life. His community wanted him to be remembered for who he was, and not how he died.

He was 15 years old when he came into children's services care, due to concerns in relation to extra familial harm, but he remained very close to his family, who worked well with the services who were supporting him. His mother adored him. She said that "*It was agonising to say goodbye... his legacy will be measured by the lives he touched, the hearts he reached*".

Kieron liked reading and music and socialised with friends and spent time with his girlfriend. His father died of heart failure about a year before Kieron died, and he found this very hard. His mother said that, after Kieron died, she found something he had written where he said that all he wanted to do was to be with his Dad. He was very closely connected to both his parents, who were separated, and it was clear from workers and from speaking to his mother that they loved him very much.

After his father's death, he remained close to his mother and brothers and saw them regularly.

Kieron was initially placed with foster carers and moved into supported accommodation as a care leaver, firstly in a 24-hour supported house and then in shared accommodation where support was available during working hours. He had experience of having a job and had aspirations to follow his father's line of work in the delivery business. There were worries that he was involved in more illicit work, with workers saying, '*Kieron always had something going on*', but they were not deeply concerned and did not believe him to be involved in serious crime.

Kieron was open about his mental health needs, experiencing periods of psychosis and receiving support initially from child and adolescent mental health services and then from adult services. He had spent a period of time in hospital following a serious psychotic episode, and often spoke of hearing voices. He took medication and had a safety plan which he stuck to and had self-awareness about when he needed help.

When Kieron was 20 years old, he was murdered. He had got into an argument about a girl, and was stabbed. He was not known to be in a gang and it was a complete shock to his family and those who knew him. He is greatly missed. He had spoken to his mother just minutes before he was killed, telling her about the altercation that had happened earlier that evening with the person who then went on to kill him.

His death could not have been predicted, and when talking about the months leading up to his death, the professionals who worked with him reflected that they couldn't identify anything that could have been done differently which would have prevented the incident that led to his death. Despite this, his mother believed that he didn't have the essential life skills to live independently or semi-independently at 18. She felt that there was no consistency with social workers and other social care professionals.

Those who worked with Kieron really struggled with Kieron's murder. One individual said that it took 15 months to write Kieron's closure summary and that he would have benefitted from some form of process to reflect and learn from Kieron's death.

The professionals we spoke to described him as hard to pin down and because he was over 18, they struggled to receive information from the police. He wasn't having a lot of contact with the leaving care service, but he regularly saw the support worker from his accommodation. The workers who knew him, spoke very fondly and sensitively of Kieron, and were very caring about him.

His mother said he had a lovely soul and always encouraged people, and also that he had a lot of style. She said he was portrayed in a negative light throughout the trial – but there was so much more to him.

4.6 Young people who died from medical conditions

A small number of young people's deaths were linked to potential mismanagement of a medical condition - in the group we looked at, this was often diabetes. The level of health support and supervision of such conditions drops off very suddenly when young people reach adulthood and for those living alone, things can go wrong very quickly. In David's story, and for others in this group, the deceased young people were not found for relatively long periods, weeks not days, indicating how alone they were. For most of us, if we were out of contact with our family and friends, it would be noticed within days.

David

David is an anonymised name.

David had periods in and out of care as a young child, all on a voluntary basis with the consent of his mother. He was of White British heritage. When he was 14, a care order was determined on grounds of neglect and physical abuse and he lived permanently away from his family. He spent his teenage years in a local children's home and then moved into supported accommodation at age 17. In the next two years, he experienced four different placements, including a period in a homeless hostel, until he secured his own tenancy where he lived in the months before he died.

David was described as very sociable and loved to be around people, but he had difficulty maintaining closer relationships and didn't have a solid social network. He had passions for swimming and ice-skating, and seemed to make some connection with people online through gaming.

Staff we spoke to said he was very likeable and would chat to anyone, often giving advice or trying to help out others. He was bisexual and had romantic relationships with women and men, one quite close, but none lasted longer than a few months. His mood could swing quite quickly from being cheerful to feeling down, but in the main, those who worked with him found him light and easy to relate to.

David qualified as a lifeguard and worked in this capacity for a short time, but unfortunately did not manage to hold onto this job.

He didn't speak about his family and wasn't in touch with his mother. The workers knew that he was troubled, and he had said to one of the staff at the care leavers hub, "*You wouldn't want to be inside my head*", but he was reluctant to talk about his emotions and was said to have a fear of therapy or counselling.

David was diagnosed with type 1 diabetes when he was 16 years old and had the benefit of close monitoring from the diabetic nurse, who developed a good relationship with him. He had an insulin pump, and his nurse monitored his blood glucose levels remotely, and she kept a regular check on how he was doing. When he reached 19 years old, she was no longer assigned to work with him and he transferred to adult services for support, where the rate of monitoring his glucose levels was considerably lower. It is possible that had the children's diabetic nurse been able to continue monitoring David's glucose levels, changes in his readings may have been identified and action might have been taken to prevent his death.

David lost a lot of connections at age 19. The children's diabetic nurse and the progression adviser from the virtual school both stopped working with him because of his age. At the same time his personal adviser left the authority. She had got to know David very well and had a great relationship with him, watching out for him and helping him keep on top of things. David had a tendency to let his accommodation get messy and out of control, but she would muck in and help him keep the place clean. His new personal adviser only knew him for a short time before his death. As one worker put it, "*None of us could stay involved once he turned 18. It was (David) and only (David). It was hard for him to buy into the adult service*".

David tended to spend a lot of time at the care leavers hub, often three days a week, where he chatted to staff and enjoyed socialising with other young people. In the summer holidays of 2025, the hub closed for three weeks for refurbishment. David's personal adviser was on leave, and at some point during this period, David died, it is believed from a lack of insulin. Those who knew him said that he was able to manage his diabetes well and understood the need for regular injections, but that when he was down or there was something going on emotionally, he might not be so diligent.

His body wasn't discovered for a long period of time, possibly two weeks. It is notable that there was no one in his life who was connected enough to notice his absence during that period and, in the end, it was neighbours who alerted the police.

Those who knew David talked about him fondly, and he clearly made connections with a number of them in children's services. They said that when he turned 19, all those connections fell away and he was left on his own. He had been assigned an adults services social worker but she acknowledged the stark reduction in support

which is just not available to young adults in the same way as it is to children and teenagers. We were struck by one of his workers who said that she could not stay involved, despite wanting to do so. As with other young people, we heard from a willing worker who faced systemic issues that made continued support from them impossible.

4.7 Further themes and patterns

In addition to the themes outlined so far in this report, there were 24 young people who died as a result of drug or alcohol overdose. It wasn't always known whether this was intentional or accidental, but highlights the danger of substance misuse and the need for specialist help in managing addiction.

There were 15 young people who had identified mental health needs and took their own lives, a number having made several previous suicide attempts. Six of this group were living in specialist mental health accommodation at the time of their death, where there would have been close monitoring, but where they were still successful in taking their own lives. This group included young people who had experienced Deprivation of Liberty orders or been sectioned under mental health orders. There is a question about the longer-term impact of living in circumstances where a young person's liberty has been denied and whether this contributed to them feeling that their life was not worth living.

When it comes to supporting young people whose liberty needs to be taken away for periods of time, serious consideration must be given to alternative forms of support that are more therapeutic in nature.

We approached local authorities in two instances where Deprivation of Liberty orders may have been a contributing factor, but they declined to be part of the review due to other conflicting processes such as inquests, which were taking place around the same time.

5. What have we learned?

As stated at the beginning of this report, we have looked at individual experience and heard from professionals and from loved ones. As a result we have been able to imagine what life was like for a small group of young people. The learning themes we have drawn out in this section will not be a surprise to those working across the care system, but these stories aim to deepen our understanding and consequently, what we might do to support this very vulnerable group of young people.

The overwhelming picture we found was of young people who are very much alone. They have lost the organic social connections which most children enjoy and so they rely on support from the state rather than family and friends. They then experience a significant drop in support upon reaching adulthood and receive hit and miss services from those working with them. The transition from childhood to adulthood does not happen neatly upon turning 18 years old. You are not one person at age 17 years and 11 months and a very different person a few weeks later. For many of us this is a difficult transition, but it is considerably more difficult for those who have experienced rejection and instability in childhood and have to somehow make sense of their past and make something of their adult lives.

For those at the sharp end of vulnerability, leaving care and losing significant levers of support at 18 leaves them more susceptible to a devastating outcome. **If we are to make meaningful progress, we must accept the need to address the so called 'care cliff'.** It is not a new challenge and young care leavers continue to say that they feel abandoned when they reach 18. The 'care cliff' often exists or is felt most keenly because the enduring relationships we rely on normally don't change simply because we turn 18. But for those missing these relationships – as many in care are – the transition really does feel like a cliff. We ask, why has it been so difficult to change this experience for young people when it has been known about for so long?

> *"On my 18th birthday, I had a short placement at a hostel. It was just terrible. My memory of turning 18 was a formal discharge from children's social care and signing up for Universal Credit."*

There are three key learning themes we have identified:

1. readiness for adulthood
2. drop in levels of support
3. workforce.

5.1 Being alone – readiness for adulthood

Whilst initiatives such as 'Staying Put'[22] have meant that some young people can stay with their foster carers post 18 years, the majority of young people in this group were living in either supported or independent accommodation, and some were homeless for periods of time. Independent living is often a clear choice made by the young people themselves, and local authority children's services have not only supported them in this choice but made the judgement that having one's own accommodation is the best option. To a young person in their older teens, being in care can mean at worst – having a social worker who keeps on checking up on you, having to attend formal reviews, not being able to do what you want because of 'policy' or not meeting what seems like some random criteria for funding, having to deal with a lot of paperwork and so on. It can feel intense and oppressive. The lure of living alone and being able to be free of these constraints is very tempting. But then when it happens, as one young person said, "*You really are on your own then".*

Thankfully, there has recently been much more focus on helping young people in care to develop enduring relationships, but what about those who find attachments hard to maintain? We heard about young people who found friends, and then fell out with them. We heard about young people who had very complex and volatile relationships with their immediate and wider family. We heard about young people who had one close relationship with a grandmother or an aunt or similar, but then that person died and they were left with no one. Trauma and rejection in childhood can lead to a genuine difficulty in making and keeping relationships in adult life and those who find attachments difficult need a concerted effort to find someone who can be there for them. There are great initiatives such as 'Lifelong Links'[23] which exist in some areas – could this be part of the wider offer to all children in care and care leavers? We heard from young people that on day one of being over 18 years old they received guidance about how to apply for various benefits, advice about where to live and what to do with their time – all very important, but could there be more focus on the emotional impact of being on your own and how to build relationships around you?

> ***"I feel that if there was someone who didn't have expectations but would just be there for me – I was emotionally and physically alone in every way – it could have made a difference. It led to an eating disorder and poor mental health. When I was younger, I always had my brother, but then without him I was literally all on my own."***

[22] Staying put: arrangements for care leavers aged 18 years and above

[23] Lifelong Links - Family Rights Group

5.2 Cast adrift – huge drop in levels of support

When young people turn 18, the amount of support they are entitled to reduces dramatically. This isn't about planning for transition, or starting that planning early, or making sure that adult services are aware of the needs of a young person. **This is about the stark reality that there just isn't an equivalence between what is available for children in care, and what is available for an adult care leaver**. The immense drop off in support services is a fact that has been known for decades and for which no amount of transition planning will compensate.

Furthermore, the framework for support is very different, and the culture and focus on relationship-based work can be absent in adult services. We frequently heard about the term 'capacity', most commonly in the context of over 18-year-olds having 'capacity' to make their own decisions and refuse services. In reality, this means that, for example, if a young person with medical needs is assessed under the Care Act 2014[24] as needing a carer to call twice a day and the young person doesn't answer the door for a few days, they are seen as having the 'capacity' to refuse the service and it is therefore withdrawn. Those we spoke to in children's services felt that their colleagues in adult services gave up too quickly and that more empathy and tenacity was needed. Working in children's services where safeguarding needs can override consent to services, professionals found it hard to understand why there is not a similar way of working in adult services in circumstances where it is felt that a young person might be at risk of harm, be it self-harm or harm from others.

The criteria for some adult services is high, with a common example being access to adult mental health support, which requires there to be evidence of severe and enduring mental illness. Young people who are suffering from depression, anxiety or feelings of extreme low self-esteem do not fit these criteria and are likely to be left with no specialist support for their emotional or mental health. For those who have experienced abuse from family or have been badly treated while alone in a foreign country, the criteria set doesn't fit. For those with medical needs, a specialist children's practitioner may disappear overnight.

There are real shortfalls in adult services for this group of young people. The very nature of them having been in care does not give them entitlement to adult services. Whilst there are often good relationships between children's and adults' services locally, the low level of support for adults is a national issue and one that has bedevilled governments over many years. The Casey Commission[25] may address some of these issues, but it will require investment and long-term action. In the meantime, local authority children's services could do more to ensure continuity for young people who

[24] Care and support statutory guidance

[25] The Casey Commission | Independent Commission on Adult Social Care

have been in care. Put very simply, if a young person has been lucky enough to have a good relationship with their children's social worker, could we not allow them to keep that social worker into adulthood? Or taking a preventative approach, if the focus of work with children in care was to help them develop enduring relationships, then the need for a high-support service from the state would be reduced to a smaller group of young people with the highest needs; with a reduced volume of demand, those who need additional support should then be more likely able to receive that support.

We heard of one local authority that is implementing a 0 to 25 service for looked after children and care leavers with no cut off point at age 18[26]. Do local authorities have to compound the change in every other area of a young person's life at 18, such as health and education, by also changing the existing relationships for the young person by transferring them to leaving care teams?

5.3 Who is helping young people make the transition to adulthood – workforce

The question we asked ourselves when undertaking this review was: "Are these a special group of people or not?" If so, what services should be in place to support young care leavers as they move into adulthood? What kind of workforce do we need to provide that support? The main source of support provided to young people who have left care comes through the framework of having a personal adviser (PA). The support provided by PAs can vary greatly from place to place, and our experience from this review was that there really is huge variation in quality of practice.

We spoke to PAs who were caring and committed, but often we felt they hardly knew the young person and given that the minimum visiting requirements are once every two months[27], it is not surprising. They were often unaware of the young person's history and context, knowing little or nothing about their childhoods and what they may have experienced. We heard of PAs who frequently went above and beyond and who had a great relationship with the young person they were working with, but we also met PAs who appeared to have very low expectations about the quality of their relationship, seeing themselves as someone to help with practical tasks or access to funds. They

[26] Solihull Children's Services are implementing a 0 to 25 looked after children service with no transition point at 18 years

[27] Statutory guidance, Children Act 1989: Volume 3 - Transition to adulthood for care leavers, states "Regulation 8(2) of the Care Leavers Regulations requires that when a care leaver moves to new accommodation, the PA must see them at that accommodation within 7 days of the move. Subsequently they must see the care leaver at the point at which the pathway plan will be first reviewed – namely after 28 days – and then they must visit the care leaver at no less than 2-monthly intervals. It is important to understand that these are minimum requirements." (page 29, paragraph 3.39)

spoke of their role as limited to providing 'information, advice and guidance', but it seemed to us that the first of those, information, was the dominant one.

The other main sources of support for young people leaving care come from those working as support officers in housing or semi-independent accommodation. This is often a profit-making arm of the service with no specific requirements for a therapeutic or social work discipline. This needs to be redressed.

We met some of the managers of such accommodation and, as with PAs, we saw a huge variation in quality of care. Again, it was hit and miss, but compared to PAs, the managers had a lot of power over both very vulnerable residents and an unqualified workforce. We were not always confident that this power was exercised in a professional way.

The work of helping a child deal with an adult world, of understanding a difficult past and planning for the future, of issues of identity, who you are, who you will be, where you belong, what you want from life – these are hugely difficult transitions and they demand a level of sophistication that we didn't see. It is a challenging task for an untrained PA, and many we spoke to seemed to avoid the emotional side of the transition, focusing on the practical needs about which they could feel confident and helpful. They weren't uncaring, but they were ill equipped. It seemed that getting a good PA who could work in a relational way was more a matter of luck than by design.

The PA role has traditionally been to deal with practicalities – we haven't asked them to do more. But now is the time to recognise that if we are to help those with the greatest needs, there is a need for more investment in the workforce, more of a multi-disciplinary approach including mental health expertise.

The young people we heard about had dealt with enormously difficult life experiences and turbulent childhoods. Being truly alone at 18, the loss of your own children, travelling for years in hostile territory, managing complex medical conditions, living in restrictive environments where the daily freedoms we take for granted are not there – these are extreme and challenging circumstances. To help young people come to terms with these experiences and face adulthood, we have an unqualified workforce, without a framework for the specialist knowledge and skills required to support the levels of complexity and the isolation of young people leaving care.

6. What can we change?

It was not within the scope of this review to develop detailed and specific policy recommendations. However, in what follows we have outlined broad areas where we believe more attention – from the DfE, from other government departments, from local authorities and other public service organisations such as the NHS – would make a significant impact on the lives of young people leaving care.

6.1 Workforce

The biggest major change we recommend is an overhaul of the framework for support to young people leaving care. The current workforce supporting young people leaving care is adequate for some, but it is not fit for purpose for those with greatest need. There is a need for a recognition of the complexity of the task of assisting young people through the transition to adulthood and we recommend a major national review of the knowledge and skills required by the workforce. This is not just about training or qualifications for PAs, it's about ensuring there is understanding of systemic practice, mental health expertise, and recognising the need to build trusted relationships with young people and, where possible, help them to reconnect with their families. There is nothing to stop local authorities from undertaking their own workforce reviews. In particular, they could consider the impact of transfer from looked after children's teams to leaving care teams, and to provide more continuity for those at age 18 – if one local authority can provide a 0 to 25 service, why can't others?

6.2 Improved support and awareness for those in custody

Work is needed to improve the identification of care-experienced people in custody so that data on deaths in custody can provide more meaningful insights and learning about the experiences and outcomes of care leavers. There is also a need to strengthen understanding within prisons of the vulnerabilities associated with care experience and to support more trauma-informed engagement with care-experienced young adults. Consideration should be given to the role local authorities can play in supporting care leavers in custody, including through dedicated custody coordinator roles within leaving care services to help identify and respond to their needs. Further work is needed to develop better alternatives to custody for care-experienced young people and young adults.

6.3 Supported accommodation for young people leaving care

We ask directors of children's services to look again at the quality of the support and accommodation being provided to young care leavers living in supported or semi-independent accommodation in your areas. Are the commissioning arrangements working well enough to provide sensitive, skilled, empathic support for 17- and 18-year-olds who still require considerable help to move into adulthood and may be living on their own for the first time?

To build on this, the national roll out of the Staying Close programme[28] will provide investment from DfE to assist local authorities to make a step change to their housing offer to care leavers.

6.4 Health services for those with medical conditions

There is a need for adult services to provide the same level of support to young vulnerable adults with medical conditions as they have received from children's health services. This will require a national initiative, and Government will need to work with health authorities. At the very least, we suggest that local authorities enable looked after children nurses to take a more active role with those young people over age 18 who have specific medical needs.

6.5 Lessons learned following the death of a young person

After the death of a young person, there isn't a mandatory process for reflecting and learning lessons in the same way that exists for the death of a child. Consideration should be given to instigating a similar process following the death of a young adult who has been in care as is currently required by the national Child Safeguarding Practice Review Panel for child deaths. In the same vein, we heard that local authorities are not routinely invited as an 'interested person' to the inquest in the coroner's court, despite the statutory duties local authorities have towards care leavers[29]. We recommend that this should be remedied.

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[28] In line with government's Enduring Relationships strategy, the Staying Close programme aims to shift the system away from preparing young people for independence and instead focus on providing homes for care leavers that build interdependence and connection. It will also improve access to wider services including mental health offers.

[29] As 'relevant children' and 'former relevant children' under the Children Act 1989.

Finally and importantly, the staff we spoke to talked about wanting a way of marking and paying respect to the life of the young person, in the way that funerals and memorials do, and to ensure their memory is honoured with dignity.

Appendices

Appendix A – Roundtable participants

The following organisations attended or supported the roundtables discussions held for the review.

Government

- Association of Directors of Children's Services (ADCS)
- Barnet London Borough Council
- HM Government
- HM Prisons and Probation Services
- Local Government Association
- NHS England
- Office for Standards in Education, Children's Services and Skills (Ofsted)
- Office of the Children's Commissioner for England

Support organisations

- Action for Children
- Barnardo's
- Become
- Care Leaver Association
- Career Matters
- Centre Point
- Coram Voice
- Da'aro Youth Project
- Drive Forward
- For Baby's Sake Trust
- National Association of Virtual School Heads (NAVSH)
- National Children's Bureau (NCB)
- National Leaving Care Benchmarking Forum (NLCBF)
- National Society for the Prevention of Cruelty to Children (NSPCC)
- Rees Foundation
- Spectra

Appendix B – Data

Overview of all SINs considered

Reviewers considered notifications reported through the Child Safeguarding Incident Notification System (CSINS) relating to the deaths of young people ages 16 to 24 notified between **1 January and 31 December 2025**. This comprised all notifications of the deaths of care leavers at ages 18 to 24, and also included those deaths of either looked after children or care leavers ages 16 or 17 where abuse or neglect was not a factor in the incident and, therefore, was not in scope of the work of the national Child Safeguarding Practice Review Panel.

The last section of this appendix provides an overview of 16 notifications of young people selected for further enquiry, as representative of the identified themes across all notifications considered. From these, the reviewers sought to have initial discussions with key professionals from the relevant local authorities and, where possible, with family and friends of the young people. Key incident characteristics are noted as well as the themes identified by the reviewers. Of these 16, an account of the experiences of six of the young people are included in this report, at section 4.

There were a total of 112 notifications for care leavers age 18 to 24

Number of notifications relating to care leaver deaths age 18 to 24 by age, 2025

Age	Count
18	22
19	18
20	17
21	13
22	11
23	16
24	15

Number of notifications relating to care leavers age 18 to 24 by gender or sex[30], 2025

Gender or sex	Count
Female	47
Male	65

Number of notifications relating to care leavers age 18 to 24 by ethnicity, 2025

Ethnicity	Count
Asian	4
Black	13
Mixed	13
White	76
Other	6

[30] Data on gender was collected and reported up to 31 March 2025. Data on sex has been collected and reported since 1 April 2025. Sex should be provided as recognised in law, i.e. the sex as recorded on a birth certificate or on a gender recognition certificate. Previously, gender included transgender as a category and may have meant that gender identity was reported in some cases for male and female, as opposed to legal sex.

Number of notifications relating to care leavers age 18 to 24 by disability[31], 2025

(A notification can have more than one disability or none)

Disability	Count
Confirmed disability status or other category	14
Learning or understanding disabilities	11
No disability	63
Not known	1
Other mental health conditions	22
Physical disabilities	9
Sensory disabilities	6
Social and behavioural difficulties	10

Number of notifications relating to care leaver deaths age 18 to 24 by key recorded characteristics, 2025

(A notification can have more than one characteristic or none)

Key incident characteristics[32]	Count
Abuse (domestic, physical, sexual, emotional)	8
Criminal exploitation	6
Knife crime	3
Life-limiting / serious illness	12
Mental health	23
Not known	9
Road traffic accident	7
Substance, drug, or alcohol misuse	24
Suicide	40
Other	23

[31] The recording of disability has improved since 1 April 2025 due to the provision of specific options for the recording of this information and improved guidance.

[32] Key incident characteristics listed here do not entail all possible incident characteristics; a full list of 'incident characteristics collected can be found in the Serious Incident Notification guide.

Number of notifications relating to care leaver deaths age 18 to 24 by known to agency type, 2025

(A notification can have more than one known-to agency or none)

Other individual characteristics	Count
Former UASC	11
Known to health	63
Known to police	46
Youth Justice, Prison or probation	18

There were a total of 11 notifications for looked after children or care leavers age 16 to 17 where abuse or neglect was not a factor

Number of notifications relating to looked after children and care leavers no abuse or neglect deaths age 16 to 17 by age, 2025

Age	Count
16	3
17	8

Number of notifications relating to looked after children and care leavers no abuse or neglect deaths age 16 to 17 by gender or sex[33]

Gender or sex	Count
Female	4
Male	7

Number of notifications relating to looked after children and care leavers no abuse or neglect deaths age 16 to 17 by ethnicity, 2025

Ethnicity	Count
Asian	0
Black	0
Mixed	c[34]
White	c
Other	0

[33] Data on gender was collected and reported up to 31 March 2025. Data on sex has been collected and reported since 1 April 2025. Sex should be provided as recognised in law, i.e. the sex as recorded on a birth certificate or on a gender recognition certificate. Previously, gender included transgender as a category and may have meant that gender identity was reported in some cases for male and female, as opposed to legal sex.

[34] 'c' indicates where a value has been suppressed to preserve anonymity.

Number of notifications relating to looked after children and care leavers no abuse or neglect deaths age 16 to 17 by disability, 2025

(A notification can have more than one disability or none)

Disability	Count
Confirmed disability status or other category	c
Learning or understanding disabilities	3
No disability	7
Not known	0
Other mental health conditions	c
Physical disabilities	c
Sensory disabilities	0
Social and behavioural difficulties	c

Number of notifications relating to looked after children and care leavers no abuse or neglect deaths age 16 to 17 by key recorded characteristics, 2025

(A notification can have more than one characteristic or none)

Key incident characteristics[35]	Count
Abuse (domestic, physical, sexual, emotional)	0
Criminal exploitation	0
Knife crime	0
Life-limiting / serious illness	2
Mental health	1
Not known	1
Road traffic accident	2
Substance, drug, or alcohol misuse	0
Suicide	4
Other	2

[35] Key incident characteristics listed here do not entail all possible incident characteristics; a full list of 'incident characteristics collected can be found in the Serious Incident Notification guide.

Number of notifications relating to looked after children and care leavers no abuse or neglect deaths age 16 to 17 by known to agency type, 2025
(A notification can have more than one known-to agency or none)

Other Individual characteristics	Count
Known to health	9
Known to police	5
UASC	0
Youth Justice, Prison or probation	2

Overview of notifications selected as representative of the identified themes across all notifications

From the overall group of notifications, 16 young people's deaths were selected by the reviewers as representative of the identified themes across all notifications considered for further enquiry and potential discussions with professionals from the relevant local authorities and, where possible, family and friends of the young people.

DfE made initial contact with the relevant local authorities on behalf of the reviewers for each of the 16, and the reviewers took forward conversations with the local authorities. An account of the experiences of six of the young people are included in this report, at section 4.

Number of selected notifications by age

Age	Count
16	0
17	1
18	3
19	2
20	2
21	2
22	0
23	4
24	2

Number of selected notifications by gender or sex[36]

Gender or sex	Count
Total	16
Female	6
Male	10

[36] Data on gender was collected and reported up to 31 March 2025. Data on sex has been collected and reported since 1 April 2025. Sex should be provided as recognised in law, i.e. the sex as recorded on a birth certificate or on a gender recognition certificate. Previously, gender included transgender as a category and may have meant that gender identity was reported in some cases for male and female, as opposed to legal sex.

Gender or sex	Count
Gender different at birth[37]	1

Number of selected notifications by ethnicity

Ethnicity	Count
Asian	0
Black	3
Mixed	3
White	10
Other	0

Number of selected notifications by disability

(A notification can have more than one disability or none)

Disability	Count
Confirmed disability status or other category	0
Learning or understanding disabilities	2
No disability	10
Not known	0
Other mental health conditions	3
Physical disabilities	2
Sensory disabilities	1
Social and behavioural difficulties	1

[37] Notifications reported since 1 April 2025 record the young person's sex – as recorded at birth or on a gender recognition certificate – as well as whether the young person's gender identity was different to their registered sex at birth. As a result, the 'total' of young people in this table comprises the sum of male and female only; those reported as 'gender different at birth' will already have had their sex (male or female) accounted for in the total.

Number of selected notifications by key incident characteristics

(A notification can have more than one characteristic or none)

Key incident characteristics[38]	Count
Abuse (domestic, physical, sexual, emotional)	2
Criminal exploitation	1
Knife crime	1
Life-limiting / serious illness	1
Mental health	2
Not known	1
Road traffic accident	0
Substance, drug, or alcohol misuse	1
Suicide	11
Other[39]	2

Number of selected notifications by themes identified by the reviewers across all notifications considered

Identified themes	Count
18-year-olds on their own, and heightened vulnerability as they face adulthood (suicide)	3
Young women who have had their children removed (suicide)	3
18- and 19-year-olds in adult prisons (drug overdose or suicide)	2
Asylum seeking young people, including some waiting for an immigration status decision or receiving a negative decision (suicide)	2
Young people managing long-term health conditions (often diabetes)	2
Young people who are experiencing or have experienced transgender transitions (suicide)	1
Young people who have experienced deprivation of liberty or detention under the Mental Health Act 1983 (suicide)	2
Victim of criminal exploitation (homicide)	1

[38] Key incident characteristics listed here do not entail all possible incident characteristics; a full list of 'incident characteristics collected can be found in the Serious Incident Notification guide.

[39] 'Other' comprised 'Other - self-neglect' (1) and 'Other – unexpected', both of which were noted to have had diabetes, identified by searching across all fields of the notification form.

Most recent Ofsted ILACS of notifying local authorities for selected notifications

Ofsted ILACS	Count
Outstanding	5
Good	5
Requires improvement	4
Inadequate	2

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