Teeswide Safeguarding Adults Board

Learning from Regional and National Safeguarding Adult Reviews

Thematic Analysis of SARs Involving Transition

Introduction

"At 18 nothing changes, yet everything changes"

"The needs of young people do not change or stop when they reach 18, although the laws and services supporting them often do. This can sometimes result in a 'cliff edge' where formal support for a young person ceases once they turn 18. Transitional safeguarding is an approach that moves through developmental stages, rather than just focusing on chronological age"[1].

In 2018 Research in Practice published *Mind the Gap*[2] which first coined the term 'Transitional Safeguarding'. In 2021 the Department of Health and Social Care published *Bridging the Gap*[3] which highlighted why transitional safeguarding is needed and how the contribution of adult social work is essential to developing and embedding a more transitional approach to safeguarding young people into adulthood. More recently, the *National SAR Analysis 2019-2023*[4] highlighted transition as a key theme.

Transitional safeguarding was a feature in Teeswide Safeguarding Adults Board's (TSAB) Molly and Jack SARs[5].

In April 2024, TSAB's Communication and Engagement Sub-Group together with Hartlepool & Stockton and South Tees Safeguarding Children Partnerships (SCPs) agreed to run a 'Spotlight on Transitional Safeguarding' campaign in 2025. The purpose of this report is to identify good practice from SARs in relation to transition and areas for learning that can help to inform future considerations for TSAB and local Safeguarding Children Partnerships and support planning activities for the awareness campaign.

Understanding Transition[6]

The term 'transition' is often used by professionals interchangeably to describe different phases. It can mean:

- Transition into adulthood
- Transition between services
- Transition of accommodation/housing
- Transition of legal rights and entitlements

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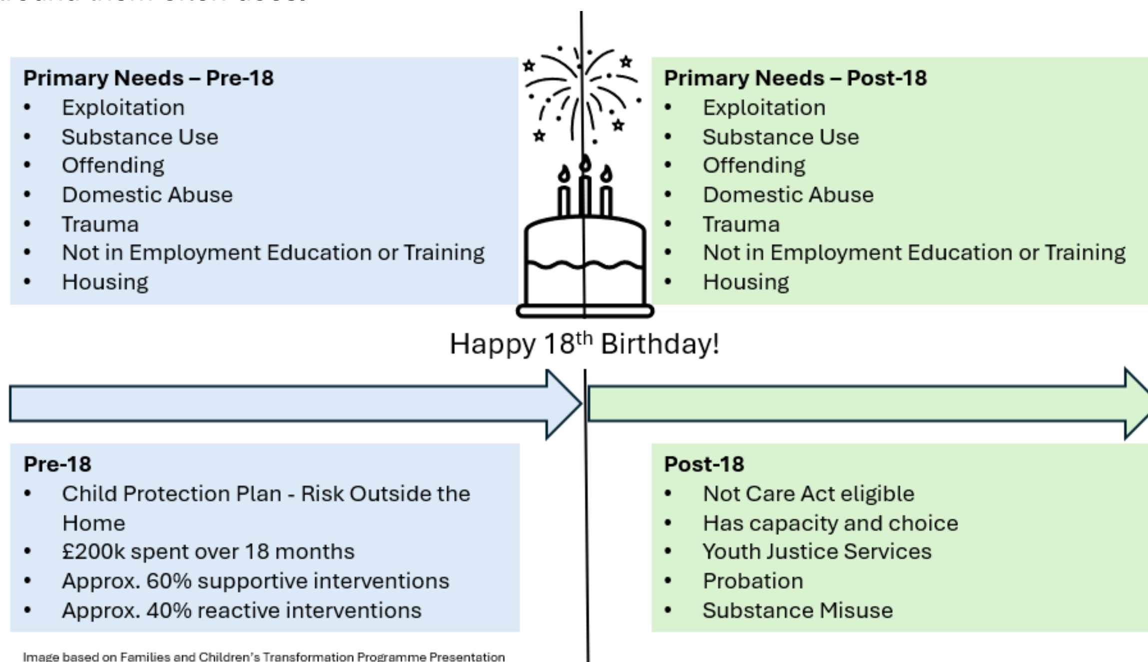
[1] Norfolk SAB - 7 Minute Briefing Transitional Safeguarding
[2] Transitional Safeguarding - Adolescence to Adulthood: Strategic Briefing (2018)
[3] Bridging the Gap - Transitional Safeguarding and the Role of Social Work with Adults
[4] Second National SAR Analysis Report 2019 - 2023
[5] TSAB SAR Reports
[6] Research by David Murray-Dickson, Cardiff Council

There are often transitional 'risks' to consider for young people with complex needs[7], vulnerabilities and/or at risk of abuse/neglect. The term *'Transitional Safeguarding'* encompasses preventative activity as well as a protective response to harm. The term is not intended to mean statutory services, a specific team, or a threshold to be reached.[8]

The diagram below shows clearly how primary needs do not change at 18, but the support around them often does.



"If homelessness, mental health, substance misuse, and criminal justice systems were able to influence and reduce the needs of young people before they required these services as adults, that would likely yield benefits to the public purse as well as to young people".[9]

Key Findings

19 SARs (involving **20** people) have been reviewed (which includes 2 TSAB SARs) where transition was identified as a key theme. (See appendix 2). The figures below are based on what is explicitly mentioned within the SAR reports, not what may be inferred through the narrative.

- **9** male, **10** female, and **1** undisclosed
- The cause of death in **14** cases were either related to suicide or drugs/alcohol. **3** were due to natural causes, **1** due to murder and in **2** cases the adults were still alive.
- **10** individuals were care experienced, **2** had been identified as a Child in Need, **5** lived in the family home as a child, **3** cases did not specify (however two were known to children's social care)
- **16** involved mental health issues
- **7** involved physical health issues

[7] Complex needs is a term used in health to describe the interface and interaction between physical and mental health needs, learning disabilities and autism. However further social aspects may provide further complexity, such as experience of abuse and neglect as a child. (Cocker, Holmes, Cooper 2024).
[8] Cocker, Holmes, Cooper 2024
[9] Cocker, Holmes, Cooper 2024

- **13** involved substance misuse
- **5** people were autistic (**2** were also bipolar), **1** SAR referred to Autism as part of the Terms of Reference but did not specify if the individual was Autistic, **1** was suspected to be Autistic but was on the waiting list for assessment when they died.
- **5** people had a Learning Disability (or borderline), **1** was waiting for an assessment when they died.
- **7** cases featured self-neglect.
- **5** cases featured sexual exploitation (or at risk of).
- **4** cases featured criminal exploitation (or at risk of).
- **13** had experienced trauma or Adverse Childhood Experiences (ACEs).
- **14** involved housing/accommodation/placement issues.

Key Themes

From the 19 SARs reviewed, the following key themes relevant to transition were identified. (Further detail is included in Appendix 1, which also includes how TSAB will address the learning from these SARs through existing workstreams).

1. Legal Literacy
2. Transition Pathways and Planning
3. Transitional Safeguarding – Preventing and Protecting from Harm
4. Exploitation
5. Neurodiversity
6. Leading Disability / Special Educational Needs
7. Self-Harm / Suicide / Death by Misadventure
8. Substance Misuse
9. Mental Health
10. Care Experienced Young People
11. Housing / Homelessness / Placements
12. Mental Capacity (also linked to Legal Literacy)
13. Multi-Agency Working
14. Working with People and Families / Engagement
15. Trauma / Adverse Childhood Experiences
16. Criminal Justice

Considerations for TSAB and SCPs

This report will be shared with the Safeguarding Children Partnerships to consider how current Safeguarding Children Practice Reviews will address any learning identified.

1. How can TSAB and SCPs take on board the learning and good practice (that has been highlighted in appendix 1), ensuring that transition is 'a golden thread' that runs through all workstreams? E.g. SWOT analysis exercise, discussion at Development Days to inform Strategic Plans, learning from other SABs/SCPs, listening to young people and young adults?
2. How can partners working with Children and Adults be strengthened? To consider:
    - Ensuring the workforce across children and adults are appropriately trained in confidently applying legislation that is applicable to both and escalating/ seeking legal advice when appropriate? (See also Appendix 4).

- Promoting existing resources and raising awareness of who has responsibilities under the Mental Capacity Act.
- Ensuring single agency and multi-agency MCA training across children and adults incorporates enough detail around unwise decisions, positive risk taking, impact of trauma, adolescent brain development, brain injury, substance misuse, addiction, impulse control disorder, mental health, fluctuating capacity, neurodiversity and executive functioning.
- Checking that the e-learning course on Information Sharing and Consent incorporates both adults and children.
- Enquiring how partner agencies are currently implementing NICE Guidelines.
- Enquiring if partners including justice sectors are aware of the Transitional Safeguarding and Justice Report and its considerations for services and the workforce.
- Reviewing and seeking assurance that multi-agency (and single agency) strategies, policies, procedures, guidance, information sharing agreements, audit and review processes, assessment processes are reviewed to reflect on effective transition arrangements and that they include clear linkages with other relevant agencies/teams.
- Reflecting on opportunities that exist to promote better working relationships across children and adult workers to improve networking, communication, shadowing opportunities, training and learning from each other.
- Working together to improve front line workers' knowledge of the range of support services available for children and adults. E.g. TSAB's Find Support in Your Area
- Working together on areas of common interest such as neurodiversity, Learning Disability, reasonable adjustments, suicide, self-harm, substance misuse, drug and alcohol related deaths, exploitation, missing from home.
- Continuing to be cited on progress regarding Missing from Home and Right Care Right Person.
- Seeking assurance that there are appropriate commissioning arrangements to support effective transition processes to take place. Are there any gaps or delays in services such as Learning Disability assessments for 16-17 year olds?
- Reflecting on how connections with Care Experienced Teams and Housing Teams can be strengthened across Children and Adults across all partner agencies. Raising awareness to wider professionals of each others' remit/duties and legislation across Children and Adults that underpins each others' work.
- Working together to help influence wider discussions to ensure there is enough appropriate housing to meet local needs for young people and adults.

3. Are partners across all agencies assured that 17.5 year olds with complex needs (including Looked After Children), with vulnerabilities or who are at risk of abuse/neglect have effective and robust plans in place to ensure a smooth transition to adult services/teams?
4. How can TSAB and SCPs be assured that appropriate pathways are in place (and being utilised) to support vulnerable young people and adults without care and support needs but who are at risk of harm due to abuse or neglect?
5. Can Health partners consider how they identify/support/refer young people who have risk factors, emotional needs or symptoms which do not meet a diagnostic threshold but are at risk of developing a mental disorder, and those with undiagnosed and unmet needs,

particularly those whose needs become more acute as family, educational and other supports diminish? *(Patrick)*

6. Are there effective transition processes in place for when a care leaver turns 25? (We do not want to create another 'cliff edge' at 25).

Appendix 1 - Key Themes

Legal Literacy

Current legal frameworks facilitate provision of care and support for young people leaving care, with special educational needs or transitioning into adult social care, to ensure that partner agencies work more closely to meet those needs in a holistic way. "However, the tension between safeguarding duties and the rights of adults to take capacious decisions in respect of their private lives, even where those decisions are unwise or harmful, and the restricted legal framework for intervention results in a marked inconsistency between the approach to safeguarding as children with care and support needs reach adulthood".[10] "Binary adults' and children's safeguarding legislation policy and practice frameworks creates gaps for young people to fall into".[11] "Despite the enabling preventative powers of the Care Act and underpinning 'wellbeing principle', lack of legal literacy, pressures on services, limited resources and capacity can all serve to limit the support offer to young people".[12]

Practitioners and Managers across Children and Adult Services should be confident in applying their legal knowledge with appropriate training provision in law relating to young people and young adults.[13]

Practitioners should have access to up-to-date information about the legal frameworks and current case law and seek legal advice and expertise earlier for high risk, complex cases and consider legal options for supporting victims and disrupting perpetrators, or if there are significant concerns linked to mental health, mental capacity and the impact of coercion, addiction, impulse control disorder or exploitation on a person's ability to put decisions into effect.[14] Decisions should clearly record the legal options that are considered[15].

Practitioners need to be confident in knowing when it is appropriate to share information without an adult's consent[16].

TSAB has/will address these findings through:

- Legal Literacy training for practitioners which includes MCA, MHA including S117 (Adult K) and reiterates the need to clearly record legal options considered.
- Annual Legal Literacy training for Board members.
- E-learning jointly commissioned by TSAB and SCPs includes Care Act, MCA, DoLS, Human Rights Act, Information Sharing and Consent
- High Risk Adults Panel includes legal representation (Molly)
- Adult Sexual Exploitation Toolkit includes Disrupting Perpetrators Toolkit (Molly)
- MHA S117 Regional Protocol in development (Adult K)
- Consent Guidance to be developed (Bernadette)

[10] Max SAR
[11] Cocker, Holmes, Cooper 2024
[12] Cocker, Holmes, Cooper 2024
[13] Mrs A, Sylvia, Adult O, Mr D, Rachel, Q&Y, Madeleine SARs
[14] Mrs A, Rachel and Molly SARs
[15] Mrs A and Molly SARs
[16] Rachel SAR

Transition Pathways and Planning

> **"Age isn't the factor that determines whether you're an adult or not. It's your situation, your experiences, how you feel about yourself, how you feel in the world"** – *Care Experienced Young Person*

The Care Act places responsibility on children services and adult services to work in an integrated way to ensure good communication, high quality of care and better outcomes for people going through transition[17]. Transition planning and assessments should be collaborative to promote a young person's independence and help to prevent needs/risks from escalating[18]. NICE Guidelines recommends that the process for transition should start at the age of 9, and by 14 at the latest, particularly if there are "complex needs or apparent risks to allow for robust contingency planning".[19]

Several SARs questioned the efficacy, quality, consistency and timeliness of transition arrangements between child and adult teams/services. This was not only for social care, but for other services such as mental health, drug and alcohol services and between health disciplines to allow for a complete analysis of global health needs and holistic planning"[20].

Care and support needs are defined within the Care Act as 'needs arising or related to a physical or mental impairment or illness'. Local Authorities (LAs) have a duty to complete Care Needs Assessments to determine if someone has eligible needs for care and support based on set criteria within the Care Act. It can often be the case, that children who have experienced abuse, neglect, and/or trauma who may have emotional or developmental needs, do not readily fall into the Care Act's definition of care and support needs once they reach 18, which can result in services being withdrawn "despite there being ongoing risks or support required for their complex needs".[21] "The LA has an obligation under s.58-66 of the Care Act to support safe transition into adulthood and to prevent social care needs escalating (s.2 Care Act 2014) or homelessness (s.195 Housing Act 1996) by providing advice and support before eligibility thresholds for statutory interventions are crossed"[22].

Due to their young age, some adults may not be formally diagnosed as having a physical or mental health illness/impairment. In some cases, this appeared to be a barrier to accessing support. To assess if someone has eligible needs, a formal diagnosis of an illness or impairment is not required, but the practitioner carrying out the assessment should have gathered all necessary evidence that the person is living with a physical, mental, sensory, learning or cognitive disability or illness, substance misuse or brain injury that leads to them having the needs that are identified within the assessment[23].

The ethos of the Care Act is that assessments should be needs-led and not restricted by available services[24].

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[17] Adult O SAR
[18] Max SAR
[19] Q&Y SARs
[20] Jasmine SAR
[21] Q&Y and Max
[22] Sylvia and Patrick SARs
[23] SCIE: Care Act Eligibility Criteria
[24] Patrick

Practitioners should not always walk away and close involvement when support is declined.

Generally, recommendations related to having effective and robust policies, procedures and guidance in place for transitions and to conduct an audit of cases for 17.5 year olds with complex needs, vulnerabilities or at risk of abuse/neglect.

TSAB has/will address these findings through:

- Multi-Disciplinary Team Guidance reviewed (James)
- Decision Support Guidance references multiple lower-level concerns (Bernadette)
- Find Support in Your Area webpage signposts to voluntary sector organisations
- Transitions process to be discussed for those identified as a Child in Need and other vulnerabilities such as diabetes, substance misuse and homelessness (Jack)
- TSAB's Information Sharing Agreement

Transitional Safeguarding – Preventing and Protecting from Harm

"Stability is definitely something I see being safe as, you know, like you're in one place, you're in one situation and it's not going to suddenly change" – *Care Experienced Young Person*

"Transitional safeguarding goes beyond the statutory duties in respect of transition planning for young people with care and support needs who are moving from children to adult services. The term describes the need for an approach to safeguarding adolescents and young adults fluidly across developmental stages, despite the differences between the legal frameworks for children and adults. The principles of transitional safeguarding require practitioners to meet the positive obligations under the Human Rights Act 1998, Article 2 (the right to life) and Article 3 (the prohibition on torture, inhuman or degrading treatment) and respond appropriately where there is a foreseeable, real and imminent risk. However, this must be balanced against the obligation to respect private and family life (Article 8) and liberty (Article 5)".[25]

"Emotional maturity and life skills do not develop overnight and for young people, particularly who have experienced trauma or underlying neurodiversity and/or mental health conditions, their development may be very significantly delayed. The legal framework is therefore designed to ensure that careful forward planning takes place across relevant statutory partners in anticipation of this obvious deadline, with a variety of additional duties and powers that facilitate a more fluid approach to meet the needs of people with additional needs and vulnerabilities".[26]

"Making Safeguarding Personal (MSP) is the key approach that underpins adult safeguarding practice. It prioritises the involvement of the person in identifying their outcomes and focuses on what they want to achieve to be safe. MSP provides a way of working with young adults that can adapt to their personal developmental needs, ensuring their active participation, and provides an inclusive safeguarding response".[27]

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[25] Max SAR
[26] Patrick SAR
[27] Transitional Safeguarding (Cocker, Holmes, Cooper 2024)

Some SABs have developed Transitional Safeguarding Procedures or Risk Management Frameworks. Examples can be found in Appendix 4.

TSAB has/will address these findings through:

- Adult Exploitation Strategy including a Transitions Protocol in development (Molly)
- Spotlight on Transitional Safeguarding awareness campaign coordinated by TSAB and SCPs – including a Transitions Webinar (Jack)
- Multi-Agency Audit and themed discussion on transition has taken place at Operational Leads Sub-Group (July) and report shared with TSAB (September). (Jack)
- Business Managers from TSAB and SCPs routinely discuss learning from SARs and SCPRs at quarterly meetings
- Joint Review Protocol (TSAB, SCPs and CSPs) considers other partnerships during learning review processes
- Think Family Guidance

Exploitation

Exploitation of children into adulthood featured in several SARs. Key recommendations were for SABs to have a clear strategy, guidance, pathways and training on exploitation (including transition age) and to seek assurance that there are mechanisms and support services in place to support victims of exploitation and that professionals know how to access that support and refer cases.[28]

There is a lack of national guidance regarding Adult Sexual Exploitation[29] and as previously mentioned, "differences in legal frameworks between children and adults can result in a very different system response more governed by age…rather than risk"[30]. This can lead to professionals being unsure of all the referral routes available to support exploited children as they become adults. "The children's system has a clear focus on welfare and emphasises protection of children from harm and promotes risk management approaches. Whereas for adults, current legislative frameworks places an emphasis on promoting wellbeing and that adults have the right to make informed decisions about their own lives, even if those decisions appear unwise. The difficulty which can arise around this key principle is when coercion or other factors become so significant that they have a serious adverse impact on how this 'right / ability' is exercised. This was evident in Rachel's case where her ability to make decisions to stay safe was impaired by the abuse and exploitation she was experiencing…strict interpretation of the eligibility criteria can result in victims of sexual exploitation not qualifying for services and / or a safeguarding response because they are not assessed as having care and support needs. In considering how to address this, the prevention duty in the Care Act provides a possible platform for more flexible approaches in considering how young adults at risk of exploitation can access appropriate support. It is also important to bear in mind the potential cost benefit to early intervention and support because without it, victims are likely to appear elsewhere in the health and social care system as they grow older which may result in more costly service responses."[31]

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[28] Rachel and Molly SARs
[29] Rachel and Molly SARs
[30] Rachel SAR
[31] Rachel SAR

Some cases suggested that a process should be developed for supporting adults at risk of exploitation (recognising the complexities around consent) who do not meet the criteria for Section 42 adult safeguarding enquiries to be initiated and that an escalation process for high-risk cases should be considered[32].

When working with child and adult victims of exploitation, practitioners should always consider whether a referral through the National Referral Mechanism (NRM) should be made[33].

Professionals should have appropriate training in respect of exploitation of children and adults to ensure professionals have the necessary skills to identify issues of coercion and control and can investigate, effectively gather intelligence and share information to disrupt perpetrators[34].

TSAB has/will address these findings through:

- Adult Exploitation Strategy including a transitions protocol (Molly)
- Adult Sexual Exploitation Toolkit including Guidance, Risk Screening Tool, Referral Pathway, Disrupting Perpetrator Toolkit and links to Police's Information Sharing form to gather intelligence (Molly)
- Adult Sexual and Criminal Exploitation Training (Molly)
- E-Learning on Child and Adult Sexual Exploitation, Criminal Exploitation/County Lines, Human Trafficking and Modern Slavery
- Modern Slavery First Responder Training (Molly)
- County Lines Learning Briefing and ASE Learning Briefing (Molly)
- Learning from Regional and National SARs Report involving ASE (Molly)
- Spotlight on Sexual Abuse and Exploitation Awareness Campaign (Molly)
- TSAB and Newcastle SAB raised the need for national ASE guidance via the National SAR Protocol, but sadly this did not influence any national change. (Molly)

Neurodiversity

"Neurodiversity is a word used to explain the unique ways people's brains work. While everyone's brain develops similarly, no two brains function just alike. Being neurodivergent means having a brain that works differently from the average or *neurotypical* person."

"The impairments associated with autism are on a dimensional spectrum, characterised by difficulties in social communication, restricted interests, repetitive behaviours, and sensory behaviours. In addition to these central features, up to 70% of children and young people with autism can have at least one co-occurring mental health diagnosis. Further, research evidences that autistic people are at higher risk of suicide than non-autistic people, with up to 35% having planned or attempted suicide during their lifetime. Their risk is increased by factors such as camouflaging (which is when autistic people actively hide their autistic traits), alexithymia, which makes it difficult for autistic people to identify and describe their emotions and repetitive thoughts, which can lead to feeling trapped in an unbearable situation"[35]. A high proportion of cases reviewed in this report involved suicide, self-harm or drug/alcohol

[32] Kate SAR
[33] Kate and Molly SARs
[34] Rachel and Molly SARs
[35] Patrick SAR

related deaths. Out of the 5 autistic adults in this report, all died due to suicide or misadventure.

Some SARs highlighted delays in young adults receiving assessments for Autism and there was a lack of understanding from some agencies on how to effectively support an individual who was neurodiverse and ensuring that reasonable adjustments were made. Partners across children and adults should be trained in neurodiversity and reasonable adjustments.[36]

"2013 NICE guidance on children with a diagnosis of autism advocates that transition planning should start when the young person is 14, with an updated assessment of their needs to ensure a smooth transition to adult services…Max was not transferred appropriately from CAMHS to AMH for continued treatment and to enable provision of an appropriate adult social care package, including suitable accommodation".[37]

Although the Health and Care Act 2022 has introduced a requirement for all CQC registered provisions to provide mandatory neurodiversity training for staff, there is no equivalent requirement for schools and colleges. However, the public sector equality duty under the Equality Act 2010 requires all public bodies to make reasonable adjustments to ensure their services are accessible to people with disabilities, including neurodiversity, which may involve changes to policies or training to support this.[38]

TSAB has/will address these findings through:

- JJ SAR Action Plan
- Working with Autistic Adults webpage (SK)
- Seeking assurance that partner agencies have training on autism and Learning Disabilities (SK)
- Seeking assurance on implementation of the autism strategy (SK)

Learning Disability / Special Education Needs

Key learning was around effective and timely transition processes and assessments and possible gaps in service delivery for the provision of learning disability assessments for 16-18 year olds[39] and transition considerations for all young people with disabilities irrespective of whether they are in receipt of a health or social care package[40].

Similarly to Autism, there was further learning around reasonable adjustments.[41]

The SEN Code of Practice describes the duty on education, health and social care to work together to plan and jointly commission services for young people, explaining the interface between duties under the Children and Families Act 2014, the Care Act 2014 and the National Health Services Act 2006 for young people with special educational needs or disabilities with or without Education Health Care Plans[42].

[36] Patrick SAR
[37] Max SAR
[38] Patrick SAR
[39] James
[40] Adult O
[41] Mr D
[42] Patrick SAR

TSAB has/will address these findings through:

- Reasonable adjustments for people with a Learning Disability, Sensory Need or Autism (James, SK)
- Seeking assurance that partner agencies have training on autism and Learning Disabilities (SK)

Self-Harm / Suicide / Death by Misadventure

The cause of death in **14** cases were either related to suicide or drugs/alcohol. **5** of those involved autistic/neurodiverse people.

Self-harm falls outside the statutory safeguarding adult definition under s.42 of the Care Act, which can mean there is no single agency overseeing instances/referrals in respect of self-harm or suicide attempts. There was a recognition that GPs are a key agency who should be informed of suicide attempts/self-harm to have a better understanding of the overall picture and cumulative and escalating risks[43].

Health Trusts when reviewing cases at Frequent Attender meetings should consider multiple attendances, attempted suicide and significant overdose events from a cumulative risk perspective, to ensure that frequent attendance and the risks posed to the individual are being appropriately considered and managed[44]. They should ensure that patient information forms completed by emergency departments and hospital psychiatric liaison teams explicitly prompt staff to ask patients or their family/carers whether they have recently attended any other hospitals, to facilitate appropriate information seeking/sharing.[45]

TSAB has/will address these findings through:

- Self-harm / suicide webinar is being held during National Safeguarding Adults Week 2024 on autism and the links to suicide (JJ)
- E-Learning on self-harm and suicide prevention

Substance Misuse

There was a recognition that outreach support is often an effective way to engage with young people who have substance misuse issues[46]. In Jack's SAR, the transition arrangements for substance misuse services was excellent, ensuring a flexible approach so that the Young Person's Substance Misuse worker continued to work with Jack post 18.

Professionals across Children and Adults should be confident in knowing what drug and alcohol support services are available, how they can be accessed and referral pathways[47].

All front-line services should be aware of, and able to use robust drug and alcohol screening tools such as the DUDIT, AUDIT or Assist-Lite tools to identify and record the level of substance related risk in individuals which are applicable to 16-17 year olds and adults.[48]

All frontline services should be aware of the importance of addressing smoking with vulnerable individuals because of the associated health and fire risks.[49]

[43] Patrick and James SARs
[44] James SAR
[45] Patrick SAR
[46] Jack SAR
[47] James SAR
[48] Jack SAR
[49] Jack SAR

TSAB has/will address these findings through:

- Seeking assurance on the connectivity and sharing learning between Drug and Alcohol Related Deaths and SAR processes (Bernadette)
- Joint Working Protocol between TSAB and SCPs
- Vulnerable Dependent Drinkers Training
- Vulnerable Dependent Drinkers Learning Briefing
- E-learning on substance misuse
- Find Support in Your Area includes drug and alcohol support services
- Smoking / fire risks addressed through Adult K SAR and Fire Risks Learning Briefing
- Drug, alcohol screening tools will be promoted in TSAB Newsletter (Jack)

Mental Health

Three quarters of mental health problems are believed to start under the age of 24.[50]

A number of SARs recognised that there needed to be better joined up working between Child and Adolescent Mental Health Services (CAMHS) and Adult Mental Health Services (AMHS) as well as how they link to other agencies such as substance misuse services, leaving care teams etc[51]. Transition planning should begin when the young person is 14. "Intervening early at the onset of mental illness improves prognosis, reduces future demand on mental health services and leads to better outcomes for patients."[52]

It is critically important that young people in high-risk cohorts are able to access a quality community mental health service without delay when they turn 18[53].

Commissioning of CAMHS and AMHS often takes place within different frameworks which can result in care pathways being developed separately and decisions can often be resource driven rather than needs led[54].

Care leavers "are identified in the Joint Commissioning Panel for Mental Health (JCPMH) report as being at high risk of experiencing negative longer term outcomes in terms of developing mental health or conduct problems where difficulties are encountered around transition".[55] Care leavers or people who have experienced abuse or neglect "may not be eligible for adult mental health services, but they may be experiencing emotional needs/ have personality disorders which need a response in order to prevent harm and intensive use of public services. It is important to have access to ongoing mental health and therapeutic support for victims moving into adulthood. However, a previous national study tracking transition outcomes revealed that up to a third of teenagers, mostly with "emotional disorders", whom CAMHS considered were suitable for transfer to adult mental health services, lost mental health support because referrals were not made. This was either due to the young person not wanting to be referred, or CAMHS practitioners pre-judging that the referral was unlikely to be accepted. The study also revealed that a further third experienced an interruption in their care"[56].

Transition policies for the LA and mental health services should align to each other (with an equivalent policy in respect of physical health needs)[57].

[50] Kessler et al 2005
[51] Kate, Mrs A, Rachel
[52] Patrick SAR
[53] Patrick SAR
[54] Patrick and Rachel SARs
[55] Rachel SAR
[56] Rachel
[57] Jasmine

Referral pathways between agencies and mental health crisis needs to be better understood to enable urgent mental health care to be provided when needed.[58]

Good practice was noted in Patrick's SAR where CAMHS have introduced a transitions practitioner who works in their complex needs service, to support young people to transition smoothly to adult mental health services.

TSAB has/will address these findings through:

- JJ SAR Action Plan
- TSAB has been cited on Right Care, Right Person

Care Experienced Young People

"Research shows that 80% of looked after children have Disorganised Attachment Behaviour (DAB); children with DAB will likely present with challenging and difficult behaviours, which is correlated to placement instability. These children expend significant amounts of energy trying to obtain a sense of control, security and safety. Their internal model of self and others is skewed and these children find self-regulation difficult. They believe that they have the power to generate anger, fear, distress or panic in others; they also feel frightened and alone and crave a sense of belonging and safety. A child in these circumstances is self-reliant because their internal model anticipates that a carer will not respond to need. The child expects rejection and is likely to exhibit behaviours that create situations that may cause them to be rejected. Rejection reaffirms the internal working model that the child is unlovable".[59]

Legislation requires that children's services, adult social care, health and education liaise closely with respect to transition for young people leaving care. Transition planning should be instigated early, with ample preparation time for when the person turns 18 to establish what care, support and accommodation arrangements will be[60].

Each young person leaving care, especially those with complex needs, should have a profession-led overarching care and support plan[61]. Assessments and care planning should be a collaborative process with the individual, carers and professionals involved ensuring the young person's wishes are at the heart of discussions[62]

Finance, home environment, stability and belonging are important to a person's safety as well as building independence and practical skills. Physical, relational and psychological security are also important to avoid needs emerging or escalating, as well as reducing loneliness and isolation and thus seeing safeguarding not through the lens of eligibility, but as a person-centred preventative approach.[63]

Complex cases involving young people with significant risks to their wellbeing should not be closed without a multi-agency professionals' meeting to consider how best to manage the risks involved.[64]

[58] James
[59] Mrs A, Shemmings and Shemmings, 2011; Howe, 2010
[60] Mr D, Rose, Madeleine
[61] Mrs A SAR
[62] Madeleine
[63] Cocker, Holmes, Cooper 2024
[64] Mrs A

A number of SARs recognised housing, accommodation and placements as a complicating factor for this group of people.

Recommendations from SARs often related to carrying out audits or seeking assurance of Care Experienced Young People's cases and transition processes[65]. Mrs A's SAR recommended that each agency should have a care leaver's champion. In Madeleine's case, a Transitions Worker was located in the leaving care service and was an example of good practice.

> TSAB will address these findings through:
> - A local Discretionary SAR involving a Care Experienced Young Person will identify learning regarding transition.

Housing / Homelessness / Placements

The LA has an obligation to support safe transition into adulthood (under s.58-66 Care Act) and to prevent social care needs escalating (under s.2 Care Act 2014) or homelessness (and s195 Housing Act 1996) by providing advice and support before eligibility thresholds for statutory interventions are crossed[66]. There are also duties for Care Experienced Young People and through the Homelessness Reduction Act 2017.

Lack of appropriate housing is a national issue. Jack's SAR recommended that the SAB should lead discussions about the need for more, and more appropriate, housing for people with complex presentations, particularly those who are difficult to manage in services[67]. Steps should be taken to identify options to increase the availability of appropriate temporary accommodation options for young people who are at risk of exploitation and have ongoing issues around substance and / or alcohol misuse[68].

Some individuals were placed in accommodation which was unsuitable for their needs. Where this is the case multi-agency discussions should take place for proactive risk management.[69] Contextual risk assessments are needed when placing children or adults with care and support needs who are known to be at risk of sexual or criminal exploitation or substance misuse.[70]

Housing services should consider the type of property offered to care leavers to ensure it represents a good opportunity for care leavers to settle into independent living (this requires comprehensive information sharing, for example about suicidal risk).[71]

The SAB should seek assurance that the Duty to Refer in the Homelessness Reduction Act 2017 is being consistently and appropriately used by all appropriate services (including 16-17 year olds)[72].

The SAB should remind housing professionals to carefully consider the risks associated with placing a person out of area, away from their support networks and local services[73].

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[65] Mr D
[66] Sylvia
[67] Jack
[68] Kate, Molly, Rachel
[69] Sylvia, Max
[70] Sylvia
[71] Mrs A
[72] Kate, Jack
[73] Jack

TSAB has/will address these findings through:

- Discussions re appropriate housing for people with physical health conditions such as diabetes (Jack)
- Seeking assurance on Duty to Refer responsibilities (Jack) and accommodation provision duty within Domestic Abuse Act (Molly)
- Duty to Refer Learning Briefing (Josh)

Mental Capacity (also linked to Legal Literacy)

"The Mental Capacity Act 2005 (MCA) sets down the right of a competent adult to take decisions, and applies to those over the age of 16. There can be a significant tension between the principal under section 1 of the MCA, that the fact a decision may be unwise does not mean that the person lacks the capacity to take that decision, and the duty on a local authority under section 42 of the Care Act 2014 to devise a safeguarding plan for adults with care and support needs who are experiencing abuse or neglect, where they are unable to protect themselves from that abuse. To take a competent decision, an adult must be able to understand information about the decision to be made, retain that information and apply it to the decision-making process, and communicate a decision. Practitioners must ensure they break down the information to be weighed in a manner that will best facilitate this process and consider the person's…ability to implement decisions taken and to (consider) the consequences and the impact of someone else's undue influence on the decision-making process".[74]

Several SARs reflected that practitioners need to be confident in applying the Mental Capacity Act and DoLS across Children and Adults and that professionals need robust systems, processes and relevant training, including unwise decisions, positive risk taking, impact of trauma, adolescent brain development, brain injury, substance misuse, addiction, impulse control disorder, mental health, fluctuating capacity, neurodiversity and executive functioning[75]. "Training should be joined up between children and adults' services, with practitioners from both areas attending training together. This will ensure a shared understanding of thresholds, responsibilities, and provide opportunities for professional networks to develop which can only strengthen working relationships across teams"[76].

In some cases, mental capacity was not considered at all when it would have been appropriate to do so. It was apparent in some SARs that some agencies were unaware of their duties under the MCA (for example care providers or children services).[77]

Multi-agency networks need to be used more widely to holistically assess capacity in complex areas such as the impact of trauma on cognition[78].

Recommendations from SARs generally related to seeking assurance from partners on training and robust systems, processes and application of the MCA and raising awareness of the issues emerging from SARs that involved MCA.

[74] Max
[75] Mrs A, Mr D, Child G, Jasmine, Jack, Rose, Patrick, Q&Y
[76] Jasmine
[77] Colin, Jasmine
[78] Jasmine

TSAB has/will address these findings through:

- Community of Practice – developing a new webpage to share good practice and resources linked to MCA (James)
- Mental Capacity Act Guidance being reviewed considering the impact of coercion addiction, executive functioning (Bernadette), brain injury (Jack)
- Safeguarding Adults Training for Managers of Services / Legal Literacy Training
- E-learning on MCA and DoLS
- Care Providers Briefing on MCA and Best Interest Decisions (Stephen)
- Information for Carers Briefing – Lasting Power of Attorney (Stephen)

Multi-Agency Working

Effective Multi-Disciplinary Team meetings, information sharing, escalation, professional challenge, professional curiosity (including when someone is not seen, did not attend/was not brought) and recognising and responding to cumulative risk were noted in a number of SARs[79]. There was a recognition that out of area placements add another level of complexity and need for effective multi-agency working across borders. “Commissioners/ placement authorities should maintain an effective and active relationship with placements (out of borough and more widely) through the operation of formal and informal processes of oversight”.[80]

Partners should develop mechanisms to ensure multi-agency transition planning results in a robust, clear coordinated care plan, developed in consultation with the young person in a timely manner. These need to draw together all partners in the professional network as well as those within the young person’s wider support network (e.g. parents). Reviews of the plan should take place regularly, analysing which interventions are effective and setting out clear contingency plans so that all those involved, particularly the adult at risk, understands what to do if the risk is not reduced.

Some SARs recognised a gap around collaboration to draw together the “bigger picture” in terms of adult victims, suspected perpetrators, and locations, which might support a co-ordinated approach to pursuing perpetrators.[81]

The SAB should seek assurance from its statutory partners that there are multi-agency protocols and guidance which ensure there is a shared understanding across the wider partnership of the arrangements for responding to incidences of adults reported as missing, including…information sharing, and joint working to minimise the risk of further episodes[82].

TSAB has/will address these findings through:

- Seeking assurance on the effectiveness of MARAC (Bernadette)
- High Risk Adults Panel (HRAP)–escalation and multi-agency management of high-risk cases with strategic oversight and includes consideration of children and perpetrators
- Professional Curiosity Briefing and webinar during NSAW (Susan)
- Professional Challenge Briefing & Professional Challenge Procedure (Adult D)
- TSAB has been cited on the work Cleveland Police are doing in relation to ‘Missing From Home’ (for Children and Adults), with updates due at a future meeting.
- The QAF has been strengthened to incorporate out of area placements.

[79] Colin, Adult O
[80] Sophie, Sylvia, Madeliene
[81] Rachel and Molly
[82] Rachel, Kate, Madeline

Working with People and Families – Engagement, Person-Centred Approach, Advocacy, Key Workers

> **"Madeleine's voice was not heard by many of the people working with her: care planning was done about her, without her – this increased her anxiety and sense of hopelessness."**

Many SARs recognised the need for a flexible approach to support young people going through transition. Planning should begin as early as possible for young people with complex needs and vulnerabilities with a phased handover of care and support rather than a strict cut off point when a person turns 18. Children may benefit from having a 'pen picture[83]' that travels with them into adulthood, to build professional understanding and truncate the timescale for developing a positive relationship as each new worker/service is introduced.[84]

Making Safeguarding Personal ensures the young person can be part of and influence their own care, support, protection or High Intensity User plans[85]. "What is needed is safeguarding that balances rights and risks, integrates protection and participation and is person-centred and holistic".[86]

Agencies should be flexible in offering assertive outreach or considering other ways to enable positive engagement with young people[87] - responding to letters or attending appointments may not always be the best way for them to engage. Agencies should have flexible 'Did Not Attend' or case closure policies and procedures to ensure someone stays in touch and a young person does not become someone "nobody owns"[88].

Agencies should consider reasonable adjustments to maximise the chances of effective and sustained engagement and communication[89]. Agencies should be mindful that transport difficulties or a person's needs can impact on their ability to physically attend appointments[90]. Where an individual is known to several services, agencies should be mindful of multiple appointments and ensure these are coordinated as far as possible.[91]

Practitioners should remain curious and tenacious in seeking ways to engage young people, particularly when there are complexities such as mental health or substance misuse.[92]

Wherever possible staff should be consistent to build up positive and trusting relationships. Regular changes in staff can result in young people feeling overwhelmed and frustrated through being subject to multiple assessments and having to repeat their story[93].

A lead professional, key worker, care coordinator or advocate was recognised as good practice to help develop a trusted relationship, particularly for cases where there were a number of agencies involved, where there was limited/no engagement, or the person was at

[83] A brief description about a person and what is important to them
[84] Madeleine
[85] Sam – (HIU plans can help reduce the number of avoidable A&E visits and hospital admissions)
[86] Cocker, Holmes, Cooper (2024)
[87] Jack, Q&Y
[88] Mrs A
[89] Jasmine, Colin, Adult O
[90] Child G, Jasmine
[91] Child G
[92] Madeleine SAR
[93] Kate

high risk of harm.[94] Wherever possible this should be the person who already has the best relationship with the individual and family and voluntary sector staff are important to consider[95]. There should be provision of advocates to support individuals' involvement in decision making processes and enable timely challenge, including through the courts where appropriate.[96] It is best practice that the lead professional remains consistent throughout the transitions process.[97] Effective supervisions can support front line staff to maintain a person-centred approach in complex cases, where young people's engagement is ambivalent.[98]

TSAB will address these findings through:

- Making Services Easier for People to Engage In Guidance (Adult K, Jack)
- Sought assurance of availability and use of advocacy services (Adult K)
- This is Me Passport (SK)
- Understanding family dynamics and a think family approach (Susan)
- Single Agency DNA Policies and Procedures reviewed (Adult F)

Trauma / Adverse Childhood Experiences (ACEs)

Awareness of trauma and how it impacts on children and adults is becoming more well known as more research emerges and training is provided on Trauma Informed Practice. ACEs can have a lasting effect on a person's life, can change brain development and affect how the body responds to stress. ACEs are linked to chronic health problems, mental illness, and substance use in adulthood.

"Failing to support young people's recovery from harm and trauma can lead to problems persisting and/or worsening in adulthood, creating higher costs for the public purse".[99]

Many SARs recognised the impact of trauma and that staff need to have training and work in a trauma informed way to prevent re-traumatisation and offering a trauma informed response.[100]

TSAB will address these findings through:

- Trauma Informed Practice Training (James)
- Trauma Informed Practice Workbook (James)
- QAF includes supportive supervision and vicarious trauma (Molly)
- E-learning on Trauma Awareness

Criminal Justice

A number of SARs referred to individuals who were known to the criminal justice system and youth offending services.

Young people facing extra familial harm, very often overlap with young people involved in youth justice services. The language to describe these young people often moves from 'victim' to 'perpetrator' post 18 and these discourses need challenging[101].

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[94] Jasmine, Rose, Max
[95] Patrick
[96] Sylvia
[97] Max, Sylvia
[98] Mrs A
[99] Chowdry and Fitzsimons 2016; Kezelman et al 2015
[100] Sam, Q&Y
[101] Transitional Safeguarding (Cocker, Holmes, Cooper 2024)

Appendix 2 - About the Adults

1. Max (Bedfordshire SAB)

Max was 18 years old when he died from an accidental overdose. Max was in foster care from birth and placed for adoption at 18 months old. His adoptive parents decided to instruct care proceedings when Max was 16 and following this he stayed in a residential unit with 2:1 support until accommodation was found for him at age 18. Max was autistic, had a borderline Learning Disability, anxiety, ADHD, sensory issues and Raynaud's. He demonstrated aggressive behaviours such as self-injury and intrusive sexual/violent thoughts and there were concerns regarding substance misuse.

2. Madeleine (Croydon SAB)

Madeleine was 18 years old when she died due to suicide. Madeleine was first assessed by social care services when she was 12 and at 16 she was taken into care. During that time, she experienced various placements including a secure accommodation in Scotland before moving into Independent Living in Croydon. Madeleine had mental health concerns linked to emotional, social and behavioural difficulties including autism, emotional dysregulation, OCD, anxiety, violent outbursts, threats to harm herself and others. She demonstrated offending behaviours such as criminal damage, assault and possession of cannabis and would regularly go missing. She had a long history of substance misuse.

3. Sylvia (Croydon, Brompton and Kingston SAB)

Sylvia was 19 years old when she died due to a suspected drug overdose. She suffered head trauma injuries as a child and possibly due to this had frontal lobe impairment. She experienced physical and emotional abuse from her father and witnessed his domestic violence towards her mother. At the age of 16, Sylvia tried "Spice" (a synthetic drug) which had catastrophic consequences for her as she became acutely psychotic and never fully recovered. The long-term impact on her mental health and cognitive function increased her vulnerability to exploitation and her substance misuse became entrenched. Sylvia was diagnosed with schizophrenia, emotionally unstable personality disorder and possible mild learning disability. She was made subject to a Care Order, but placements struggled to meet Sylvia's needs and she moved repeatedly, including to a specialist unit for young people at risk of child sexual exploitation. She spent long periods of time detained in psychiatric facilities and multiple placements, including under a Community Treatment Order[102]. Sylvia would often go missing and there were ongoing concerns that she was experiencing exploitation as an adult.

4. Kate (Cumbria SAB)

Kate was 18 when she died due to a drug related death. Kate was known to services due to her risk of child exploitation (sexual and criminal). Kate was open to Children's Services until her 18th birthday but did not receive ongoing support from Adult Services as she had no care and support needs under the Care Act 2014, however drug and alcohol services, youth offending team and leaving care service remained involved with her. Kate had been on the waiting list for a Mental Health assessment at the time of her death and Adult Social Care had commenced a Care Act assessment in the days leading up to her death.

5. Sam (Hampshire SAB)

Sam was a Looked After Child from the age of 12, due to aggression towards his mother. He had experienced a number of traumas in his childhood. Between the age of 12 and 17 Sam had numerous placements in hospitals, children's residential homes and a residential school including four mental health admissions in his teens. In 2013 as Sam approached his eighteenth birthday he was discharged from Child and Adolescent Mental Health Services. It was felt that he did not have a 'full mental health disorder', so he was not referred to adult mental health services. An earlier diagnosis of

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[102] https://www.mentalhealthlaw.co.uk/Community_Treatment_Order

autism had been 'removed' at Sam's request. Sam's care and support needs were assessed as 'moderate', so he did not meet the eligibility criteria for services for adult social care. However, Sam appeared to have had great difficulty in managing many aspects of everyday life including his own safety and personal relationships. Sam was known to Probation and MAPPA.

6. Ms A (Havering SAB)

Mrs A was 20 years old when she took her own life by jumping out of a window. It is unclear if she had intended to take her own life. She had been a looked after child and was known to the police, community MARAC, NHS Trusts providing mental and physical health treatment and to the adult social care safeguarding team. She had a boyfriend and had experienced the loss of a baby through miscarriage. There were concerns regarding substance misuse and self-harm.

As a child, Mrs A and her siblings suffered physical and emotional abuse along with severe neglect, they were placed on the child protection register. Charges of cruelty against Mrs A's mother were pursued but later dropped as the Crown offered no evidence. Mrs A experienced a number of placement breakdowns, and she was separated from her siblings. Mrs A was described as exhibiting challenging and difficult behaviours and assessed to have ADHD and Disorganised Attachment Behaviour. Mrs A had additional educational needs, with a statement for speech and language.

Mrs A presented with some unusual behaviours and some complex health and mental health needs including Fabricated and Induced Illness. She was known to take on different personas, gave false identities and addresses.

7. Q and Y (Havering SAB)

Q and Y were white British males, who had been known to children's and adult social care, mental health and drug support services. Both had a history of presenting with very complex needs including substance misuse and suicidal ideation. They also had a history of adverse childhood experiences.

Q was found unresponsive in his bedroom in May 2020. He was aged 18 years old when he died. At a Coroner's inquest, the cause of death was recorded as a mixed drug overdose and a verdict of accidental death was reached. Y was 20 years old when he died. He was found in a room in his semi-independent living accommodation. A Coroner's inquest concluded a mixed drug overdose and suicide as the cause of death.

8. Colin (Kirklees SAB)

Colin was a man in his early twenties who lived in supported living accommodation. He had a learning disability and some physical problems. Colin was murdered by peers in the local community. Colin had been in foster care as a child and had special educational needs. He made the decision to move to supported living accommodation to develop his independence. However, records show that Colin had less independence in the supported living environment than he did when he lived with a foster carer. With the help of his foster carer, Colin began to develop his relationship with family members, which continued until his death.

A psychologist's report for Colin gave insight into his development and recommended preparatory planning for independence. Unfortunately, no such work was undertaken with Colin until shortly before his death. Instead, the provider continued to rely on a voluntary agreement with Colin, who was deemed to have capacity to make health and welfare decisions, that he would not go out unaccompanied.

Over time, Colin began to exhibit more disruptive behaviour and some violent incidents ensued, culminating in the Police being called when carers felt that they were unable to manage his behaviour.

In the weeks and months prior to Colin's death, he started asserting his right, as an adult, to go out into the community unaccompanied. Colin began to socialise with a large group of people of a similar age, and with similar vulnerabilities. Late-night incidents occurred, including in an incident where Colin was a victim of an assault, with an unsubstantiated 'throwaway' comment made that Colin was a paedophile. Colin continued to associate with the same wider group after his assault and was subsequently killed by two of his peers.

9. Adult O (Kirklees SAB)

Adult O was a 21 year old female when she died due to sepsis and bronchopneumonia. She had complex health needs from birth including cerebral palsy, scoliosis, blindness, epilepsy, quadriplegia and profound learning disability. Adult O lived with and was cared for primarily by her mum. She attended a special education school and at 19 years old she left school, after that time her contact with health and social care services was minimal. She did not go through a formal transition process from children to adult services in accordance with NICE Guidelines.

Adult O was admitted to hospital with sepsis, the A&E department raised a Safeguarding Concern due to Adult O's physical condition. She was noted to have a grade four necrotic pressure sore to her left heel, sores to her sacrum, hip and genital area. Adult O's mum told staff that she was the main carer for Adult O and that she did not require any additional support at home.

10. James (North Yorkshire SAB)

James was the younger of two boys. His parents separated when he was a young boy, resulting in him losing all contact with his father. Attempts made by James in later life to re-establish contact were sadly rejected by his father. James' older brother left the family home, leaving him to reside solely with his mother.

As James became a teenager it was apparent that he and his mother lived separate lives, with James spending most of his time with his teenage friends.

James did not always make the best choices in life: substance misuse and offending behaviour became regular features of his life. This led, eventually, to him serving a custodial sentence within a young offender institution.

James died at 18 years of age by hypoxic brain injury an out of hospital cardiac arrest and by hanging.

11. Mr D (Portsmouth SAB)

Mr D has a learning disability and was 21 years old at the time of his emergency admission to hospital. The circumstances leading up to this incident were complex, and Mr D had a long history of involvement with health and care services since childhood.

At the age of 11 he was removed from the family home due to neglect and his parents' inability to support his nutritional needs. At this time, he weighed 16 stone 7lbs and required oxygen as a result of his obesity. Mr D appears to have experienced stability of placement through his 7 years in care with just two placements. He successfully lost weight and at the age of 16 was discharged from Paediatric Outpatient services as he no longer required oxygen at night. As Mr D approached the age of 18, there were instances of unplanned contact with his mother. Mr D showed signs of becoming anxious and distressed and there were instances where he self-harmed and went missing. Mr D remained in foster care until the age of 18 when he was deemed to have the capacity to choose to return to the family home. On leaving care he weighed 15 stone 4 lbs and was no longer obese. Foster carers and professionals expressed concerns about his mother's behaviour and her capacity to change. Over the next three years, Mr D's weight increased to 29 stone.

Mr D was admitted to hospital on an emergency basis, with a grade 4 pressure sore and osteomyelitis. He required surgery for debridement of the wound. It was deemed by all professionals that it was not safe for Mr D to return home. Mr D was judged to lack capacity to make informed decisions regarding his health needs. Mr D was discharged to a residential placement.

12. Child G (Portsmouth SAB)

Child G was 18 years old at the time the review was published. Child G had a degenerative and life limiting condition that required full time care and support. There were concerns about the mother's ability to meet the care needs of Child G, despite considerable ongoing support and packages of care from health professionals and children services. Child G was a young person that had contact with around 24 organisations and numerous professionals, yet despite this suffered a level of persistent neglect which at one point became acute and life threatening.

13. Jasmine (Richmond and Wandsworth SAB)

Jasmine was a 20-year-old woman, who had been known to children's services due to safeguarding concerns arising from poorly managed diabetes and emerging mental health issues. Jasmine found it difficult to maintain positive relationships in her personal life and would often refuse help from professionals. Her history shows patterns of seeking support in managing her chronic health and conditions, but not attending follow up appointments or complying with her medical regime. She was found dead in her supported accommodation it is believed she died as a consequence of complications relating to her diabetes.

Jasmine experienced a number of adverse childhood experiences that resulted in significant trauma and are likely to have impacted on her ability to sustain positive relationships. She did not like professionals coming into and out of her life and could be private about her health issues.

Jasmine had a diagnosis of emotionally unstable personality disorder, eating disorder and possibly autistic spectrum disorder, and experienced periods of depression. She was diagnosed with insulin dependent diabetes mellitus at the age of four, and also experienced irritable bowel syndrome, diabetic retinopathy and diabetic ketoacidosis. She had multiple admissions to Accident and Emergency and the acute hospital wards due to poor adherence to her insulin regime.

14. Sophie (Richmond and Wandsworth SAB)

Sophie died in residential provision at the age of 19, because of injuries sustained from a ligature. Sophie had been a Looked After Child and her care was being managed through transition to adult mental health and social care services. Sophie had a diagnosis of bipolar affective disorder, depression and atypical autism. Sophie had a history of self-harming and it was well known that she found change particularly challenging, she had difficulty in expressing her feelings, and displayed disproportionate behavioural responses to interruptions in routine or stressful situations.

15. Rachel (Solihull)

Rachel was 20 years old. Rachel had previously been a victim of sexual abuse, and had a history of mental health difficulties and self-harming behaviours. She was also a victim of sexual exploitation and trafficking from the age of 17 onwards. Following an overdose requiring hospital admission, Rachel became looked after by the LA. Rachel was found dead in her bedroom at the supported accommodation where she had been living. The outcome of an inquest was the Coroner reaching a determination that the cause of death was drug related.

16. Rose (Surrey)

Rose had been known to services in Surrey for most of her life, she had experienced significant adverse childhood experiences, including offending behaviour which led to incarceration and

homelessness. There were concerns relating to self-harm and dual substance misuse. In her early teens, Rose became looked after by the LA. Rose died at 26 years old due to suicide by recreational and prescription drugs.

17. Patrick (Sutton)

Patrick was 24 years old when he died due to suicide by ligature. Patrick had bipolar affective disorder, Autistic Spectrum Disorder (Asperger's Syndrome), mixed anxiety and depressive disorder and a history of self-harm and suicidal ideation.

18. Jack (TSAB)

Jack was a 20 when he died from diabetic ketoacidosis. He had been placed in the hotel under the severe weather protocol having been no fixed abode. There were concerns regarding self-neglect due to mismanagement of his diabetes, substance use disorders and homelessness.

19. Molly (TSAB)

Molly was a victim of Child Sexual Abuse. She was known to police as part of Child Sexual Exploitation Operations to disrupt perpetrators and they would ensure Molly was taken home if found when missing. Molly had Post Traumatic Stress Disorder (PTSD) and a history of intentional and accidental overdoses. Professionals felt this was due to her traumatic experiences of abuse.

At the age of 17 Molly fell pregnant and her relationship was known to be abusive. She used substances during her pregnancy and the baby was placed with Molly's mum when born.

When Molly turned 18, she was largely deemed as an adult with mental capacity to make her own decisions.

In her adult life, there were concerns about domestic abuse, self-neglect, unstable housing, self-harm, drug use and sexual exploitation by multiple perpetrators, some of which were known to be part of Organised Crime Groups.

Molly was supported by multiple agencies including adult safeguarding. Molly died at just 25 years old.

Appendix 3 – National Legislation and Guidance Applicable to Children and Adults

The systems in place to safeguard children and adults, whilst sharing a common aim of preventing abuse and neglect, have developed in accordance with different legislative and policy frameworks and arguably divergent conceptual frameworks. The attached document from Research in Practice offers an overview of these differences[103] (see attached).

Research in Practice -
National Legislation A

Relevant National Legislation and Guidance referred to in SARs involving Transition

- The Children Act 2004
- Care Act 2014 and Care and Support Statutory Guidance
- Mental Capacity Act 2005 (applicable from 16 years old)

[103] Research in Practice – Transitional Safeguarding Strategic Briefing

  - Deprivation of Liberty Safeguards 2007 (see Patrick)
- Housing Act 1996
- The Homeless Reduction Act 2017
- The Homelessness Code of Guidance 2018
- Mental Health Act (including S117) - A person under 18 who has a mental disorder and needs the protection of the Act can be detained and treated under it. There is no lower age limit on the powers of the Act.
- Equality Act 2010
- Human Rights Act 1998
- Children and Families Act 2014
- Children and Social Work Act 2017
- SEN Code of Practice
- 2013 NICE Guidance
- National Health Services Act 2006
- Working together to Safeguard Children 2018
- Health and Care Act 2022
- Domestic Abuse Act
- ADASS Out of Area Safeguarding Arrangements 2016

Appendix 4 - Useful Resources and Further Reading

Local Government Association - Transitional Safeguarding Resources - LGA One Stop Shop for Transitions Resources

Research / Reports

- Analysis of Serious Case Reviews 2014-2017 (2020) (31% of cases aged between 11-17)
- Coram Voice, Disability, Disparity and Demand (2024) - Analysis of the numbers and experiences of children in care and care leavers with a disability or long- term health condition
- Coram Voice: Disability, Disparity and Demand Summary (2024)
- Department of Health & Social Care - Bridging the Gap - The Role of Social Work with Adults (2021)
- Her Majesty's Inspectorate of Probation - Transitional Safeguarding and Justice
- Research in Practice - Child Exploitation - Hearing Young People's Voices
- Research in Practice – Mind the Gap Transitional Safeguarding Strategic Briefing (2018)
- Research In Practice – Multi-Agency Practice Principles for Responding to Child Exploitation
- Research in Practice - Transitional Safeguarding – A Knowledge Briefing for Health Professionals
- Transitional Safeguarding in Brent - A Scrutiny Task Group Report
- Transitional Safeguarding: Transforming How Adolescents and Young Adults Are Safeguarded
- TSAB Thematic Analysis of SARs involving ASE

  2.1.1.A - Learning from Regional and Na
- Walsall Multi-Agency Audit Transitions to Adulthood

Videos / Webinars
- Camden Safeguarding Children Partnership – Video - Introduction to Transitional Safeguarding
- Newcastle SAB - Transition Event PowerPoint Slides
- Partners in Care and Health PowerPoint Slides - Transitional Safeguarding Progress and Innovations (2023)
- Research in Practice - Dez Holmes - Transitional Safeguarding Blog Recording

- Research in Practice - Risks, Resilience and Relationships: Safeguarding Adolescents into Adulthood Video
- Research in Practice – Safeguarding During Adolescence – The Relationship between Contextual Safeguarding, Complex Safeguarding and Transitional Safeguarding (2019)
- Sussex - A Framework of Best Practice for Transitional Safeguarding for Care Experienced Young People – Michael Preston-Shoot
- The Stage Project - Sexual Exploitation and Transitions (2020)
- Transitional Safeguarding and Why We Need It - Animation

Transitions Procedures / Guidance / Briefings

- Centre of Expertise on Child Sexual Abuse
- Hampshire SAB - Multi-Agency Risk Management Framework (for those who don't meet s.42)
- Havering SAB - Transitions to Adulthood Panel
- NICE Guidance - Transition from Children's to Adult's Services for Young People Using Health or Social Care Services
- Norfolk SAB - Transitional Safeguarding 7 Minutes Briefing
- North Yorkshire Safeguarding Children Partnership - Pathway of Support for Children and Young People with Self-Harming Behaviour or Suicidal Ideation
- Northumberland SAB - Transition Procedures
- Pan Bedfordshire Transitions Briefing
- Sutton - Transition for people with SEN
- The Children Society - Child Exploitation Guidance and Resources
- The NRM and Transition into Adulthood - West Midlands Violence Reduction Partnership
- West Sussex Safeguarding Young People (17+) Protocol
- York SAB - Preparing for Adulthood Multi-Agency Protocol
- York SAB - Transitional Safeguarding 7 Minute Briefing
- York SAB - Transitional Safeguarding Protocol