



**Learning from Safeguarding Adult Reviews about
Transitional Safeguarding: Building an evidence base**

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Learning from Safeguarding Adult Reviews about Transitional Safeguarding: Building an evidence base

Abstract

Purpose of paper:

The purpose of this paper is to set out the evidence base to date for Transitional Safeguarding in order to support authors of Safeguarding Adult Reviews (SARs) where Transitional Safeguarding is a key theme in the review.

Design/methodology/approach:

The paper draws on key evidence from several published sources about Transitional Safeguarding in England. This evidence is presented in the paper as a framework for analysis to support SAR authors. It follows the same four domain framework used in other adult safeguarding reviews: direct work with individuals; team around the person; organisational support for team members; and governance. This framework was then applied to two SARs written by two of the article's authors.

Findings:

The framework for analysis for Transitional Safeguarding SARs was applied as part of the methodology of two separate SARs regarding three young people. Key reflections from applying the framework to both SARs are identified and discussed. These included: providing an effective framework for analysis which all participants could utilise; and a contribution for developing knowledge. Whilst many issues arising for safeguarding young people are similar to those for other adults, there are some unique features. The ways in which the gaps between children and adults systems play out through inter-agency and multi-professional working, as well as how 'lifestyle choices' of young people are understood and interpreted are key issues.

Practical Implications:

This paper presents an evidence base regarding Transitional Safeguarding for SAR authors who are tasked with completing a SAR where Transitional Safeguarding is a key theme.

Originality and value:

The paper draws together key literature and evidence about Transitional Safeguarding practice with young people. It argues that this framework for analysis provides SAR authors with a useful tool to support their analysis in this complex area of practice.

Key words: Safeguarding Adult Reviews; Transitional Safeguarding; Adult Safeguarding; Young People

Introduction

This paper presents an evidence base about Transitional Safeguarding in England that draws together key publications and literature published since 2018. The purpose of presenting this evidence is to support its use as a framework for analysis by authors undertaking Safeguarding Adult Reviews. Transitional Safeguarding is an emerging area of practice that recognises the gap that exists between the binary notions of “childhood” and “adulthood” within existing safeguarding systems. This gap is particularly pertinent when analysing the deaths of young adults who meet the criteria for Safeguarding Adult Reviews. Best practice when undertaking a SAR indicates use of relevant evidence regarding areas of abuse and the nature of the circumstances of the individual (SCIE and RiP, 2022). This assists authors in ensuring that their analysis of the factors contributing to poor safeguarding practice are identified and scrutinised so that relevant learning emerges to inform recommendations for improvements to practice.

Context and background to Transitional Safeguarding

According to Holmes and Smale (2018), Transitional Safeguarding is, “an approach to safeguarding adolescents and young adults fluidly across developmental stages, which builds on the best available evidence, learns from both children’s and adult safeguarding practice and which prepares young people for their adult lives” (Holmes and Smale, 2018, p. 3). Transitional Safeguarding is not a prescribed model, rather it is an overarching approach underpinned by key principles of participation, using best evidence, acknowledging equalities and diversity issues, and is designed to be responsive to local circumstances. Transitional Safeguarding provides a language to describe a complex area of practice concerned with the specific safeguarding needs of young people, which is contextual/ecological, developmental and relational (Holmes, 2022) The current ‘cliff-edge’ between children’s and adults social services in England at eighteen years of age, means that young people are not always supported effectively. This results in unmet needs and often costlier later intervention, as those young people, where support ends at eighteen, are too often located within criminal justice, homeless, substance misusing and/or mental health populations (Cocker et al., 2021b). This appears to be one of the reasons why SARs are written about them, as unfortunately some young people die or take their own lives due to safeguarding risks not being understood and addressed at this time in their lives. There are also a range of complex practice issues involved which mean that inter-agency and partnership working are sometimes lacking.

Transitional Safeguarding covers more than the safeguarding risks for young people known to social services who need care and support provided when they are young adults. There are other groups of young people at risk of abuse, neglect and exploitation whose needs have not been traditionally addressed by adult safeguarding services (Cocker et al., 2021b) and it is these systems issues relating to the transition points – or gaps – that need addressing, including between the safeguarding system/s, the justice system/s, and health system/s including mental health (Holmes 2022). As such, it is a term intended to denote ‘boundary-spanning’: working collaboratively and creatively across institutional borders in order to tackle complex issues.

Safeguarding Adult Reviews

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3 The circumstances of each SAR are simultaneously unique and familiar. At their heart they are
4 human stories, with reviews commissioned out of a sense of discomfort. An individual has died as a
5 result of abuse or neglect, or experienced significant harm.
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8 Safeguarding Adult Boards (SABs) have a mandatory duty to arrange a Safeguarding Adult Review
9 (SAR) where an adult with care and support needs has died and the SAB knows or suspects that the
10 death resulted from abuse or neglect, or an adult is still alive, and the SAB knows or suspects that
11 they have experienced serious abuse or neglect. They are undertaken where there is the potential
12 for learning about how services might have worked more effectively together and how the
13 architecture of agency provision might have helped to prevent and/or protect that individual from
14 unmet need and risks to wellbeing.
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17 SABs also have discretion to commission reviews in circumstances where there is learning to be
18 derived from how agencies worked together but where it is inconclusive as to whether an
19 individual's death was the result of abuse or neglect, including self-neglect. The purpose of a SAR is
20 not to allocate blame or responsibility to an individual or organisation, but to identify ways of
21 improving how agencies work, singly and together, to help and protect adults with care and support
22 needs who are at risk of abuse and neglect, including self-neglect, and are unable to protect
23 themselves (Department of Health and Social Care, 2020).
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26 The SAR quality markers (SCIE and RIP, 2022) advise that reviews should specify where knowledge
27 comes from, and that the evidence used should be up-to-date. However, the first national analysis of
28 SARs (Preston-Shoot et al., 2020) criticised the number of reports where how evidence was collected
29 and understood was not specified, and SARs where limited use appeared to have been made of
30 evidence from research and earlier completed and available reviews. This created a sense that those
31 participating in reviews were starting again. The national analysis recommended the development of
32 an evidence-base for best practice concerned with different types of abuse and neglect, and
33 different fields of practice within adult safeguarding. It further recommended that building this
34 evidence-base should maximise learning from SARs and research in order to explore what facilitated
35 good practice and the barriers or obstacles that led to practice shortfalls (Preston-Shoot et al., 2020).
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38 This article responds to these recommendations with a focus on Transitional Safeguarding,
39 proposing a consolidated body of evidence to inform sector-led improvement and support authors
40 of SARs involving young people.
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45 **Evidence-base: Best Practice in Transitional Safeguarding**

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47 This evidence-base is drawn from SARs and from recent publications on Transitional Safeguarding
48 (Holmes, 2021; 2022). Holmes (2021) is a guidance document published by the Office for the Chief
49 Social Worker for Adults in the Department of Health and Social Care. It briefly sets out the case for
50 Transitional Safeguarding and provides examples of good practice in this area. Holmes (2022)
51 provides a more in-depth examination of a case for Transitional Safeguarding, citing relevant
52 literature from child development studies, health research, youth justice research, sociology, and
53 social work research. The work of Holmes and others has been used to develop a framework for
54 analysis where SARs concern young adults. It follows the same four domain framework that has
55 been used in other adult safeguarding reviews (Preston-Shoot, 2019; Preston-Shoot et al., 2020).
56 This model was adapted from studies of Serious Case Reviews (SCRs) in children's services (Brandon
57 et al., 2011). In line with 'Making Safeguarding Personal' principles, the first domain focuses on
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3 practice with the individual. The second domain focuses on how practitioners worked together. The
4 third domain considers best practice in terms of how practitioners were supported by their
5 employing organisations. The final domain summarises the contribution that Safeguarding Adults
6 Boards and other governance bodies can make to the development of effective practice with young
7 people with Transitional Safeguarding needs. The framework for analysis invites a further set of
8 questions, namely what has enabled best practice, where this is identified, and what have been the
9 obstacles or barriers to best practice, where these are also found. This then informs the structure
10 and content of a SAR about a particular young person, who will have experienced a unique set of
11 circumstances.
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15 This framework is used to summarise in each of the four domains below what is currently known to
16 be best practice in Transitional Safeguarding:
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19 ***Domain one: Direct work with individuals***

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21 Personalised. Practice is characterised by a needs-led, personalised approach. Practice is person-
22 centred and rights-based: all aspects of that individual's situation are acknowledged and taken into
23 account in the safeguarding process, including structural inequalities. Practice is relational and
24 participative, with young people/young adults involved in co-design and capacity building, in
25 assessments and reviews, their wishes and preferred outcomes known and considered. Practitioners
26 do not walk away and do not close down involvement when support is declined but are curious and
27 tenacious in seeking ways to engage young people/young adults, particularly where there are
28 complexities in the lives of young people (for example, mental health and substance misuse), which
29 compound their experiences of services. Work with young people/young adults is characterised by a
30 holistic view of the person rather than defining their needs, vulnerabilities or strengths according to
31 age or eligibility. This approach is not simply an aspiration; rather is necessary to meet the positive
32 obligations under the Human Rights Act 1998, Article 2 (the right to life) and Article 3 (the
33 prohibition on torture, inhuman or degrading treatment) and respond appropriately where there is a
34 foreseeable, real and imminent risk. This must also have regard to positive obligation to respect
35 private and family life (article 8) and liberty (article 5). Practitioners must take into account
36 everything they can reasonably be expected to know, consider exercising all available legal powers
37 available to SAB partners and record why they believed any action or inaction legally available,
38 necessary in the circumstances and proportionate to the risk.
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44 Context and history. Practice considers the history and current context of the young person and
45 their environment, at all times. It takes into account any extra-familial risks in young people's lives
46 including 'place' and 'space'. 'Place' refers to geographical locations, whilst 'space' refers to the
47 environments in which risks may occur, for example schools, parks, and fast food outlets (Firmin
48 2020). It considers the strengths and challenges in the young person's social networks. Practice
49 "thinks family" and "thinks communities", recognising the significance of meaningful and trusting
50 relationships (Holmström, 2020), but also the impact of family dynamics, and working in
51 collaboration to build circles of support. Where appropriate, carer assessments are offered.
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55 Developmental. Practice takes a developmental perspective that is not bound by age-determined
56 boundaries. It acknowledges the emerging evidence about brain development and its effects on
57 behaviour that show some elements of brain growth have a continued effect on regulation, social
58 relationships and executive functioning well into young adulthood, namely during the young
59 person's early 20s (Sawyer et al., 2018). It avoids reductive interpretation of these studies to define
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capabilities of adolescents (Moshman, 1999). It also recognises the inconsistencies in age in the legal, policy and service frameworks regarding young people's transitions to adult services and seeks to resolve tensions in these (Cocker et al., 2021a).

Prevention, protection and recovery. Practice is clearly focused on preventing harm, protecting young people/young adults from harm, and enabling them to recover from harm and trauma where this has already occurred. Practice is trauma-informed, strengths-based and outcomes focused, aimed at promoting safety and wellbeing (Holmes and Smale, 2018). Practice offers flexible and integrated support. Practice uses a risk enabling approach that can prepare and support young people with their adult lives, and so acknowledges the complex interplay of these factors as young people become adults. Preventing escalation of social care needs (a duty under s2 Care Act 2014) can be facilitated by providing advice and support before eligibility thresholds for services are crossed.

Equalities. Practice clearly recognises protected characteristics arising from gender, sexuality, race and disability. Practitioners work with the young person, acknowledging inequalities, recognising the impact on their lives, for example of racism, and addressing unconscious bias (using relevant legal frameworks such as Human Rights Act 1998 and Equality Act 2010).

Exploitation. Practice recognises the impact on decision-making of coercion and exploitation. It challenges any assumptions about lifestyle choice (Holmes and Smale, 2018). Practitioners explore with young people/young adults their decision-making, offering support and advocacy.

Mental capacity. Practice is informed by a legally literate understanding of the Mental Capacity Act 2005 (Preston-Shoot et al., 2020).

Assessment, Planning and Meeting Need. Assessments are timely and fulfil statutory requirements (Holmström, 2020). Assessments of care and support needs are incorporated into other processes, such as looked after children reviews, to minimise the need to repeat information (Holmström, 2020). Assessments of care and support focus not just on eligible needs but also on wellbeing and prevention. Assessments of risk are completed.

There is evidence of early and proportionate planning (Holmström, 2020). Planning is not limited by a focus on eligibility criteria and thresholds (Preston-Shoot et al., 2020). Care plans are followed through and reviewed. Contingency planning also occurs. There is clear evidence of pathway planning, with key worker/personal adviser offering continuity and a sustained relationship that incorporates insight into the young person's feelings and experiences.

Placements and accommodation provision are suitable. The impact of transition, of moving on, on mental health is recognised (Preston-Shoot et al., 2020). Practice is characterised by wrap-around support aimed at meeting accommodation need but also enhancing physical and mental wellbeing, and supporting young adults into training and/or employment. Options are considered, with adherence to the young person's preferences unless contraindicated.

Domain two: Team around the person

Working together. Agencies work together across service and geographical boundaries rather than in silos, in order to offer an integrated system of planning and support, recognising the inter-connected

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3 nature of harms and risks. This involves primary and secondary health care, children's social care and
4 adult social care, child and adolescent mental health services and adult mental health providers,
5 housing, and substance misuse services, modelling whole system thinking (Holmes and Smale, 2018).
6 Practice is characterised by collaboration, information-sharing and co-location. There is a clearly
7 agreed lead agency and key worker to facilitate and coordinate planning and decision-making
8 (Preston-Shoot et al., 2020).
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11 Information-sharing. There is early and proportionate sharing of information about risk and
12 regarding the range and level of support required (Holmström, 2020). Information is shared without
13 consent when this is necessary to safeguard a young person or young adult at risk and/or to prevent
14 or assist with the detection of crime.
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17 Legal literacy. Practice is legally literate, whereby there is less focus on eligibility and more on
18 preventative work and wellbeing. Advice and support are sought to address the inconsistencies in
19 age in the legal, policy and service frameworks regarding young people's transitions to adult services
20 (Cocker et al., 2021a). Legal rules are used to prevent and to disrupt sources of harm. It is core to the
21 professional standards of those working in health and social care that they understand the
22 limitations of their statutory powers, but also the legal mechanisms available to ensure safe,
23 protective care is in place.
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26 Safeguarding literacy. Adult safeguarding concerns are referred appropriately, using the criteria in
27 section 42(1) Care Act 2014, including without consent when necessary to safeguard a young person
28 or young adult at risk, and decision-making regarding the duty to enquire is robust and lawful
29 (Preston-Shoot et al., 2020).
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32 Multi-agency meetings. Practice is characterised by the use of multi-agency, multi-disciplinary
33 meetings, such as MARMs, to share information, identify needs and risks, and agree a coordinated
34 plan, with a lead agency and key worker clearly identified. Pathways for convening multi-agency
35 meetings are clearly stated and understood (Preston-Shoot et al., 2020).
36

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38 Recording. Reasons for decisions, including of mental capacity assessments and best interest
39 decision-making, are clearly recorded (Holmström, 2020).
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41 42 43 ***Domain three: Organisational support for team members***

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45 Supervision. Practitioners are offered reflective, trauma-informed supervision, to enable them to
46 manage the emotional impact of the work and explore any unconscious bias. Supervision enables
47 practitioners to maintain a person-centred approach in complex cases where a young person's
48 engagement may be ambivalent (Preston-Shoot et al., 2020).
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51 Training. Practitioners and managers are offered training to develop their knowledge of and skills for
52 Transitional Safeguarding. This includes understanding the developmental needs of young people,
53 proportionate risk-taking, legal literacy, mental capacity, trauma informed practice, and
54 development of skills of professional curiosity and enquiry into young people's lived experiences
55 (Preston-Shoot et al., 2020).
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58 Communication. Professional and personal relationships and organisational cultures that support
59 joint working at all levels within and between organisations.
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4 Specialist advice. Practitioners and managers across services have access to specialist advice and
5 guidance, for instance from lawyers and from mental capacity and mental health specialists
6 (Holmström , 2020).
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9 Co-production. Commissioners and providers involve young people/young adults in co-design/co-
10 production of services for safeguarding young people.
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13 Commissioning. Commissioners (health, housing and social care jointly), providers and young
14 people/young adults regularly conduct needs analyses and review available services to identify any
15 gaps in provision, ensuring that planning is responsive and evidence-informed. Commissioning
16 recognises the importance of services that are developmental, that are not bound by rigid age-
17 determined boundaries, and that offer flexible support. Commissioners escalate concerns about
18 shortages of accommodation and other resources and contribute actively to the assessment of
19 suitability of proposed placements (Preston-Shoot et al., 2020).
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23 Management. Senior managers demonstrate leadership that spans boundaries, essentially
24 embracing a life-course and contextual/ecological approach. The setting of a clear vision across
25 different service areas and having ‘a ‘listening’ senior management open to change’ are managerial
26 strengths and necessary enablers to facilitate improvement in Transitional Safeguarding approaches
27 to working with young people (Cocker et al., 2021b., 2).
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30 Policies and procedures. There are agreed multi-agency procedures and practice guidance to
31 support Transitional Safeguarding (Preston-Shoot et al., 2020). This includes clear pathways for
32 victims of exploitation, including access to therapeutic and mental health support.
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34 Staffing. Caseloads allow for the development of relationship-based practice as transitional
35 safeguarding cannot be time-limited work (Holmes and Smale, 2018). Staff have sufficient
36 knowledge and experience to manage case complexity. Recruitment and retention of staff enable
37 continuity of relationships with young people/young adults (Preston-Shoot et al, 2020).
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40 ***Domain four: Governance***

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43 Safeguarding Adults Board (SAB). The SAB routinely exercises its statutory mandate by seeking
44 assurance regarding how Transitional Safeguarding is being developed and embedded in policy and
45 practice locally.
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48 Strategic response. The SAB works closely with the Community Safety Partnership (CSP) and with the
49 Children’s Safeguarding Partnership (CSP) to ensure system-wide, coordinated oversight of
50 Transitional Safeguarding locally. This might involve shared chairing arrangements, shared work
51 groups or shared objectives between SABs, SCPs and CSPs (Walker-McAllister and Cooper, 2021). It
52 might include a cross-age strategic group to direct activity for both children and adults, with a shared
53 vision of purpose, clear terms of reference, multi-agency membership and clearly defined
54 responsibilities (Preston-Shoot et al., 2020).
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57 Quality assurance. Regular case audits of transitional arrangements are conducted (Holmes and
58 Smale, 2018).
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3 Reviews. Safeguarding Adult Reviews and Child Safeguarding Practice Reviews are used to develop
4 arrangements for care leavers.
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7 **Applying the evidence-based framework to two SARs**

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10 The afore-mentioned evidence-base was first used as the underpinning knowledge for two SARs.
11 Both SARs are publicly available on the relevant Safeguarding Adult Board websites, with further
12 details concerning learning, including the recommendations for improvements in practice The first, a
13 thematic review (Havering SAB, 2022), focused on two young adults with complex needs: substance
14 misuse, mental health concerns, impact of adverse childhood experiences and family dynamics,
15 suicidal ideation and lack of engagement with services. Both died as a result of drug overdoses.
16 There were three key lines of enquiry. The first considered the range of existing provision and any
17 gaps for young people/young adults with complex needs. The second considered the impact of
18 substance misuse, physical or mental impairment or illness, including dual diagnosis, on the risks
19 experienced by these two young people/young adults, including the service response to those
20 issues. The third focused on the use of statutory powers and duties. The commonalities across the
21 two cases revolved around how Transitional Safeguarding was understood and implemented, how
22 the local authority, as corporate parent, responded when 'child in need' plans and care orders were
23 proving ineffective, and there was a lack of use of adult safeguarding procedures. There were
24 shortfalls in responses to their health, and care and support needs, concerns about the assessment
25 of mental capacity, and questions about the adequacy of multi-agency working particularly in terms
26 of addressing repetitive and escalating risks.
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31 The evidence-base above offered a whole system framework through which to interrogate the
32 complex issues encountered by practitioners and managers when working with Child/Adult Q and
33 Child/Adult Y. It enabled those involved in the review to appraise positive developments in
34 Transitional Safeguarding policy and practice following the recommendations of a previous SAR
35 (Havering SAB, 2017; Wallace and Cocker, 2021) but also to delineate the further strategic and
36 operational enhancements that appeared indicated across the four domains of analysis.
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40 However, these four domains are situated within a fifth domain, namely the legal, policy and
41 financial context. This enabled attention to be drawn again to the impact on services of financial
42 austerity, the disjunction between the structure of legal rules for safeguarding young people/young
43 adults and what research reveals about adolescence (Holmes and Smale, 2018), and the lack of
44 national provision for young people/young adults with severe and enduring forms of mental ill-
45 health and/or dependence on drugs and alcohol.
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49 The second SAR was a single case review (Croydon SAB, 2022) and focussed on a young adult of
50 mixed ethnicity (White British /Black Nigerian) who also had complex needs, including a long history
51 of mental health concerns (including autism) and substance misuse, which compounded her
52 experience of services. This young person was care-experienced and lived in an 'out of borough'
53 unregulated placement as part of her leaving care provision, where she took her own life. The key
54 lines of inquiry in this SAR included: the infrastructure for transition; cross-borough working; mental
55 health service provision; the effectiveness of multi-agency working; and gaps/barriers in service
56 provision, including the impact of Covid-19.
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59 In complex cases, transitions planning requires careful multi-agency working, particularly regarding
60 mental health and placement provision. The Transitional Safeguarding issues across the children's

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3 and adults divide, were not fully understood for this young person. Her voice was not heard by many
4 of the people working with her: care planning was done about her- without her. In terms of multi-
5 agency management, support for this young person's mental health was fragmented from a young
6 age. Health partners were not adequately engaged with multi-agency assessment processes (for
7 Special Educational Needs and Disabilities (SEND) or transitions assessments) so gaps in therapeutic
8 services to meet her identified behavioural needs were not met or reported to commissioners. This
9 raised an issue about the lack of national provision for young people/young adults with severe and
10 enduring forms of mental ill-health and/or dependence on drugs and alcohol. Risk identification
11 and multi-agency management was also poor. Very little consideration was given to indications of
12 high-risk factors for self-harm and suicide. The lack of escalation processes for partners or
13 commissioned services meant that those working directly with her had little organisational support.
14 Finally, poor understanding of Transitional Safeguarding issues as well as the legal and policy
15 framework to support transition and young people with autism, together with poor multi-agency
16 communication, created unrealistic expectations that social care would manage her needs
17 independently of health input.
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23 The afore-mentioned evidence base provided a framework to structure this SAR report and address
24 each of the four domains in the analysis and recommendations. As with the previous SAR, the
25 evidence-based Transitional Safeguarding framework enabled links to be made between all four
26 domains. Given that the evidence suggests that Transitional Safeguarding requires a 'whole systems'
27 change to the way in which all agencies work together (Holmes, 2021; 2022), this framework
28 enabled detailed examination of practices, which then supports wider learning within and between
29 organisations and structures through the SAR review process. Central to this is working with families.
30 Co-production is a key quality marker of good practice, where family members influence the lines of
31 inquiry and final product of the safeguarding adult review process (SCIE and RIP, 2022)
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37 Discussion

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39 Analysing practice and the context for that practice through the lens of an evidence-base that is a
40 synthesis of findings from multiple SARs and research studies, representing the state of knowledge
41 in a field of adult safeguarding, conveys several advantages. For the SABs that commission SARs, and
42 the reviewers that author them, the approach represents explanatory accountability. The findings
43 and recommendations that emerge are CLEAR (Buckley and O'Nolan, 2014), namely they outline the
44 case for change, are learning oriented and evidence based. Responsibility for taking the learning
45 forward is specifically assigned with a built-in timeframe for review. As discussion of the fifth domain
46 has highlighted, assignment of responsibility for responding to the findings of individual SARs will
47 sometimes be directed towards national government, or other national bodies, if lessons are to be
48 learned rather than repeated. The national network of SAB chairs now has an escalation pathway to
49 draw to the attention of the Department of Health and Social Care, and the Home Office, findings
50 that require a national rather than a local SAB response¹.
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55 For SAR participants, the evidence-base provides a vantage point from which to survey what
56 facilitated and what impeded best practice across four domains of direct practice, the team around
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59 ¹ This may be found at: <https://nationalnetwork.org.uk>
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3 the person, organisational support for the team, and governance. It helps to make sense of their
4 experience, to orientate their learning about the psychosocial world of everyone involved and the
5 structures surrounding them (Dore, 2020). The reflection so afforded can prove emancipatory.
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8 For everyone involved, using an evidence-base that contributes to understanding and knowledge,
9 and helps to explain and explore policy and practice, SARs represent an opportunity for critical and
10 transformative learning within a human rights and social justice framework (Dore, 2020). This is
11 critical in the sense of exploring the constraints on practice, including the influence and impact of
12 the legal, policy and financial context within which adult safeguarding is situated. It is transformative
13 in the sense of informing debate amongst policymakers, researchers, practitioners and managers
14 about a desired future, a new direction for policy and practice, what could be instead of what is
15 (Calhoun, 2014; Cooper, 2020).
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19 Seen in this light, SARs are human stories, rooted in an understanding of what matters deeply for
20 service users and those working with them (Preston-Shoot, 2003), that aim for a system turn, the
21 development of understanding that takes practitioners, managers and policymakers beyond
22 incremental tinkering with present practice and its context, to an envisioned future. This is
23 Transitional Safeguarding embodying what UNESCO² refers to as “futures literacy”.
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26 However, learning from tragedies only takes us so far. SARs, SCRs/Children’s Safeguarding Practice
27 Reviews (CSPRs), highlight when things go wrong, not when they work well. They can highlight
28 where failure is most intense and mask areas where poor practice affects a larger number of young
29 people. Manthorpe and Martineau (2015, p345) caution against social work practice being over-
30 influenced by ‘high-profile, rare events to the detriment of its reviewing, communicating, observing,
31 listening and monitoring tasks.’ As important as these stories are, they should always be considered
32 as particularly high-profile instances of the contexts in which they are located (Parton, 2004).
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35 Several of the themes arising in the four domains are familiar across many SARs, SCRs/CSPRs and are
36 not unique to young people. For example, the national analysis of SARs includes mental capacity, risk
37 assessment and safeguarding practice as critical areas for improvement (Preston-Shoot et al., 2020).
38 Poor multi-agency planning and communication are other familiar themes often seen in SARs and
39 SCRs/CSPRs. The common themes are not just about practice issues (domain one), but include
40 broader communication between organisations, regulators, providers and commissioners of services
41 (domain two).
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44 What makes all Transitional Safeguarding SARs different is the focus on the specific issues and risks
45 that young people face and the inadequacies of the current systems to meet their needs and address
46 their risks. Five issues are highlighted. Firstly, it is the interface between systems, which are often
47 played out through interagency and multi-professional relationships, that appear to be where the
48 breakdowns occur. For young people, these gaps may manifest around safeguarding concerns and
49 disclosures about risks that young people face that are often different to other age groups.
50 Communication between agencies when young people are placed out of area, and professionals are
51 working across borders become particularly complex when they turn 18 due to the differences in
52 criteria, statutory guidance, and interpretation. This is evident when care-experienced young people
53 continue to access support from leaving care services in their originating borough and adult
54 safeguarding services in places of residence see their needs as the responsibilities of those teams.
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² <https://en.unesco.org/futuresliteracy>

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3 Secondly, limited resources and austerity have impacted on both children and adults social care and
4 health services; for young people with multiple and complex needs, this can mean that their needs
5 and risks are not adequately addressed because, as a cohort, they are not necessarily the priority for
6 each service. Thirdly, there may be differences between how professionals working with children
7 and adults understand 'independence' and dependency', which can mean that the young person's
8 needs are not clearly understood (see second SAR above). Attitudes to risk are different between
9 systems and a young person's risks may not be clearly addressed as a result; risk elimination is
10 broadly the children's approach and risk enablement is an adults' approach. The 'rule of optimism'
11 (Dingwall et al., 1983), which can predominate in children's services, may be reinterpreted through a
12 strength-based approach in adults' services. Caught between and across the children's and adults'
13 systems presents a unique opportunity for young people to fall through the gaps, which is what SARs
14 explore.

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18 Fourthly, whilst assessing decisional and executive mental capacity is a common feature of SARs,
19 when assessing the mental capacity of the young person regarding specific decisions, there appears
20 to be limited understanding of the impact of substance misuse on mental capacity, particularly
21 around young people making what are perceived to be 'unwise' choices. There is a lack of
22 understanding about complex safeguarding needs, which can be perceived as 'lifestyle choices' (e.g.
23 substance misuse, alcohol misuse, Child Criminal Exploitation and Child Sexual Exploitation) (Holmes,
24 2022). Issues of 'lifestyle choice' also feature in SARs regarding people who experience
25 homelessness or are alcohol dependent (Alcohol Change UK, 2019; Preston -Shoot,, 2020). However,
26 when the person is aged 18-25, these 'lifestyle choices' convey a wealth of unique meanings and
27 prejudices.

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31 Finally, there are further issues that are specific to the 18-25 age group, and exaggerated for those
32 young people who are care-experienced. They face additional pressures and stresses regarding lack
33 of clarity about their future living situations, due to moves or transitions to adult lives, without the
34 support that other young people can access from their birth families, friends and communities. This
35 underpins the importance of early planning and preparation for transitions / independence for these
36 young people. Young people report a lack of inclusion of their voice when planning occurs, even
37 though there is evidence that the involvement of young people has considerable value for them and
38 for the service (Cossar et al., 2011; Jobe and Gorin, 2013; Warrington, 2016).

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41 For SAR authors writing about the deaths of young people, the developing evidence base provides a
42 framework to draw out both the common and unique issues for that young person, where
43 something has gone very wrong. Further analysis of the SARs already undertaken about young
44 people will support continued development of this framework. The SAR library on the SAB Chairs
45 website and the Research in Practice database from the national analysis provide opportunities for
46 this additional work.

51 Conclusion

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53 Transitional Safeguarding is an emerging area of practice, which means that the evidence base is still
54 developing. The framework described above for Transitional Safeguarding summarises current
55 knowledge in this area, so that it is available to other SAR authors. Over time, additional knowledge
56 will add to this evidence base. Whilst many of the issues and learning from Transitional Safeguarding
57 SARs are similar to other SARs, SCRs/CSPRs, there are unique and specific differences because of the
58 needs and risks that young people experience. It is incumbent on all SAR authors to consider
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3 carefully how they contribute to supporting good practice, making use of, and building on, the
4 evidence base of what works. This will help identify the learning to support services to improve and
5 prevent future deaths.
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14 in this article.
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