

1. What is Transitional Safeguarding?

It is about recognising that the needs of young people do not change or stop when they reach 18, although the laws and services supporting them often do. It is about making sure people have the help they need to keep safe and as independent as possible. It is an approach to Safeguarding that moves through developmental stages, rather than just focussing on chronological age. It builds on best practice and learning from both adult and children's services.

"Those working with adults should be curious about the childhood of the adult they are supporting. And those working with children should be ambitious about the adult they are helping to create (Dez Holmes 2021)"

7. Further Information:

[Annual health checks and people with learning disabilities - GOV.UK \(www.gov.uk\)](https://www.gov.uk)

Link to Safeguarding Adults Reviews National Library (just put in search for transitional SAR's)
<https://nationalnetwork.org.uk/search.html>

[Was Not Brought Rapid Read](#)

6. Key Points Case Study 2:

Complex cases require multi agencies carefully working together to understand voice and needs of children and young people.

Safeguarding issues across children's and adults' services were not fully explored and understood by the multi-agency partners.

Support was declined at certain points, and when this happens health professionals should remain curious in seeking to engage young people.

Lack of understanding about transitional safeguarding. Responses to the person was generally when was in crisis.

Safeguarding: 7 Minute Briefing May/June 2022

TRANSITIONAL SAFEGUARDING



5. Key Points Case Study 1:

Adult O not going through a formal transition process is identified as one of the root causes to her not having the appropriate health and social care oversight as an adult.

LD annual health checks should be undertaken from 14 years, supporting opportunities for transition in relation to health needs. Being offered LD checks from 14 may have provided an opportunity for health professionals to understand who was involved in her care and potentially recognise that she had minimal health and social care input. It may have provided an opportunity to understand mums needs further.

2. Case Study 1

Adult O was 21 years old when she died from sepsis in October 2020. She had complex health needs from birth and attended a special school. At nineteen she finished school and had minimal contact with health and social care. She had two previous hospital attendances in 2017 and 2018 for sepsis which required ICU admissions. Due to administrative coding Adult O was not placed onto the learning disability (LD) register until 2018. It was identified that not all agencies were aware that her mum had anxieties regarding health appointments/environments and hence sometimes she did not bring Adult O to health appointments. This would be code as Was Not Brought.

3. Case Study 2:

Madeleine was 18 years old and known to many services when she died by taking her own life. She had autistic spectrum disorder, emotional dysregulation, and obsessive-compulsive disorder. She had a long history of mental health and been an inpatient at 9 years old. She had been excluded from schools due to her challenging behaviour. She was assessed by social services at 12 & 16 and taken into care. She had 8 different placements in 5 months and moved to a secured accommodation out of area. Just before she was 18, she was moved to independent living in another area which was also out of area.

4. Further Information:

[Case Study 1 - Safeguarding Adult Review - Adult O \(kirklees.gov.uk\)](#)

[NICE guidance NG43 Transition from children to adults' services for young people using health or social care services](#)

[Bridging the Gap: transitional safeguarding and the role of social work with adults - GOV.UK \(www.gov.uk\)](#)