SAFEGUARDING BOARD
ISLE OF MAN

The Learning from a Serious Case Management Review

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Introduction

In accordance with the Isle of Man Safeguarding Act 2018, which places a duty on the Safeguarding Board to review practice, identify lessons to be learnt and apply these lessons in future safeguarding work in the Isle of Man, this Serious Case Management Review was commissioned by the Independent Chair of the Safeguarding Board, Glenys Johnston OBE, to review the practice in relation to the care and support of several children between 2002 and 2011.

The review was led by Lesley Walker an Independent Social Work Consultant with no previous involvement with the Isle of Man or the cases which were the subject of the review.

A Review Panel, made up of managers who were not involved in the case, provided oversight and support to the Review, professionals who were not involved with the case provided chronological information and a report of the practice of their agency.

Very few practitioners or managers who were involved in the case or practice at the time remain the Isle of Man but in accordance with best practice, meetings were held with practitioners and managers to explore what happens now and what if anything needs to be improved.

The reflective and thoughtful contributions of everyone involved in the review, including family members is appreciated by the Safeguarding Board

The Review Panel has borne in mind the significant passage of time since agencies were involved with this case and has listened carefully to the views of professionals and available family members. It has examined case records and independent agency reports, has factored in the prevailing cultures and pressures within respective organisations at the time the incidents that led to the review took place and has endeavoured to produce recommendations which are pertinent to safeguarding practice in 2019.

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A number of agencies contributed to the Review including the: -

- Isle of Man Constabulary
- Children and Families Service

- Health Service
- Department of Education, Sport and Culture

Analysis and Learning.

The following areas were highlighted by the review as examples of good practice: -

- The eventual conviction of the father/foster carer, due to the dedication of the police officers involved.
- The referral by the school when the children first made allegations of physical abuse.
- The prompt safeguarding action taken to protect the children when they first disclosed physical abuse which led to their removal to foster care.
- The initial identification that the father/foster carer's job brought him into contact with children.

The Review concluded that there are a considerable number of lessons to be learnt from the analysis of practice in this case. The following themes emerged and assisted in identifying the key learning: -

Recognition of sexual abuse and staff's understanding of the disclosure process.

This Review highlighted that throughout the involvement with these children, there appeared to be a lack of understanding about indicators of sexual abuse. There were lots of concerns about the children's presentation and behaviours, that even without the disclosures they made, warranted an in-depth look at their family situation. Incidents were seen in isolation and there was a failure to put the information together, to develop a comprehensive picture of the children and their family.

Even when direct disclosures were made by the children no longer living in the family, there was sometimes little or no follow up in relation to the allegations and no protective action taken in respect of the children who remained at home. These failures were compounded by the fact that the early physical abuse allegations were so poorly dealt with, including returning the children home, that it left the children with no confidence about the ability of statutory agencies to protect them.

There was also a lack of understanding of thresholds for intervention. The view was taken, that if a criminal case threshold was not met, then there was insufficient evidence to take any further action. Children and Families should have been assessing risk on the balance of probabilities and acted to protect the children, which is distinct from the police's consideration to charge and prosecute an offence.

In addition, there appeared to be no knowledge that disclosure is not a simple or straightforward process and does not usually occur as a one off but that for many it is a journey. Assumptions were made that because some of the children had not disclosed directly, that abuse could not have occurred. The NSPCC commissioned research of disclosures of childhood abuse "No one noticed, no one heard" published in 2013, highlighted that on average it takes seven years for a young person to disclose sexual abuse.

The young people in the NSPCC study desperately wanted someone to notice something was wrong. They wanted to be asked direct questions and wanted professionals to investigate sensitively but thoroughly-this finding was supported by the Review.

Key Learning

- **A.** The need for staff to fully understand the behaviours and presentation that is indicative of sexual abuse.
- **B.** The need for staff to be aware of the factors that have an impact on disclosure and how best to support and facilitate this.

Multi-agency engagement in the protection and planning for children and young people in need of safeguarding.

This historic Review identified very poor engagement on a multi-agency basis in both identifying and assessing the issues and risks to the children in this family. Very significant improvements have been made to practice in the Isle of Man over the last number of years and the Review Team and professionals, gave significant reassurance in relation to the robustness of current practice. However, this Review provided all the agencies with an opportunity to challenge themselves and each other about whether any improvements can be made in respect of multi-agency engagement that would keep children safer. Those involved identified that attendance at and information provided to Core

Groups could be improved. Also, greater clarity about the use of professional meetings was needed.

It was also recognised that there is an excellent opportunity to reinforce the key changes brought about by the Safeguarding Act 2018, as the regulations have now been approved. The Act confers duties to co-operate with the Safeguarding Board and safeguarding bodies and imposes a duty on relevant safeguarding bodies to safeguard children and vulnerable adults. These duties provide an opportunity for a renewed focus on how the agencies work together, understand each other's roles and build enhanced trust and engagement in their day to day work. The Board needs to use data and audit to provide assurance that multi-agency safeguarding practice is effective and in line with policies and procedures.

Key Learning

- **C.** The importance of multi-agency engagement in all aspects of the child protection process, particularly core groups and Section 46 Investigations.
- **D.** The necessity of using professionals' meetings, where necessary, to allow open and honest discussion in complex cases.

Working with challenging families.

There is no doubt that the staff working with the parents in this case faced significant challenges. There are numerous references and very significant evidence of the difficulties, including aggression, continual challenge, refusal to co-operate and clear blocking of attempts to engage or speak to the children. Unfortunately, as in other cases there is clear evidence the staff became caught up in this and lost focus on the children.

The Care Plan presented to the court that recommended a non-continuation of the Care Proceedings and stated that; "due to a lack of engagement by the parents it has not been possible to gain any insight into family life or family functioning and not possible to complete the core assessment because of this". Despite this, no further action was taken, and the case was closed. This missed opportunity set the tone for all the other engagement with the family, where

the blocking, withdrawal and challenge kept agencies at arm's length and ultimately allowed the abuse to continue.

During this Review, it was generally felt that the context and training currently offered in the Isle of Man, did provide a strong base for staff but it was helpfully identified that, "the tool box to deal with the issue of work with challenging families, is not complete." Whilst, the work recommended earlier to improve the effectiveness of core groups, which develop and deliver the child protection plan, would provide an opportunity for a more supportive multi-agency structure, that would assist joint working and challenge in difficult cases, more specific guidance for staff in dealing with uncooperative and hostile families was felt to be required. This would need to be backed up by appropriate training.

Key Learning

- **E.** That opportunities exist to challenge fixed mind sets through reflective supervision or other supportive conversations particularly when dealing with challenging families.
- **F.** The need for staff to feel confident in working with challenging families and that current policies, procedures and guidance exist to guide and support their work.

Evidence of the voice of children and young people in all work.

Sadly, there was little evidence of the children's voices being heard or proactively sought in this case. There was little evidence, of any professional trying to build a meaningful relationship with the children, that could have led to disclosure or a clear view about the realities of their life at home. This was despite many issues and indicators of abuse being recorded by professionals, which raised serious concerns about their welfare. The failure of social workers to speak to the children was a missed opportunity to gain information about the realities of their lives.

Culturally in the Isle of Man, the child's voice is now embedded in all work currently carried out by social workers and significant input and resources have been put into direct work with children. The police also reflected the importance of this and feel it is fully embedded and reflected in all their work. It was felt that other professionals and sectors may not feel as confident in

eliciting the views and feelings of children and young people and this could be built into the work required from the learning identified in relation to children's disclosure.

Key Learning

G. The need for all professionals and sectors to enhance their confidence and build in opportunities to hear the voice of children and young people in all aspects of their work and record this accurately.

Professional curiosity and challenge across agencies

There was also a lack of "professional curiosity" in significant aspects of this case and very limited challenge both within and across agencies. Again, agencies were very open in reflecting on the culture in their own organisations at the time, they recognised there was generally little challenge of officers or senior managers and this also applied to the lack of action or direction of travel in the case.

All agencies described a very different position within their organisations today, with clear whistleblowing policies in place. Moreover, they highlighted the improvements including the Safeguarding Board's Multi-Agency Escalation of Concerns Policy and the Resolving Professional Differences in Safeguarding Policy - Multi Agency Reflection Discussion process that has given them permission and confidence to escalate cases and providing them with formal routes to challenge each other. The lack of clarity in relation to the use of professional's meetings as a useful tool to discuss complex cases, has been highlighted earlier and merits further exploration by the Safeguarding Board on a multi-agency basis.

Key Learning

H. The importance of "professional curiosity" and the role of all professionals to respectfully challenge each other, when concerns are evident.

Robustness and awareness of the Safeguarding Board's Managing Allegations Strategy Meeting and Complex Abuse Procedures.

In 2011 it was recognised that the father/foster carer, had access to children and young people within his job role and the potential risks relating to this were highlighted. However, due process was not followed and a Managing Allegations Strategy Meeting for a person working with children was not held, therefore his employers were simply informed of the allegations and the matter was left for them to deal with. Equally, further allegations that ultimately led to the father/foster carer's conviction, did not trigger a referral for a Managing Allegations Strategy Meeting nor the Complex Abuse Procedure. Police in another jurisdiction did complete follow up enquiries in relation to his fostering status but this did not lead to any other convictions.

It is important to highlight that this failure did not, according to any information held by any agency lead to any abuse of children or young people, with whom he had contact outside of the family home. However, the importance of using the safeguarding Board's Managing Allegations Strategy Meeting and the Complex Abuse procedures and having the relevant meetings to consider potential risks and actions is clearly critical in such cases. The Review has highlighted that there is a lack of joined up understanding and agreement in relation to the operation of these procedures; therefore, these need to be reviewed on a multi-agency basis.

Key Learning

I. All staff need to have a clear understanding of the policies and processes, that relate to allegations against people working with children and where that abuse is "complex", to ensure tight multi-agency investigation.

Conclusions

The agencies involved in this case were extremely reflective of practice and what has and needs to improve. It is to the credit of agencies in the Isle of Man, that the Safeguarding Board commissioned this Review of this historic case and used it to reflect in depth, on their current practice and use the learning as an opportunity to challenge themselves, in relation to how they can further improve current systems and practice.

The fact a Safeguarding Board now exists, with an Independent Chair who is directly responsible to the Council of Ministers and that its operation, is embedded in legislation and regulation, demonstrates the commitment of the Government to oversee and improve safeguarding on the Isle of Man. Its role; to co-ordinate work to protect and safeguard children and to ensure the effectiveness of that work and the Chair's role to constructively challenge the agencies ensures oversight of necessary improvements.

Due to the historic nature of the case, it needs to be recognised that very significant improvements have already been made to safeguarding legislation, structures, culture, procedures, processes and practice. This has been also been backed up by single and multi-agency training and more robust governance and assurance systems across all agencies. It was not the role of this Review to provide assurance that the changes are robustly embedded on a multi-agency basis and the Safeguarding Board should consider how it wishes to seek assurance in relation to this.

Recommendations

The following recommendations were agreed as the best way to address the key learning from this review. The Safeguarding Board should :-

1. Review its training strategy, to ensure that there is sufficient focus on multi- agency training that engenders effective practice between agencies particularly focussing on professional curiosity, effective professional challenge and reflective supervision.

    1a. All agency representatives on the Safeguarding Board should review their single agency training on Child Sexual Abuse, particularly to ensure sufficient focus on the key indicators and the disclosure process.

2. Review their current training on recognising and responding to child sexual abuse and ensure there is clear understanding about the process and conditions for disclosure.

2a. In respect of the Isle of Man Constabulary and the Children and Families' Department they should develop a joint working protocol for child protection inquiries.

3. Provide clarity on the use of professional meetings as a tool in dealing with difficult and complex cases, highlighting the opportunity they provide for multi-agency reflection.

4. The Board should consider how to seek assurance, that multi-agency practice is of a high standard, through enhanced audit and data, provided directly to the Board. In particular, the robustness of Sec 46 investigations and attendance and information sharing at Child Protection Conferences and Core Groups.

5. Consider developing a protocol for working with challenging and hard to engage families, that ensures staff remained focussed on the child.

6. Review the Managing Allegations Strategy Meeting (MASM) and Complex Abuse Procedures in conjunction with the Office of Human Resources and relaunch and promote how and when to apply them.

End of report