GD2025/0087

SAFEGUARDING BOARD
ISLE OF MAN

ANNUAL REPORT 2024/25

Contents

Board Members' Introduction

Welcome to the Isle of Man Safeguarding Board Annual Report for 2024/25, covering the period from 1st April 2024 - 31st March 2025. We hope you find this report informative and reflective in relation to safeguarding practice locally. It reports on the Board's progress and impact in safeguarding children, young people and vulnerable adults.

We would like to reinforce that the Board is a multi-agency partnership involving the most senior leads from key safeguarding organisations, with clear responsibilities to ensure our local citizens are protected from abuse and harm through our collective endeavours.

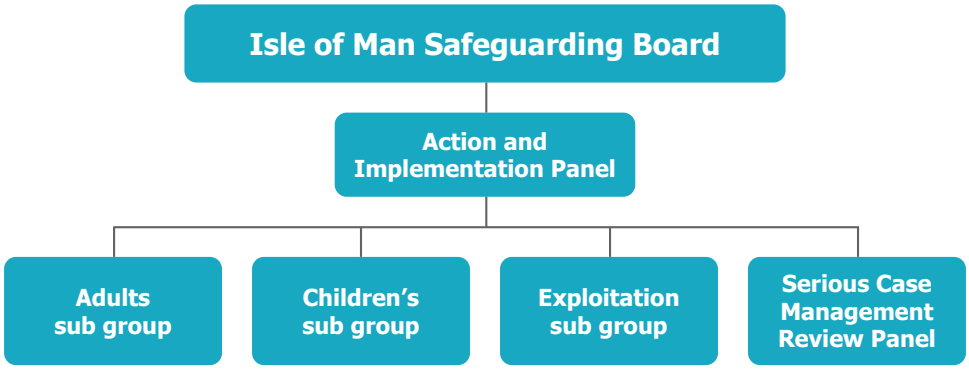
This report seeks to provide an honest appraisal of our successes and impact as well as identifying where improvements are required, to strengthen the safeguarding system and practice locally.

You will be able to read how we have sought to develop and improve as a Board and we are looking forward to some specific development time in early 2025, to focus on our effectiveness as a Board, with our three newly appointed independent members. Our new multi-agency performance datasets are beginning to provide us with reliable information to help us understand practice, inform our work and allow us to challenge where necessary.

We would like to provide our thanks to all of our dedicated front-line staff in all partner agencies and all sectors, for their support and steadfast commitment to safeguarding children and adults on the Isle of Man. We recognise the commitment of our safeguarding leads in driving multi-agency practice improvement Also, the Board business team who have supported us in ensuring we are able to meet our key functions and supporting our staff to deliver on the Board's business priorities and necessary improvements.

We are looking forward to working with all sectors and our communities locally to further promote our key messaging that "safeguarding is everyone's responsibility" and to promote key messaging around safeguarding through our now annual safeguarding week, quarterly newsletter, website, social media and other means. We welcome all input to improve safeguarding locally and continue to develop our culture of high support but high challenge, to ensure locally citizens are adequately protected.

Governance Structure Chart



Reflections from the Independent Chair

My role as the Independent Chair is to receive assurance about safeguarding practice from the agencies and to drive effective joined up multi-agency work. Also, to independently scrutinise the standard and quality of safeguarding practice for children, young people, and vulnerable adults, to ensure they are protected from abuse and harm. The Independent Chair can never be the sole provider of feedback, reflection or challenge, and the Board are continuing to develop a culture of "high support" and "high challenge", to ensure a culture of continuous improvement.

This year my key focus has been on receiving assurance on a range of areas of safeguarding practice, leading detailed and robust scrutiny of single and multi-agency practice in relation to both adults and children, and overseeing the publication of learning from Serious Case Management Reviews (SCMRs). I have also been overseeing and driving improvements to address the learning from those reviews and the scrutiny that has been undertaken. The partnership has a detailed assurance schedule, and this year agencies are increasing in confidence in asking questions and challenging reports and presentations. However, there is still significant work to do, to ensure well triangulated evidence is presented, that provides robust evidence of real improvement and impact.

In the section on key achievements detailed within this report, there is good evidence of continued progress against key areas of work within the Board's Business Plan. The scrutiny evaluation led by myself, focussed on Self-Neglect is detailed on pages 11-15. This was a key Board priority following the Thematic Review of Self-Neglect published in 2022 and provides strong evidence of the impact of collective multi-agency action on both practice and service user outcomes. It evidences the difference the Board agencies can make in protecting local citizens from abuse and harm, when they come together to improve. It was a delight to hear the stories of service users whose lives had been changed through the collective work of practitioners locally.

However, scrutiny also identified some significant areas requiring improvement particularly in relation to the protection of children and young people from the risks of harm outside the home, which includes the risk of criminal and sexual exploitation. The findings from scrutiny are presented on page 11. This is a challenging area of safeguarding in all jurisdictions and there is considerable work to do to strengthen safeguarding systems locally. I will be supporting all agencies in their improvement whilst holding them to account, to ensure the necessary improvements occur in a timely way.

In addition, I have worked closely with Board members and relevant Ministers to discuss necessary improvements to safeguarding practice, and how changes to policy and legislation can best support the Safeguarding Boards' work. In particular, Board members have supported necessary changes to legislation, specifically amendments to the Safeguarding Act 2018 to ensure it better guides and supports practitioners, by placing a clear duty to share information to promote the welfare and safeguarding of children and vulnerable adults. Practitioners' concerns about sharing information and the basis for legitimately overriding consent to safeguarding, has been one of the greatest barriers to effective safeguarding locally. The proposed legislative changes to support improved practice will be progressing through Tynwald in 2025. Alongside this, new accessible Consent Guidance will be approved and rolled out later in 2025.

The Board's risk register highlights the most significant areas of concern, risks and barriers to effective safeguarding and helps direct agencies and others to address, challenge or influence where necessary. Alongside information sharing, there is much to do to improve professionals understanding of consent in the context of safeguarding risks. In particular, the fact that consent is not required where safeguarding risks exist and a lack of consent can be over-ridden to safeguarding individual in specific circumstances. The Board will be providing user friendly guidance for professionals to support their decision making in preventing abuse and/or harm.

Another significant barrier to effective safeguarding that continues to be highlighted locally, is the lack of a comprehensive Early Help Strategy and Pathway to ensure that children and their families receive early help and support. A Serious Case Management Review Child J published in 2021 highlighted this as an issue and recommended: "That the board seek assurance that an early help strategy is being considered and developed to intervene early in the lives of children similar to Child J. This should include a professional framework to improve professional's knowledge and understanding of the impact of Adverse Childhood Experiences" Whilst there has been some good work undertaken locally in relation to early intervention a clear and accessible multi-agency pathway is still not available, and the lack of this continues to be raised in reviews and by service users and parents as a significant gap. It is encouraging that the Community Safety Partnership is now taking a lead role in trying to progress work in this area on a multi-agency basis and it will be important that the Board continue to seek assurance on progress and escalate issues requiring action.

Ms Lesley Walker
Independent Chair

IOM Context

ISLE OF MAN

The Isle of Man is a self-governing British Crown Dependency located in the Irish Sea, roughly equidistant between England, Ireland, Scotland, and Wales. It's not part of the United Kingdom, but the UK is responsible for its defence and international representation.

POPULATİON BREAKDOWN
84,069 PEOPLE.

20.7%

57.3%

22%

16 NURSERIES

33 PRIMARY SCHOOLS INCLUDING 1 MANX SPEAKING ONE AND ONE PRIVATE SCHOOL

6 SECONDARY SCHOOLS INCLUDING 1 PRIVATE SCHOOL

1 UNİVERSİTY COLLEGE ISLE OF MAN

Our Business Priorities and Key Achievements

The management and delivery of the work on the following key priorities:

1 Ensuring effective multi-agency safeguarding practice for vulnerable adults

Why is this important - to continue to ensure a shared understanding and multi-agency approach to risk and harm for vulnerable adults and ensure that they are appropriately safeguarding

Achievements -

- Evidence that campaigns raising awareness of adults who Self Neglect and where to seek help, have significantly increased awareness and referrals into statutory services.
- Audits evaluating multi-agency practice against the new procedural guidance, evidenced the positive impact on practice and service delivery to vulnerable adults and their families.
- Consultation with service users and their families by the Independent Chair confirmed the positive impact of interventions on their lives and outcomes.

2 Safeguarding Adolescents from risks and harm outside of the home

Why is this important - Risk outside of the home is a complex and challenging area of safeguarding children and young people and requires practitioners to think about the places, spaces and face associated with children and their context where risk or harm may occur. To ensure that all partner agencies can recognise, respond to and analyse risks associated to child exploitation and other forms of extra-familial harm and adopt a contextual safeguarding approach to reduce the risk

Achievements -

- Collaborative work with partner agencies facilitated by a safeguarding consultant, to develop a comprehensive and effective multi-agency procedure and pathway, to improve practice with exploitation, following scrutiny.
- Established a steering group to develop an agreed multi-agency process and pathway with the aim of presenting this to Board to be adopted as new way of working later in 2025
- Designed and delivered a series of high-impact awareness campaigns regarding critical areas of child exploitation - online abuse, child sexual exploitation, child criminal exploitation.

3 Improving the multi-agency response to childhood neglect.

Why is this important - Neglect is the highest concern referred into Children's services and the majority of children subject to a Child Protection plan is due to concerns of neglect. Therefore, it is important to ensure that there is a collective response across partner agencies to prevent the harmful impact of neglect on children and young people.

Achievements -

- A Multi-Agency working group was established to explore examples of best practice models and frameworks to effectively work with children and their families when there are concerns of childhood neglect.
- A preferred model had been identified and future plans developed to engage with Professor Jan Horwath- a leading authority on child neglect, with the aim of developing a comprehensive multiagency framework to strengthen a coordinated response across partner agencies.

4 Embedding learning to improve practice.

Why is this important - There is an abundance of key messaging and learning from case reviews locally and from the UK which highlights the need for multi-agency system improvements to safeguarding practice. This priority will support partner agencies to have effective systems in place to ensure that learning and practice improvements are effectively disseminated and embedded across agencies and have a demonstrable impact for services offered to children and vulnerable adults.

Achievements -

- The key success factors for evaluating the impact of learning onto Practice to be tested via scrutiny in late 2025.
- Shared learning from local & national reviews across partner agencies via learning briefings and workshops.
- Specialist training provided when identified via audit and learning review, i.e. Trauma informed approach to Risk Outside of the Home, Child Sexual Abuse within the family environment.
- Significant progress made against Serious Case Management Review's recommendations & actions.
- ICON programme adopted by Multi-agency partners with phase 1 successfully completed within Midwifery and Health Visting Services.

Year in View

Launch of the new Continuum of Need and Threshold Guidance, following a series of consultation sessions with partner agencies to ensure that the guidance provided all sectors with appropriate guidance to identify the appropriate level of need for children and offer the right type of support

Board hosted the second Safeguarding week for children and adults which included events and promotion of safeguarding issues - Child exploitation (child sexual exploitation & Child criminal exploitation) and use of victim blaming language. A series of themed interviews with Manx Radio regarding child exploitation and financial exploitation of adults, adult exploitation and other forms of adult abuse. Police activity with a sample of hotels using Operation Make Safe. Modern day slavery, internet safety, schools ran anti-bullying week campaigns.

Scrutiny activity to evaluate how the new self-neglect procedures had impacted multi-agency working with adult who self-neglect. This was a piece of scrutiny which demonstrated positive impact of services and support offered to vulnerable adults.

Online Safety and extreme propaganda / ideology campaigns exploring the use of platforms / apps and meaning of emojis in text messaging.
Successful recruitment of independent members of the Board and appointment of 3 independent members who will bring varied experience from a number of sectors.

Multi-Agency Working Group was established to develop an IOM Childhood Neglect Framework, with comprehensive and collaborative tools and pathway. The group is beginning to work with Prof Jan Horwath (specialist in Neglect) to establish a model that is IOM specific for practitioners, children and their families. The group consists of representatives across government departments, agencies in the charity and voluntary sector. This work is aligned to the findings and recommendation made in SCMR - Child N.

Multi-Agency partners have worked collaboratively with a Children Safeguarding Consultant to develop a recognised approach and guidance to information sharing and consent. These issues have been highlighted as barriers to good practice with families, within the findings of several Serious Case Management Reviews. This new guidance and way of working will be launched in late summer 2025, and the impact on practice will be evaluated in early 2026.

Board adopted the ICON programme and successful completion of phase 1 of the programme within Health visiting and Midwifery services. This work is aligned to a recommendation and findings made in SCMR - Child O. This programme is aimed to support new parents and reduce the risk of Abusive Head Trauma in infants and young children. The programme promotes that crying is a normal part of a baby's development, but for many parents this can feel overwhelming, especially when combined with pressures of Daily Life.

Independent Scrutiny by the Independent Chair

What is the purpose of Independent Scrutiny?

Independent Scrutiny should:

- Provide independent, rigorous and effective challenge to partners across all necessary areas of safeguarding practice.
- Provide assurance and support evaluation of the effectiveness and impact of multi-agency arrangements in safeguarding children, young people and vulnerable adults.
- Help drive continuous improvement, including the embedding of learning to improve practice

The Board's independent scrutiny function is particularly focused on measuring the impact of the partnership's collective work in relation to the agreed business priorities and is focused on the impact of the partnership on outcomes for children and young people and vulnerable adults locally. The methodology used is laid out in the Board's agreed Quality Assurance and Scrutiny Framework, which provides a particularly robust, evidence-based scrutiny process that puts children, young people and vulnerable adults and their families' voices and experiences at the centre. It also brings a "doing with", rather than a "doing to" approach, where the detailed analysis is presented to senior operational leads at a scrutiny event, and brings both support and challenge to facilitate the identification of improvements. As the Independent Chair I believe this model has started to drive real improvement across the partnership.

This year two scrutiny reports were produced evaluating the impact and effectiveness of multi-agency work to address two of the Board's key priorities related to adults and children:

Adults Scrutiny - The Impact of Work to Improve the Response to Self-Neglect

Background

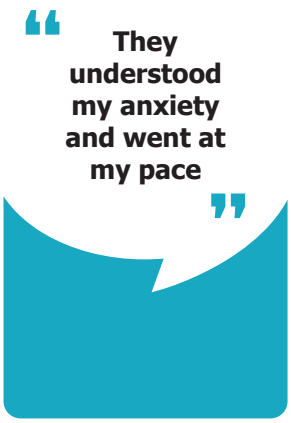
In 2022, the Board commissioned an independent thematic Serious Case Management Review of seven adults who had died in circumstances of self-neglect. The report made a series of recommendations to strengthen multi-agency responses to self-neglect, and the Board initiated a substantial programme of work to address these. In 2022, the Board developed a pathway for self-neglect that was supported by the following:

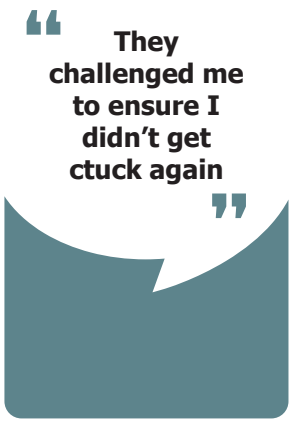
1. A self-neglect strategy and implementation plan
2. Multi-agency self-neglect procedural guidance, including practice tools
3. Terms of reference for an 'Adults at High-Risk Panel'
4. A self-neglect assurance framework
5. A feedback form for adults - Making Safeguarding Personal
6. A self-neglect competence framework
7. A self-neglect supervision aide

In September 2023, the Board held a conference aimed at raising awareness of self-neglect where the new pathway, procedures and supporting resources were formally launched. The scrutiny process therefore evaluated practice fourteen months on, using key success factors to assist the evaluation of practice and its impact for service users.

The Voice of Services Users

The feedback provided by those who had involvement from Board agencies and services was overwhelmingly positive and outlined the difference made in their lives by the staff involved with them. The feedback provided by those spoken to was overwhelmingly positive and outlined the difference made in their lives by the staff involved with them. The following quotes evidence some of the positive differences made to all the individuals spoken to:





Summary of Findings

The detailed evidence collated through scrutiny, recognised the significant progress made in establishing a robust multi-agency response to adults who self-neglect. It identified many areas of good or effective practice. There were positive examples of person-centred responses, and practitioners working hard to establish trusting relationships and ensure Making Safeguarding Personal was at the heart of their work.

The scrutiny process highlighted the dedication and skill of front-line practitioners. For many of those practitioners, their commitment to supporting adults who self-neglect has always been there. The difference is that previously they were operating without a framework of procedures, tools and the necessary multi-agency structures to support their work.

It must be remembered that working with self-neglect is complex and making a positive impact is multi-faceted. It can take a long time to achieve a reduction in risks and for some adults, this may never be achieved. The case studies and feedback from practitioners has demonstrated that overall, the strategy and procedural guidance is driving effective multi-agency working and is having a positive impact on adults who are self-neglecting. Most importantly, feedback from adults who had been supported, was overwhelmingly positive about the difference made to their lives.

The areas for development outlined in the final Scrutiny Evaluation Report are being led and overseen by the Adults Sub-Group though a robust and closely monitored action plan. The report highlighted the need to continue to test progress through audits including independent audit. It also recommended to the Board, that they need to be assured about progress on some key areas of work that impact significantly on practitioners, namely implementing the Capacity Act, Advocacy and the development of pathways across and within agencies, in particular the full implementation of the Adults at High-Risk Escalation Panel (AHREP).

This scrutiny highlighted a recurring issue, about the full and effective implementation of improvement initiatives in some agencies, particularly the need for strengthened assurance and oversight of key safeguarding improvements by individual agencies. The report reinforces the need for robust individual agency implementation plans for new

initiatives and recommended that an agreed template is used with regular reporting and rag rating of progress though the Board's sub-groups. Any barriers or challenges can then be highlighted at a much earlier point and strengthens the accountability and assurance functions of the Board.

Overall, there was much to celebrate, with considerable evidence that the Self-Neglect Strategy and Procedural Guidance is leading to high quality, effective practice that is having a positive impact on adults who are self-neglecting. It was a testament to all the leaders, practitioners, the Board business team, statutory agencies and all sectors who worked so hard to make this happen and robustly evidences the difference the collective impact of Board agencies can have on service user lives and outcomes.

The Board accepted the findings and recommendations, and work has quickly moved forward to tackle the areas requiring development.

Children's Scrutiny - Evaluation of Multi-Agency Practice to Safeguard Young People from Exploitation

Last year in the annual report I highlighted some of the initial findings from the children's exploitation scrutiny undertaken in March 2024, pending the preparation of the full scrutiny report. The purpose of scrutiny was to evaluate the impact of the Vulnerable Adolescents Strategy and Procedural Protocol for Children and Young People who are at risk of Exploitation, launched in September 2022.

Alongside the preparation of the scrutiny evaluation report, immediate improvement work was undertaken in April 2024 via a workshop to review and reset the working practices, involving a range of professionals from all agencies. This was facilitated jointly by the Board Team and the Strategic Lead for Tackling Exploitation and Violence in Barnet, a specialist in exploitation, and the area upon which the IOM Exploitation Procedural Protocols, were based. Unfortunately, this workshop highlighted further concerns and highlighted there was significant work required to ensure that young people at risk of exploitation and risk outside the home were safeguarded via appropriate assessment and planning, within a consistent and robust process applied within a contextual safeguarding framework

Voices of Parents

A number of parents whose children were identified as being at risk of exploitation were chosen randomly to speak to me. Interestingly, there was a significant presence of additional needs arising from neurodiversity that clearly had an impact on the young person's ability to evaluate and process information. This had left them at particular risk of exploitation and working with these young people requires specialist knowledge, experience and resources.

All of the families spoken to were of the view that they did not receive an adequate response or support when their child first displayed difficulties, despite some referrals to services. They highlighted that agencies and services responded in the main at this stage to say there was nothing they could offer as it was outside their remit. All

highlighted early behaviour problems at both home and school and felt that wraparound support for their child and the family, particularly in dealing with their child's autism would have made a difference. They described that there was no joined up programme of support or input across the island and felt their child fell through the gaps. They described feeling badly let down at all stages of their involvement especially with statutory agencies.

This reinforced the findings and recommendation from The Child J Serious Case Management published in 2021 about the importance of a multi-agency Early Help Strategy and pathway, as highlighted in my introduction. Progress in developing this has been slow and the Board needs to seek further clarity in relation to leadership of this work and assurance of progress.

Summary of Findings

The triangulated information pulled together from audits, observation of key meetings, access to minutes and recording system, sessions with practitioners, performance data, reports and interviews with parents provided evidence that the Exploitation Strategy had improved practice in some areas. The key areas for celebration were the improvement in multi-agency work, joint working, improved inter-agency relationships and information sharing. However, the report found there was significant work to do locally, to support best practice in working with young people at risk of exploitation, specifically centred on:

- Working in partnership with children, young people and their families.
- Working with communities.
- Having clear processes to support assessment of risk, planning and reviewing.
- Offering well-co-ordinated interventions that make a difference for those in need of early intervention and those at the higher end of need (i.e. step down from secure care).
- Developing a strategic overview of needs, gaps and trends and ensuring a robust performance dataset that supports improvement.
- Governance, assurance, oversight and leadership to ensure that practice and process stay on track and that agencies are doing what they have committed to do.
- Clarity of how to deal with cases when consent is withdrawn

The scrutiny report was presented to the Board and required conversations about how best to undertake the detailed practice improvements required in this complex area of safeguarding. In June 2024, the Board approved the project workplan and the commissioning of an external expert to lead and support partner agencies in co-producing a framework, pathways and tools to manage Risk Outside the Home (ROTH).

A newly formed exploitation sub-group will oversee this planned work and ensure regular assurance reports to Board on progress on this critical work.

Serious Case Management Reviews

The Safeguarding Board is required to undertake Serious Case Management Reviews (SCMRs) in circumstances where a child or vulnerable adult may have died or suffered serious harm, and where abuse or neglect is known or suspected, and there are concerns about how agencies may have worked together. The purpose of the review is to identify learning or areas of practice improvement and ensure work is undertaken to address the findings and recommendations.

The Serious Case Review Panel is chaired by the Independent Chair of the Board who is responsible for deciding whether the case meets the criteria for commissioning an independent review author. The Panel holds a scrutiny and oversight role to establish that recommendations have been actioned, and practice changes implemented.

The SCMRs undertaken locally have driven significant practice improvements over time, as evidenced by the impact of the Self-Neglect Thematic Review highlighted earlier in this report.

This year the Board published a learning briefing for SCMR Child O due to the sensitive information contained within the full overview report. Child O had sustained abusive head trauma at a young age which had impacted his development. The report highlighted areas of learning and made a number of recommendations, and the actions are anticipated to have been completed by the end of 2025. Child O Learning Briefing has been published on the website

As a result partner agencies have collaborated with a Safeguarding consultant to develop guidance regarding how information should be shared and parental consent considered when Children's Services are working with families where there are safeguarding concerns. The guidance will be embedded by the end of 2025 and an evaluation of the impact this change has made to practice being planned for summer 2026.

The Safeguarding Board also endorsed the implementation of the ICON programme across services on Island to assist with preventing and reducing the risk of abusive head trauma in young children and babies. A 7 minute briefing has been published on the website.

This programme aims to support new parents and reduce the risk of abusive head trauma in infants and young children. The programme promotes that crying is a normal part of a baby's development, but for many parents this can feel overwhelming, especially when combined with pressures of Daily Life.

The ICON message is:

I Infant crying is normal and will stop

C Comfort methods can sometimes soothe your baby

O It's OK to walk away for a few minutes if your baby is safe and the crying feels too much

N Never shake or hurt a baby

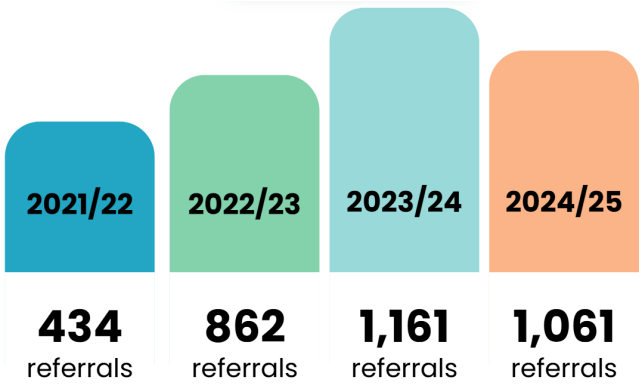
Further, during this reporting year, the Board has commissioned an independent author to undertake an SCMR – Peter, which is scheduled to conclude in late spring 2025.

Safeguarding Data

The Board now have a more comprehensive multi-agency dataset, that allows the Board to have sight of a range of data that provides insight into the performance and effectiveness of safeguarding practice. It allows the Board to ask challenging questions and guides the subgroups about areas of practice that require in-depth review through audits. The following data provides some insight to levels if safeguarding demand and the responses from adults and children & families services.

Adult Safeguarding

Referrals in this reporting period have remained significantly high, and the data shows that referral rates have increased since 2021 has increased significantly in recent years. Clearly this has a relationship with the scope of work that is possible in adult safeguarding.



Referrals to Adult Safeguarding

Re-referral rate for adult safeguarding:

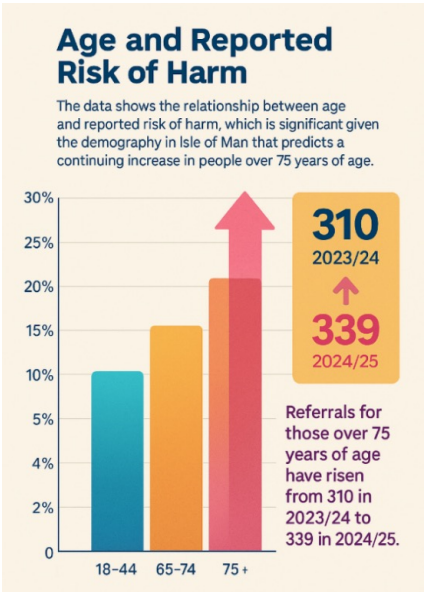
16.7% (↓ from 18.9% in 2023/2)

Signigficant elements of safeguarding casework fall to the adult social work tea.

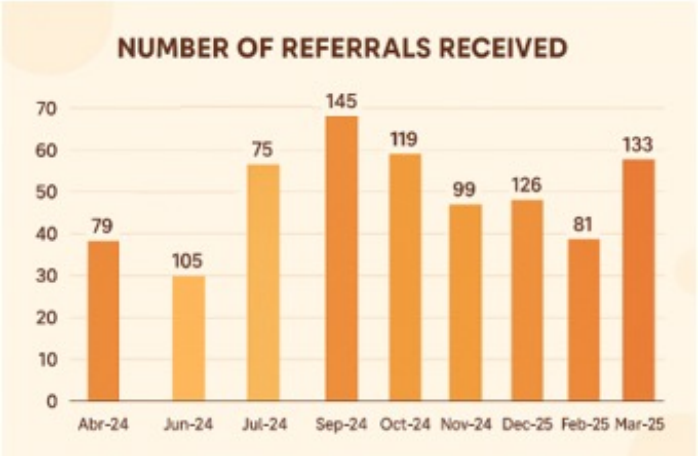
Re-referral rates for adult social work:

Generally, under 10%

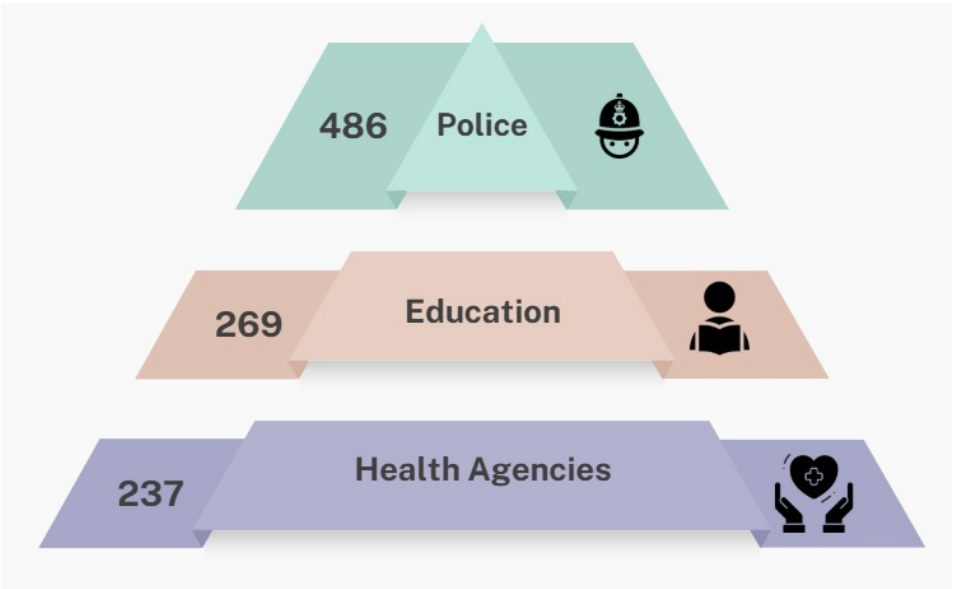
The peak in demand for adult safeguarding is likely to relate to the launch of the self-neglect strategy in Autumn 2023.



Children's Safeguarding

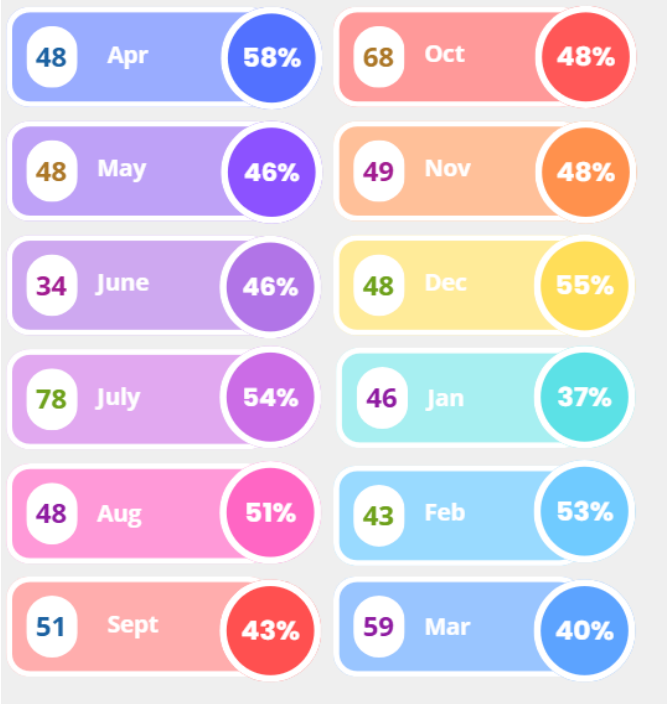


Referrals to Children's Safeguarding – Top Referring Agencies

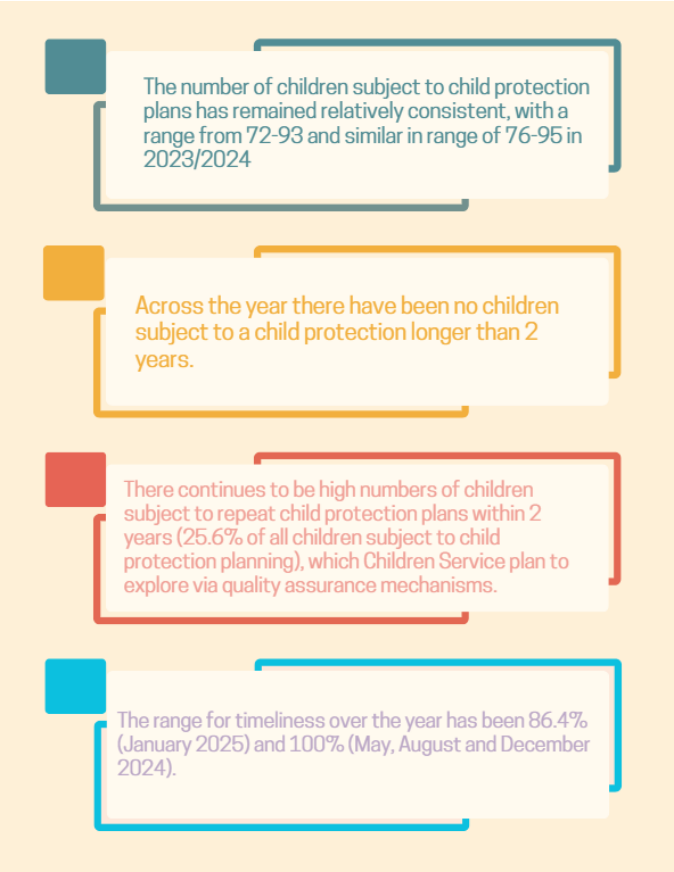


Re-referral rates

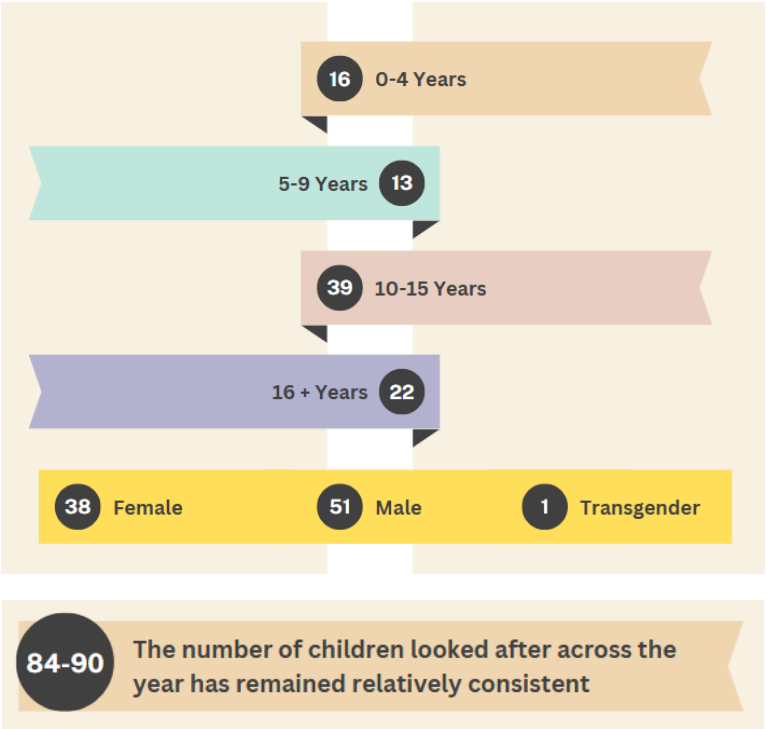
The number of re-referrals has remained higher than expected and above the UK national average. There had been several audits undertaken over the reporting period (monthly dip samples and a full audit of all re-referrals in November) which had not highlighted any significant themes or issues in regard to application of threshold. Therefore, Children's Services have invited the Safeguarding Board to undertake a multi-agency audit of a sample of re-referrals to provide independent findings and suggestions for practice improvement.



Child Protection Planning



Looked After Children



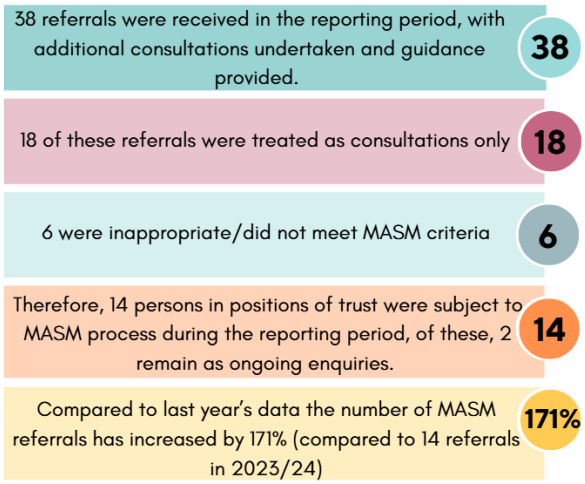
MASM – Managing Allegations against a person working with children & Vulnerable Adults protocol

The MASM protocol is a coordinated process following allegations made about professionals considered to be in a position of trust in settings / organisations providing services to children and vulnerable adults. It provides a framework for oversight of those robust multi-agency investigations of risk. This joint policy covering both adults and children has been in operation from February 2023 and is due to be reviewed in the coming year and any necessary revisions made.

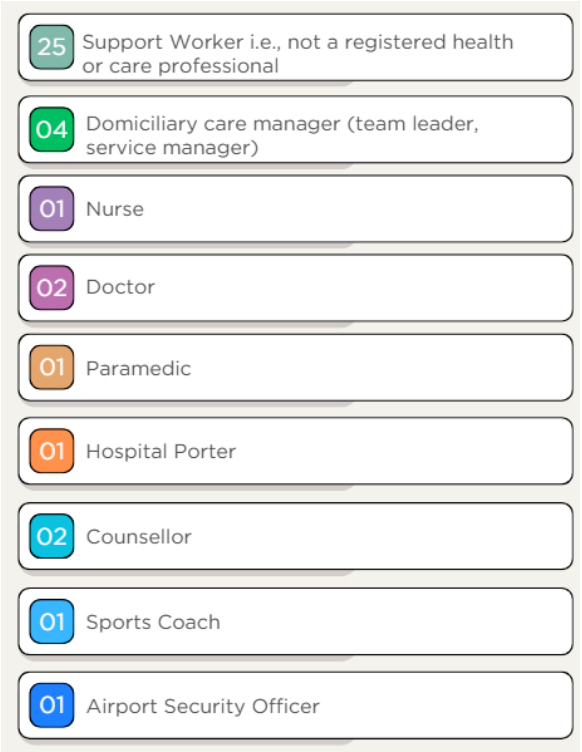
This mechanism is to ensure that all agencies are providing a safe service and explore all issues relating to conduct, risk and potential harm / abuse to children and vulnerable adults, which is led by Adults and Children's services and Designated Officers chair the process. The Safeguarding Board's dataset includes MASM activity to provide assurance regarding the management of allegations against people in a position of trust, following the findings and recommendations from the Knottfield enquiry into institutional abuse.

Adult MASM Referrals

ADULT MASM REFERRALS



Occupations of MASM referral subjects



Sources of referrals

3	Health or social care professional (social worker, psychologist etc).
11	Care Home Manager or Senior
14	Police
10	Domiciliary Care Manager or Senior
1	Other

MASM Outcomes

Substantiated	8
Unfounded	0
Malicious / Invented	0
Unsubstantiated	4
Not yet concluded	2

Substantiated MASM outcomes

4

4 referrals were received in regard to staff members in one residential setting which resulted in internal investigation and dismissal of 3 staff members. Most of the substantiated outcome cases were referred to Disclosure and Barring Service.

8

The eight cases with substantiated outcomes were in regard to a range of inappropriate conduct which includes physical abuse to care home resident, violent behaviour between staff members in work, significant medication errors, and inappropriate touching of a care home resident.

Children's MASM Referrals

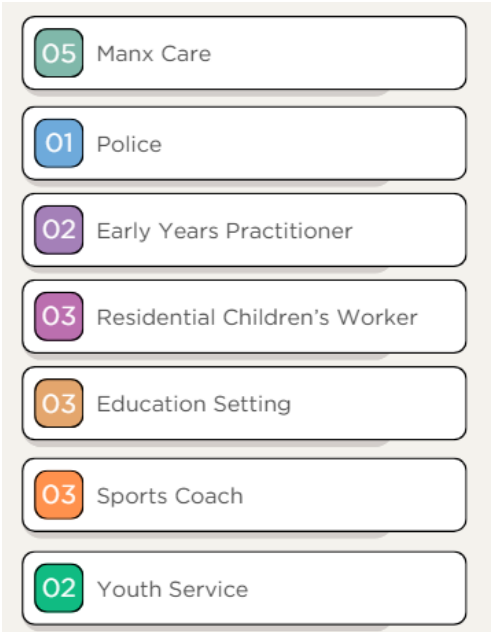
CHILDREN'S MASM REFERRALS

There have been 37 MASM referrals in the reporting period of April 2024 & March 2025, with additional consultations undertaken and guidance provided. **37**

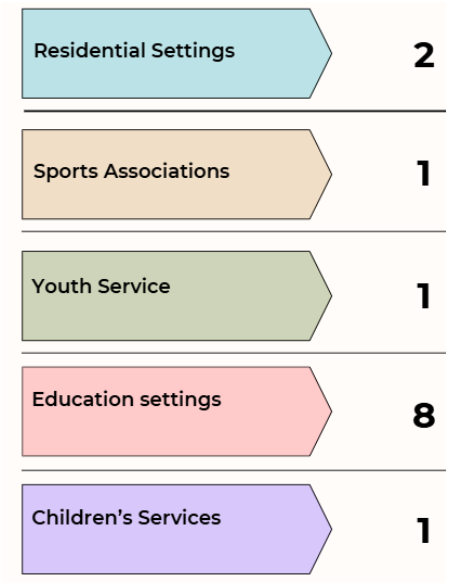
17 of these referrals were treated as consultations only, and an additional case was a joint learning review with LADO in Lancashire. **17**

19 professionals were therefore subject to MASM across the course of the year. Compared to last year's figures, the number of MASMs has been similar (23 in 2023-2024) however there has been a significant increase in the number of consultations. **19**

Occupations of MASM referral subjects



Sources of referrals



MASM Outcomes

Substantiated MASM outcomes:

The 10 cases with substantiated outcomes were in relation to being under the influence of alcohol, failure to hold appropriate professional boundaries with a child/young person or service user, arrested for aggressive behaviours and own children being subject to safeguarding procedures.

All the cases with substantiated outcomes were deemed appropriate to continue in a position of trust with children, subject to certain recommendations in regard to risk assessments, supervision, well-being support and in some cases additional training in regard to practice standards and maintaining appropriate professional boundaries.

Training Overview

Children's Level 1 - E-Learning

286 Members from Third Sector, Charities, Nurseries, and across the Private sector completed the e-learning module of child protection, recognising abuse and reporting concerns.

Adult's Level 1 - E-Learning

The majority of users (over 88%) are from Manx Care, others include Department of Education, Sport and Culture, Department of Home Affairs, Department of Health and Social Care and Treasury. **1,924**

Children's Safeguarding Level 2

7 Over the reporting period, successfully delivered 5 safeguarding children courses to over a 190+ delegates. Additionally, two half day refresher sessions were also offered

Adult's Safeguarding Level 2

4 Over the reporting period, successfully delivered 4 safeguarding adult courses to over a 100 delegates.

Other Level 2 training

3 The Board also ran an 'Essentials of Childhood Neglect', and Domestic Abuse courses at level 2

Level 3&4 Training

Level 3 training in Domestic Abuse, MASM, Core Groups & Child Protection Conferences, Self Neglect & Designated Safeguard Lead has also been delivered to delegates. Day 1 of safeguarding young people from risks outside the home was also successfully delivered.

Absenteeism Rate

5.8 % Our courses have been well attended to date and the absenteeism rate is 5.8% - factors such as illness & operational reasons were stated

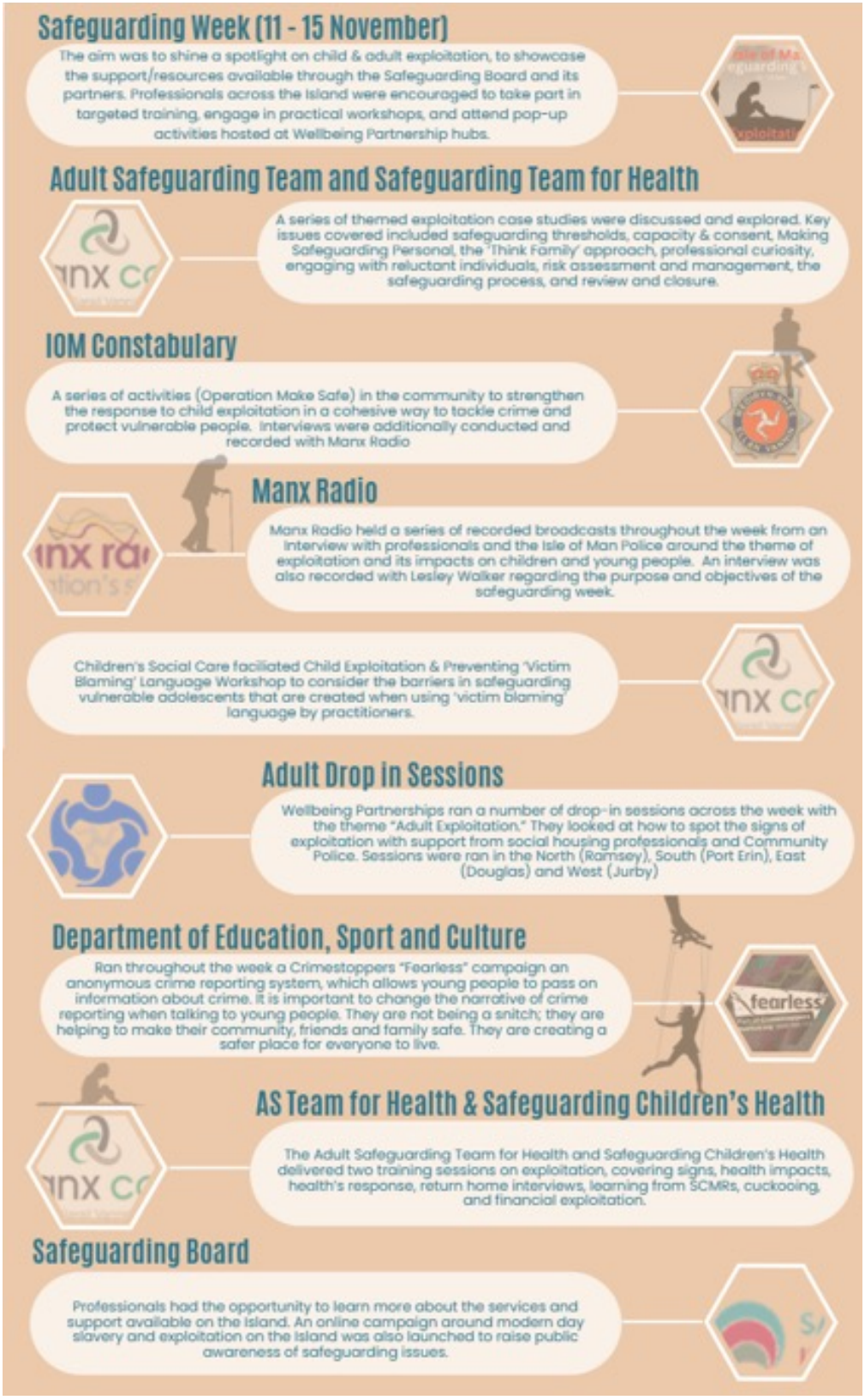
Session impact

89.7% 8.8% of respondants said that the session had a 'positive impact', and 89.7 % of respondants said that sessions were 'extremely positive'

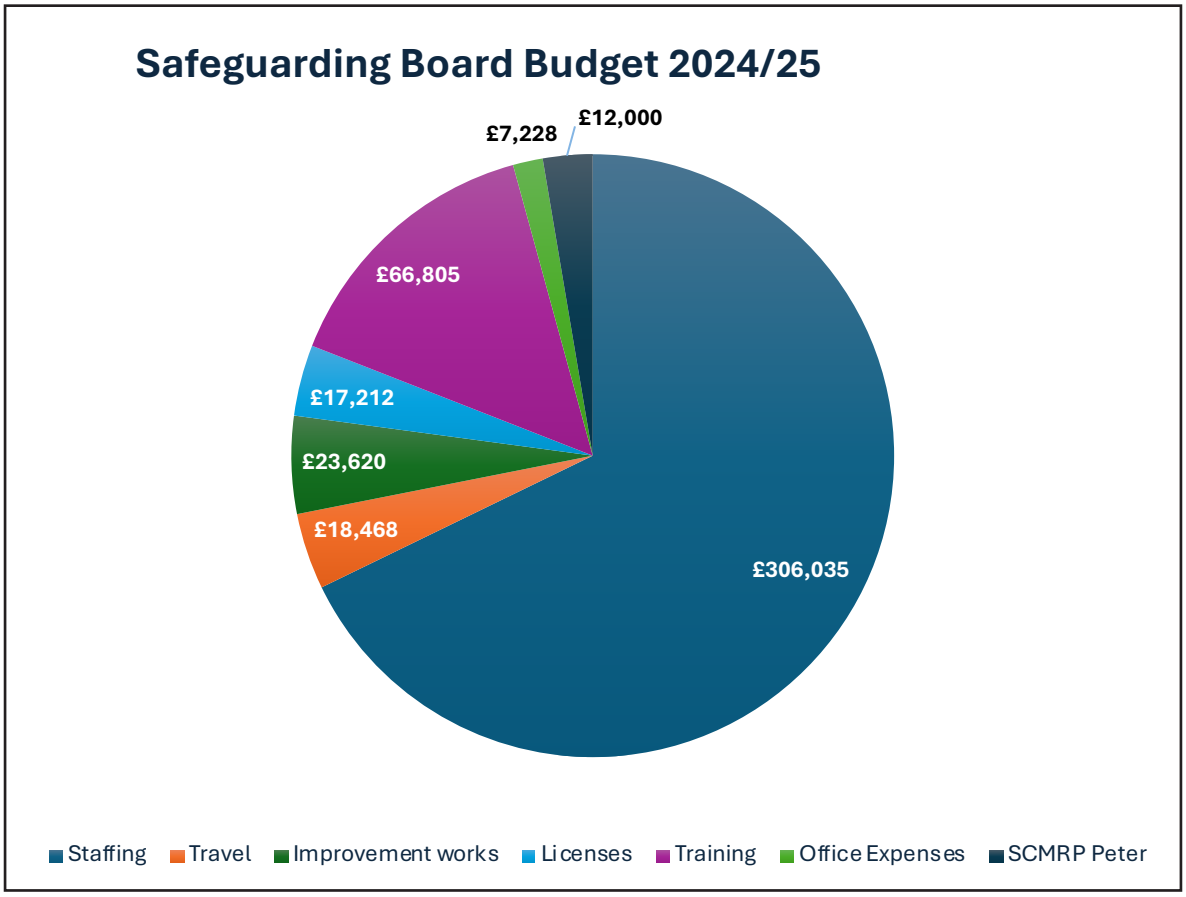
Attendance rate:

Attendance at training and workshops has continued to be high **91.3%**

Safeguarding Week – November 2024



Budget 2024 – 25



Future Plans

The focus of this year has been to progress work against the four new priorities, developing practice models and improving and evaluating service delivery.

It has also come with some challenges, in terms of Board member recruitment and staffing issues for the business team with the recruitment to the new Learning and Development Officer.

This recruitment of a new Learning and Development Officer is scheduled to complete in May 2025, and is an integral component for the small business team that supports the Board functions, and supporting the development work in the coming year:

1 **Implementation of the new Risk outside the Home process and pathway**

Risk outside of the home (child exploitation) is a complex and challenging area of safeguarding children and young people and requires practitioners to think about the places, spaces and faces associated with the child and their context using a contextual safeguarding approach. Following the Children's Scrutiny event in March 2024, partners have worked collaboratively to develop new ways of working and a joint process to manage and safeguard young people at risk of exploitation, which is aligned with existing safeguarding processes. The plan is to implement this process following Board approval in the next reporting period. The implementation will involve the introduction of the new working processes and a different approach to managing such a complex area of safeguarding, along with a bespoke training and mentoring programme. It is anticipated that this process will require additional resource across the partnership and growth bids will need to be made to ensure the successful implementation of this critical process.

2 **The development of the Neglect framework, pathway and assessment tools**

Neglect is one of the highest concerns referred into Children's Services and the majority of children subject to a Child Protection plan is due to concerns of neglect. Partner agencies will be collaborating in developing a multi-agency framework to strengthen a coordinated response to support families where there are concerns about child neglect. This work will be led by Professor Jan Horwath - a leading authority on child neglect, to ensure families are offered the right level of support at the earliest opportunity, and where necessary protective measures taken. This new framework will be launched during 2026.

3 **Extending the core training offer & other learning options. This will include further events to launch specific piece of work undertaken by partner agencies and the Board**

The core training and learning offer is developed annually based on a training needs analysis across partner agencies, identified learning from Serious Case Management Review and audit findings to support the knowledge of the multi-agency workforce and strengthen practice and service delivery. Thus supporting the dynamic practice development needs across partner agencies.

4 **Increase the engagement methods with partners, service users & their families to ensure an integrated approach to the business of the board. Therefore, being inclusive of views & shared ideas with partners across many sectors, and the citizens that they serve**

Therefore, being inclusive of views and ideas shared by partner agencies and service users across sectors to develop comprehensive approach to practice, policy and Board key messages to citizens. A variety of engagment initiatives will be developed during 2026.

5 **Take forward actions/ recommendations from SCMR Peter**

The completion of Serious Case Management review - Peter is scheduled to conclude in late spring and an action plan will need to be developed and progressed, including any additional training offered.

6 **Launch new elearning training platform**

The Board plan to develop bespoke multi-agency elearning courses for Level 1 & 2 adult and children safeguarding accessible through a leaming management system. This will extended leaming opportunities for all sectors / services, as training can be undertaken at the learners own pace and availability. This new leaming offer will be launched by early 2026.

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