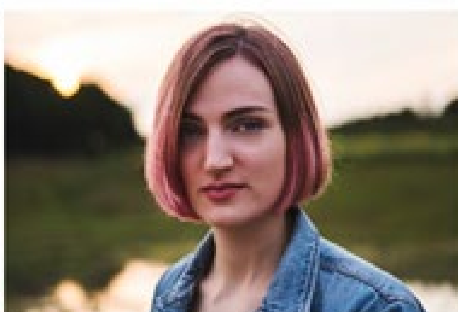
GD 2023/0004

SAFEGUARDING BOARD
ISLE OF MAN

Annual Report 2021-2022



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Independent Chair's Introduction

It is my pleasure to welcome you to the Isle of Man Safeguarding Board Annual Report for 2021/2022, which covers the performance for the year to the 31 March 2022. I was delighted to start in my role as the new Independent Chair in April 2021, albeit during a challenging time when borders were locked down due to COVID-19, and services were working hard to ensure they prioritised the needs of the most vulnerable children and adults. The members and agencies that make up the Board, were committed to ensuring that these challenges did not prevent them from thinking ahead, about the work they needed to do collectively to improve safeguarding practice on the Island. The Board used data, local intelligence, learning from reviews locally and nationally to help us develop the new two year business plan. This report explores the work that has been undertaken to ensure the Board is meeting its agreed priorities and statutory functions.

I am happy to say that there has been a huge commitment from all agencies to improve working relationships and work more collectively together. New work groups were set up and others streamlined, and you can read more about how the work is delivered on pages6-10. My first priority was to ensure there was greater clarity about the importance of sharing information to safeguard all citizens. All agencies supported the production of a new Information Sharing Protocol, Guidance and Myth busting Leaflet which are available on the website. Ensuring the Safeguarding Board had a functioning website to provide useful information for children and young people, families and carers, professionals and the voluntary and community sector was also key. This went live in February 2022 and I would encourage you to access it on an ongoing basis, as we update it and make it more accessible www.safeguardingboard.im .

The Board agencies are collectively working hard, to ensure there is an up to date set of both adults and children's policies and procedures. This has taken considerable work and commitment from front line practitioners, managers and the Board business support team and I am grateful for all the work these individuals and their agencies have undertaken to date. The updated policies are available via the website and are uploaded as they are completed and signed off. This important work will be completed later in 2022. I would encourage all agencies and sectors to access these, as it is important the advice, guidance and direction they provide is adhered to, in order to ensure all Isle of Man citizens are appropriately safeguarded from abuse and neglect.

This year the Safeguarding Board also published the Child J Serious Case Management Review (SCMR), which highlighted important improvements required by all agencies in their work with vulnerable adolescents. Our Vulnerable Adolescent Working Group has taken on board the recommendations as part of their workplan and are working to develop new more joined up ways of working, to ensure local young people are protected from abuse and harm outside the family home. A new Vulnerable Adolescent Strategy will be ready for launch in the next few months via an all Island Conference. New ways of working to identify and protect young people at risk from exploitation have been developed and a new working protocol is being drafted that outlines how agencies will work effectively together.

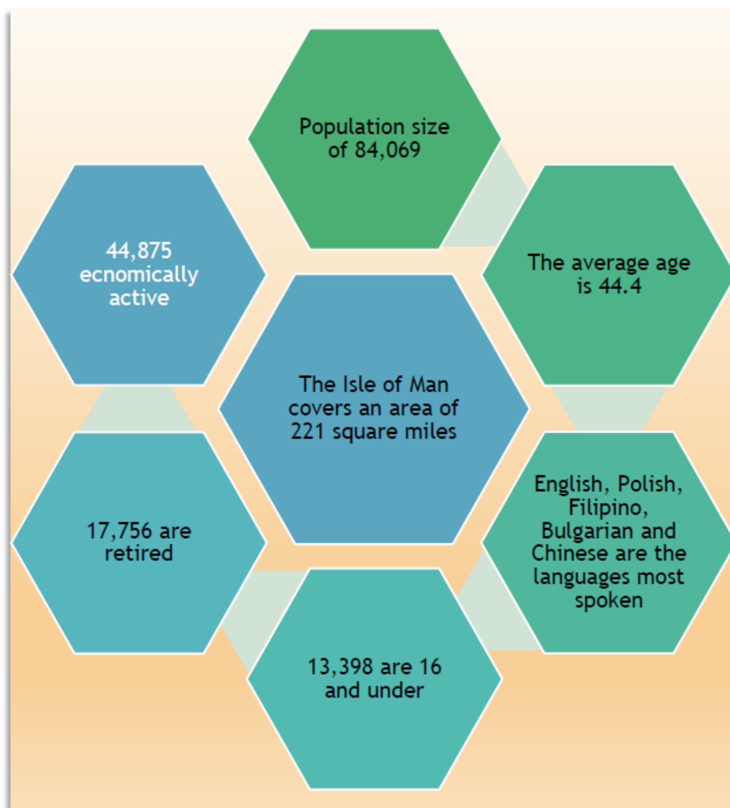
The new Adults' Quality, Training and Development Group is working to improve how we safeguard vulnerable adults and equip staff in all agencies to identify and respond to prevent abuse and neglect. A Thematic Review of Self-Neglect is currently reviewing how agencies work with self-neglect and will provide valuable learning about how to work with vulnerable adults that are

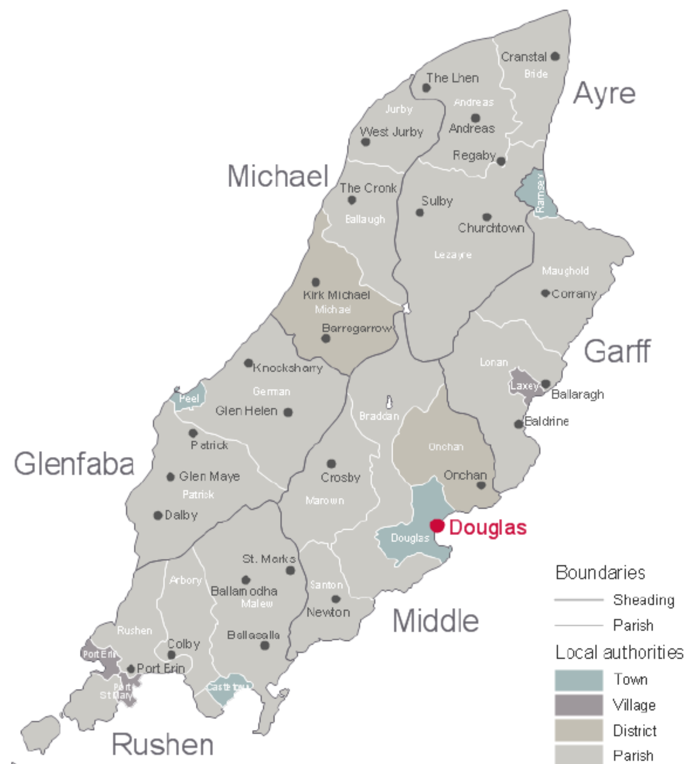
neglecting themselves. This review will be published later in 2022. Another Serious Case Management Review (SCMR) that focussed on potential learning from a domestic homicide, will also be published later in 2022 when criminal processes are completed.

Finally, it is important to reflect that there is more work to do to help communities, sectors and agencies work together and embed the understanding that **safeguarding is everyone's responsibility**." Moreover, there is still significant work to do to provide assurance that safeguarding practice is as effective as it can be. The Board has recognised that we need to improve how we evaluate partnership work and the impact it is having on practice and outcomes for children and vulnerable adults. The Board have been working hard to collate data and agree a new quality assurance framework that will achieve this. This will allow a much greater focus in the next annual report, both on assurance and the impact on the Board's work.

Ms Lesley Walker
Independent Chair

The Isle of Man Context Relevant to Safeguarding[1],





The Safeguarding Board

The Safeguarding Board, which covers the safeguarding of both children and vulnerable adults, was established under the Safeguarding Act 2018. The Act introduced:

- a statutory duty for those working with children and vulnerable adults to 'consciously consider the need to safeguard children and vulnerable adults' when carrying out their work; and
- a duty for partners to co-operate with each other when carrying out safeguarding functions.

The functions of the Safeguarding Board, are:

- To co-ordinate the work of organisations to safeguarding and promote the welfare of children and safeguard and protect vulnerable adults
- To ensure the effectiveness of work done by each of those organisations.

The statutory members of the Safeguarding Board are:

[1] https://www.gov.im/media/1375604/2021-01-27-census-report-part-i-final-2.pdf

- An Independent Chair:
- The Chief Officers of the following Departments:
    - Health and Social Care*;
    - Education, Sports and Culture; and
    - Home Affairs.

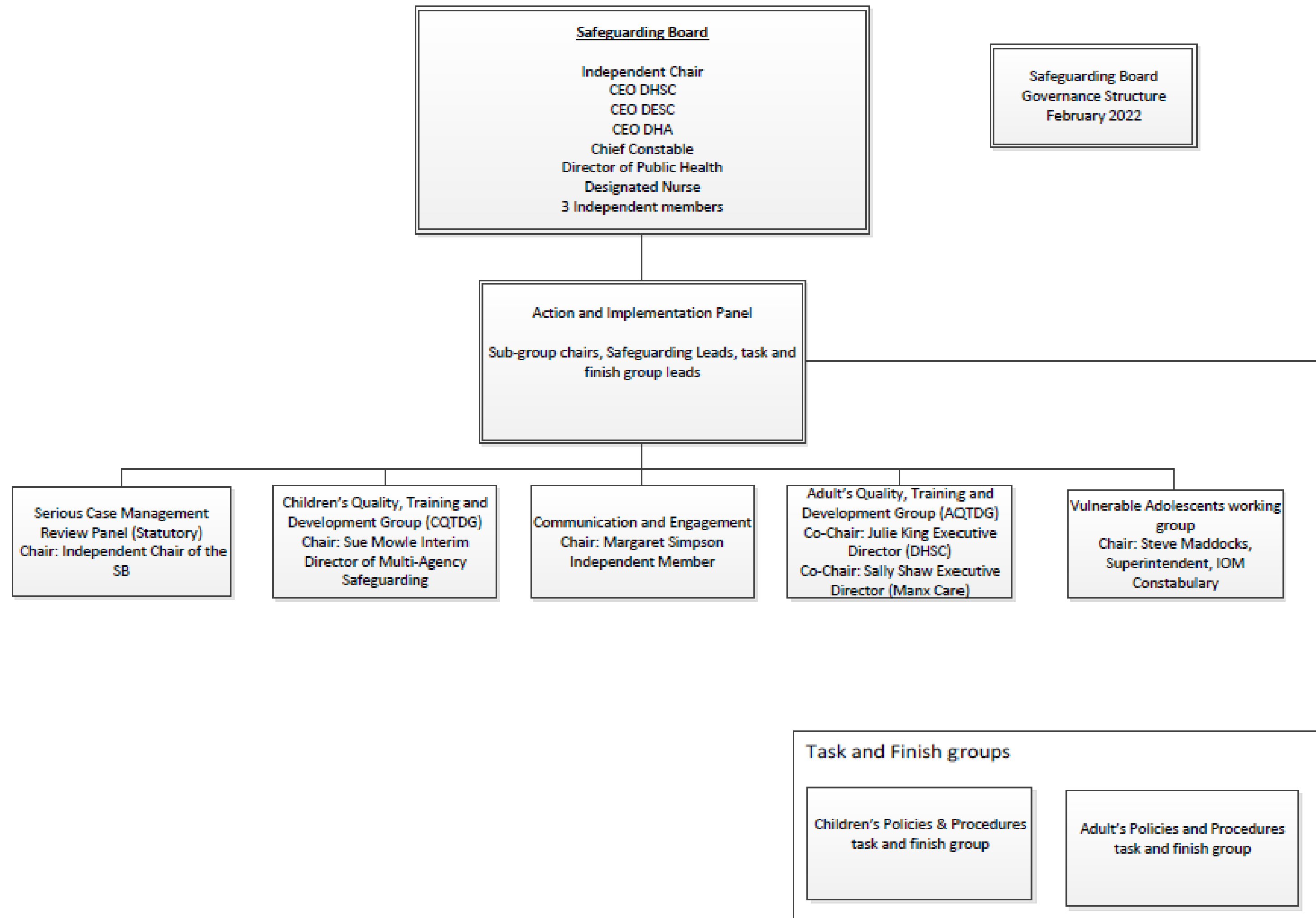
    *The Chief Officer of Manx Care has been co-opted onto the Board whilst a legislative change is made.

- The Chief Constable;
- The Director of Public Health
- The Designated Nurse; and
- Three Independent Members make up the rest of the Board.

The Board is resourced and supported by the Cabinet Office.

The work of the Board is delivered by the statutory Action and Implementation Panel, the statutory Serious Case Management Review Panel, three sub-groups and three task and finish groups. (See current structure chart.)

Structure of the Safeguarding Board



The Board increased the frequency of meetings to six times a year in early 2022 to ensure increased capacity to drive and oversee the agreed business priorities and necessary safeguarding improvements. There has been full attendance by all partners. Manx Care has been co-opted onto the Board whilst a legislative change occurs to make the CEO a Statutory Board Member:

Attendance of Statutory Board members or their representative at Board Meeting 01 April 2021 - 31 March 2022										
	Chair	DESC	DHA	DHSC	Constabulary	Public Health	Member 1 *	Member 2 *	Member 3 *	Manx Care**
Jun-21	√	√	√	√	√	√	√	√	√	
Sep-21	√	√	√	√	√	√	√	√	√	
Dec-21	√	√	√	√	√	√	√	√	√	√
Feb-22	√	√	√	√	√	√	√	√	√	√
*For information these three members are the Independent Members as appointed by the Chief Secretary										
** Manx Care as a provider of health and care services has been co-opted onto the Board.										

Priorities

The Safeguarding Board agreed two key practice priorities and three overarching priorities in the new Business Plan for 2021-2023.

The main practice priorities are:

1. Working together to effectively safeguard vulnerable adolescents

2. Ensuring an effective multi-agency safeguarding response for vulnerable adults

The overarching priorities are:

3. Strong leadership and effective, well-functioning structures and subgroups that improve outcomes and have a measurable impact

4. A workforce equipped and fit for purpose to deliver effective safeguarding practice

5. An effective communication and engagement strategy

Shared principles that underpin our key priorities:

- Person Centred Practice - the Board will ensure that children and young people and adults have opportunities to participate and collaborate in the work of the Board and that their voice is embedded in multi-agency practice.

- High support high challenge - the Board will promote a culture of high support and high challenge to develop working environments where growth and learning is accelerated.

- Promoting Practice leadership - the Board will involve front line practitioners and managers in the continuous learning process in a supportive and challenging way, in order to build practice leadership capacity across the Board.

- Promoting a culture of continuous learning - the Board will create the environment for learning, recognising the way systems influence each other and the benefits of working together rather than in individual agencies. We will ensure that we learn from best practice, case reviews and multi-agency audits, including the monitoring of the implementation of recommendations.

The first practice priority focusses on ensuring an effective multi-agency safeguarding response for vulnerable adults and is driven forward by the Adults Quality, Training and Development (AQTD) Sub-Group. A detailed workplan is owned by the co-chairs of this group, who are the Executive Director of Social Care Manx Care and the Executive Director of Quality, Safety and Engagement DHSC. The report from the chairs is detailed later in this report.

The second practice priority focusses on effectively safeguarding vulnerable adolescents and this is owned by the Vulnerable Adolescent Working Group, which is chaired by the IOM Constabulary Superintendent. Again a very detailed workplan exists for this group, who are also responsible for ensuring the actions from the review into Child J are also addressed within the agreed timescales. A report from the chair of this group on progress is highlighted later in this report.

What has been achieved - Overview

Achievements against the Business Plan Objectives

Practice Priorities

1. **Ensuring an effective multi-agency safeguarding response for vulnerable adolescents**

The Vulnerable Adolescents working group has taken responsibility for this priority and is focussed on ensuring an effective multi agency response to young people who may be at risk of harm outside the family home, especially through criminal or sexual exploitation. It has brought agencies together to focus on "Contextual Safeguarding"; that is understanding and responding to young people's experiences of significant harm beyond their families and recognising that the relationships they form in their neighbourhoods, schools and online can feature violence and abuse.

The publication of a Serious Case Management Review this year, looking at the circumstances of "Child J", a young person who almost died on the island due to an accidental overdose of drugs; reinforced the need for more effective joined up multi-agency work to identify young people at risk of exploitation, to assess the risk and to put in place a responsive and robust plan to reduce these risks. The learning and recommendations from that review are being addressed by this group and include work on a Vulnerable Adolescent Strategy and new ways of working that will better protect children and young people from extra-familial harm.

The group's key priorities for 2021-22:

- To ensure effective multi-agency information sharing, identification, assessment and response to children and young people who are at risk of exploitation.
- To offer oversight and review to the risk assessment and effectiveness of planning for children and young people that are known to be at risk of or experiencing exploitation.
- Develop and enhance multi-agency co-operation to safeguard vulnerable adolescents.
- Produce multi-agency working protocols and toolkits.
- Set up multi-agency daily, weekly and monthly exploitation meetings to protect vulnerable children and young people.

Key achievements to date:

- Improved working relationships and a shared culture and ethos about how best to protect young adolescents.
- A new Working Protocol developed that outlines new processes and ways of working together, including new daily exploitation meetings and improved information sharing.
- With support from Barnet Children's Services developed and modified their CEAM risk assessment tool for the Isle of Man context to improve the assessment of risk

- Data protection and GDPR protocols developed and agreed.

- Work on an overall Vulnerable Adolescent Strategy to raise awareness to accompany the launch of the new protocol, tools and new ways of working

- Adopted the SAFEGUARD mnemonic to be used by professionals to help them frame their concerns about a young person and also structure their assessment of risk

This group have worked particularly hard to develop new ways of working that will enhance the protection of young people in the Isle of Man. The next stage of the work will be to get the daily exploitation meetings fully operationalised and staff using the new risk assessment tools. The group then plan to develop an overarching Vulnerable Adolescent Strategy and organise a launch event to publicise the new ways of working. The group will also be engaged in developing new policies and procedures to compliment the working protocol and will oversee the commissioning of relevant and appropriate training to increase staff's confidence in working with exploitation and understanding contextual safeguarding.

2. Ensuring an effective multi-agency safeguarding response for vulnerable adults

This priority is owned by the Adults' Quality Training and Development (AQTD) group, whose role is to ensure that multi-agency safeguarding practice is effective and appropriately safeguarding vulnerable adults. The context for adult safeguarding in the Isle of Man is complicated by the lack of key legislation that would help support practitioners, such as mental capacity legislation and the principles enshrined in English legislation such as the Care Act 2014. That legislation and associated guidance set out the requirements for adult safeguarding practice to be person led and outcome focussed and the Commission for Social Care Inspection had reflected that before the Care Act in England and Wales, that the legal framework for adult protection was neither systematic nor co-ordinated. To ensure progress, the Isle of Man Safeguarding Board agencies have agreed to adopt the principles as good practice locally, and are committed to developing a Making Safeguarding Personal culture. These principles have been worked into the new multi-agency adults safeguarding policies and procedures. Moreover, the Department for Health and Social Care are leading the introduction of Capacity Legislation via the Capacity Bill and this will put assessment of Capacity on a legal and consistent footing based on the Making Safeguarding Personal principles.

The Board commissioned an independent evaluation of Adult Safeguarding Practice in 2020 and the Sylman Report recommendations make up a key part of the AQTD work plan. The group have focussed on evaluating the current Level One safeguarding training and on producing a competency framework, to assist in providing clarity about the level of training required by different staff groups. This will be used to ensure a comprehensive multi-agency training programme focussed on a robust training needs analysis. The group have also collated assurance from the key agencies in relation to basic safeguarding practice and this will be tested using the Board's new Quality Assurance and Scrutiny Framework due to be completed later in 2022. The group are working hard to develop a performance dataset that will provide them with important quantitative information to help evaluate whether vulnerable adults are being appropriately safeguarded.

Overall, this group has recognised there is still significant work to do to improve adult safeguarding practice locally and recognise the need to work at pace next year to achieve the agreed priorities in the Board business plan. This year's work has been significantly impacted by the sheer volume of

operational work for practitioners, and continued pressure on health and social care services from the COVID-19 pandemic. The group has also had challenges due to staff changes and availability, appropriate expertise and the need to rightly prioritise the development of a set of multi-agency policies and procedures to guide staff practice. The group are committed to move forward and also recognise that they will need to oversee the key improvement work likely to arise from the Thematic Review of Self Neglect cases, as outlined in the Serious Case Management Review Section of this report.

Overarching Priorities

3. **Strong leadership and effective, well-functioning structures and subgroups that improve outcomes and have a measurable impact**

A review by the new Independent Chair on progress against the previous business plan and the Boards statutory functions highlighted that, significant work was required on a number of key areas. The Boards business support teams lack of capacity and expertise, a lack of agency leadership and drive of key pieces of work, alongside the impact of COVID-19, had led to a lack of progress on key work. A new business plan was drawn up to ensure focus on the key priority areas and a number of previous sub-groups were merged to provide an Adults' Quality, Training and Development sub-group and a separate Children's Quality, Training and Development sub-group. New senior chairs from each of the agencies stepped forward to provide important leadership.

To support delivery, new role descriptors for chairs and sub-group members were disseminated and published to ensure responsibilities were clear. New impact reporting templates were also drawn up to ensure consistency of assurance from the chairs, and these are presented to the Action and Implementation Group before being scrutinised by the Board. Chairs are required to present to the Board on progress and to identify any barriers to progress. In addition, AIP and the Board receive updates at each meeting on agencies attendance at sub-group meetings.

In order to ensure that agencies in the Isle of Man are working collectively to appropriately safeguard children and vulnerable adults, agencies have recognised the need to improve assurance about the quality of single agency and multi-agency practice. The Board have facilitated a workshop in March 2022 to support agencies to develop or improve their own quality assurance mechanisms, including practice audits and use of performance data. This workshop was the first stage in developing a new multi-agency Quality Assurance and Scrutiny Framework, which will provide Board members with regular assurance about practice and will help identify good practice and any necessary practice improvements. The new framework will be developed over the next few months over a series of workshops and will also include new adults and children's datasets that will provide the Board with much needed performance data, to assist in judging the effectiveness of current safeguarding practice. Ultimately, this new framework will allow the Board to more effectively measure the impact of their collective work to improve safeguarding practice, and will inform next year's annual report.

There have been a number of challenges over recent years in relation to effective multi-agency safeguarding practice in the Isle of Man. New leaders have brought fresh eyes and a renewed commitment to collective working. The strength of this can be seen in key pieces of work, such as the work of the vulnerable adolescent group and a local commitment to develop a Multi- Agency

Safeguarding Hub, which will bring agencies together to improve information sharing and ensure more effective joint working. The Board and AIP members have been working collectively to develop the high support, high challenge culture required for effective multi-agency work. Planned development work with Board members has been delayed due to changes in leadership but this will be reviewed moving forward.

In order to support multi-agency work to strengthen practice, it was also recognised that additional capacity and input was necessary to facilitate the delivery of key work. Consultancy support was agreed to progress work on policies and procedures, information sharing guidance and work to improve practice with vulnerable adolescents. The Department for Education and Skills (DESC) also agreed to provide a secondment of an experienced Director in Education for six months to the role of Director of Multi-Agency Safeguarding, whilst options were explored to obtain additional finance to facilitate permanent recruitment into this role. This role would provide much needed drive, oversight and support for the Board's work and would help facilitate a review of the team.

4. A workforce equipped and fit for purpose to deliver effective safeguarding practice

One of the greatest barriers to effective safeguarding practice on the island, has been the lack of clarity about when information can be appropriately shared. Poor information sharing or a refusal to share information due to a misunderstanding about safeguarding duties, is a national issue and has been the consistent learning arising in Serious Case Management Reviews locally and in Domestic Homicide Reviews, Serious Case Reviews and Safeguarding Adult Reviews in the UK. In order to support the workforce to improve practice in this area, the Board has developed an Information Sharing Protocol that reinforces the commitment and imperative that information is shared across agencies and sectors. This has been signed by the Chief Executives of all the key agencies and the Chief Constable. In addition, practitioners, managers and information sharing leads from those agencies have worked together to develop Information Sharing Guidance that provides advice and guidance to staff by using practice examples. A Myth Busting Leaflet was also developed at the request of practitioners, as a quick read guide to support staff to improve information sharing. The Protocol, Guidance and leaflet were disseminated widely across all agencies in March 2022 and are available on the Safeguarding Board Website. The impact of these tools will be tested via a workforce questionnaire and through the new Quality Assurance and Scrutiny Framework once complete. An information sharing video is also planned to reinforce the key messages.

To ensure the workforce is fully equipped to deliver effective practice in line with the Boards' statutory functions, the Adults and Children's Quality Training and Development (AQTD and CQTD) sub-groups have focussed on producing a competency framework, to assist in providing clarity about the level of training required by different staff groups. This will be used to ensure a comprehensive multi-agency training programme focussed on a robust training needs analysis. The CQTD have signed off their competency framework following a series of workshops and has reviewed the current online Level One children's safeguarding training to ensure it is fit for purpose. There is significantly more work to do in the AQTD sub-group, as this group has had particular challenges with consistent membership due to changing personnel and capacity. Also the time staff had available was focussed on work on the adults' policies and procedures. Therefore much of the

work in their workplan will continue into the new financial year and additional support will be provided to the group to ensure delivery of its key objectives.

Training has been limited due to the pandemic, however some courses have been offered. During the year training has been delivered to 510 people in a classroom based environment from Level 1 to Level 3 courses and 4,186 across the two e-learning packages. To improve the multi-agency training offer, the Training Officer post currently situated within LEaD will return to be part of the Board business support team. This will ensure that training is appropriately commissioned and allows local learning to be disseminated in a more timely way. The role will also be widened to include learning from reviews. The post will also provide some much needed capacity over time, to improve communication about the Boards' work through regular newsletters, learning briefs and events. This post will be recruited after March 2022 following the retirement of the previous dedicated training officer. The board business team will also collate data and evidence to provide assurance about the numbers of staff trained and the impact of training on practice.

To ensure effective multi-agency safeguarding practice, it is imperative that staff, managers and all organisations have access to good quality policies and procedures that guide their practice. These need to be based on best practice, whilst taking account of the local context and legislation. Any multi-agency policies that existed in the Isle of Man were out of date and there were significant gaps, particularly in relation to adult safeguarding. After highlighting the risks involved, additional financial support was made available to provide effective leadership of both a children's and adults' policy and procedures groups. An independent social worker with previous experience of working in the Isle of Man was commissioned to chair the Children's Policies and Procedures Working Group and with the input and support of professionals in the group, made significant progress on updating the children's procedures. At the end of March 2022 twenty three procedures had been updated. Due to the significant progress on the children's procedures, the chair has now taken on chairship of the Adult Policy and Procedure group who are now making good progress on developing a set of multi-agency procedures.

5. An effective communication and engagement strategy

As with the other sub-groups, this group has been renamed as the Communication and Engagement Group. COVID-19 has affected the progress of this group this year. The group has reviewed its terms of reference and drafted a workplan. It has also reviewed its membership to ensure that the relevant agencies are represented. Due to the need to improve communication to assist in recognising and addressing safeguarding issues locally, the Board wanted to ensure a direct line to the Safeguarding Board itself. One of the Boards' independent members agreed to chair the group. The link to the Third Sector is vital and so to retain this link, the vice-chair of the Charity and Voluntary Organisation has agreed to remain as the vice-chair of the group.

Work has started to draft a communication strategy and a separate engagement strategy which will be published by 31 March 2023. A report of the work to improve service user involvement and to ensure their voices are heard will be covered in the next annual report.

Serious Case Management Reviews

The Safeguarding Board is required to undertake Serious Case Management Reviews (SCMRs) in cases where a child or vulnerable adult may have died or suffered serious harm, and abuse or neglect are known or suspected; and there are concerns about how agencies may have worked together. The purpose is to identify any necessary learning and use this to improve practice. The Serious Case Management Review Panel chaired by the Independent Chair of the Board, is responsible for deciding whether a case meets the criteria for a SCMR, for commissioning an independent author to undertake the review and for ensuring that the review addresses the terms of reference for the review. The SCMR Panel are also responsible for overseeing the publication of the SCMR where appropriate and ensuring that an action plan is in place to address the recommendations. They also hold a scrutiny and oversight role to establish that recommendations have been actioned and implemented.

The Board concluded and published a review into the circumstances of "Child J", a young person who almost died on the island due to an accidental overdose of drugs. The report can be found on the Safeguarding Board website here and as stated earlier in this report, significant work has been undertaken by the Vulnerable Adolescent Working Group to address the learning and recommendations arising from this review. This review alongside work already agreed in the business plan will lead to significant improvements to practice with young people at risk of exploitation locally.

The SCMR Panel also agreed that an SCMR should be undertaken to review the circumstances that led to a domestic homicide involving the mother of a young adult. The review know as Family K is ongoing and learning will be published once criminal processes linked to the homicide are concluded.

Previously, there had been a number of referrals to the SCMRP and to the previous Independent Chair, relating to adults who had died where self-neglect was considered to be a factor in their lives. Although, these cases did not meet the criteria for an SCMR, the panel agreed there was valuable learning and commissioned an independent author to undertake a reflective review into this cluster of cases. However, following another referral involving the death of a vulnerable adult known as Mr M, where self-neglect was a significant factor in his death and concerns were noted about how agencies worked together to safeguard him, the panel decided to commission a Thematic Review of Self-Neglect. This would involve a full SCMR of Mr M's circumstances as the lead review case and include the cluster of cases already identified. This was seen as the most effective way to consolidate the learning and support improvements to practice. This Thematic Review will be completed and published later in 2022.

In addition to oversight of ongoing SCMRs, publication of Child J and consideration of new referrals the panel have also reviewed progress against the recommendations of all reviews since the Safeguarding Board became a statutory body in 2018. A renewed focus on ensuring the recommendations have been fully implemented has been agreed and this is now an item on every meeting, with agencies required to provide evidence of the changes made. The panel intend to use the Boards' new Quality Assurance and Scrutiny Framework due to be completed in 2022, to begin to evaluate the impact of this learning on practice and whether this is improving outcomes for children, young people and vulnerable adults.

Independent Members' Assurance

In our view the Safeguarding Board made good progress during 2021/22. We are pleased to note that the long awaited new Safeguarding Website is up and running. It is still work in progress but a lot of good, up to date information can be now easily accessed. It is heartening to see that the information sharing guidance is now available and majority of children's policies and procedures have now been completed and uploaded on the website.

The progress on updating adults' policies and procedures has not been as timely as planned and a training programme being delivered is being worked on,

Serious Case Management Reviews reports have provided much needed learning and action plans are in place to ensure that their recommendations are put in practice.

A lot of work still needs to be done but the independent members are confident that further progress will be made in the current reporting year.

Safeguarding in the Isle of Man

Within the following section are short reports that cover the contributions of partners to safeguarding children and adults.

Manx Care

The impact of the COVID-19 pandemic and the challenges it has brought to safeguarding practice continued to present significant demands during the reporting period, notably around exploitation of vulnerable young people by criminal elements. The impact of staff absences and adapting to distanced, remote ways of working, both in practice and with partners and stakeholders, has also continued to be felt. The absence of legislation around mental capacity, neglect and lawful deprivation of liberty continues to present challenges. It is hoped that as we move towards an endemic approach to COVID-19 that recommencing training, continuing policy development and working together in a co-located safeguarding hub are improvements that can be made during the forthcoming year.

Children & Families (C&F)

Given the period of time for reporting includes a time when COVID-19 restrictions were in place. The work of C&F had to reflect this and working arrangements had to change to meet the needs of the staff, service users and Government guidelines. With this in mind C&F focussed particularly on developing information sharing, initiatives and interventions around criminal exploitation. This issue had increased significantly over this time frame, and there were no particular mechanisms for managing, monitoring or disrupting these behaviours. All agencies were aware of the lack of provision in this area and the challenges that this would bring.

Since August 2020, 48 children and young people have been identified as being at risk of or on the periphery of criminal exploitation. Of the 48 young people, 26 were identified as requiring the completion of an exploitation screening tool. 11 of these were as part of a Children & Young

Persons Act 2001 section 46 investigation. Through this process, 16 young people are considered as being at medium to high risk of exploitation.

As a result of these concerns and the emergence of these issues, a series of complex abuse meetings were convened. The meetings were convened under the complex abuse umbrella to enable the services to share and gather information in relation to the young people and adults that were involved in the criminal exploitation arena. The meetings were operational to gather the information and intelligence around young people and adults and strategic, to look at the issue from a wider perspective and to look at any additional measures that need to be taken.

These meetings were premised on the basis that there is a level of coordination from an individual or individuals to abuse or exploit groups of children/young people and in part assist in mapping out who we need to be concerned about both from a "victim" and perpetrator perspective.

Key achievements and initiatives:

The complex abuse process was initiated and being managed through 6-weekly multi- agency operational meetings and quarterly strategic meetings. An exploitation screening tool was developed and was being used by agencies where exploitation was a concern. Where appropriate this screening tool was accompanying a Multi-Agency Referral Form (MARF) into C&F Social Care, or Adult Safeguarding if concerns related to a vulnerable adult. The operational meetings were aimed at sharing information on young people at risk and about adults connected, to risk assess and to identify targets for support or who may require disruption processes. This did result in some further ongoing police investigations targeting those who may be exploiting.

Evidence of impact/likely impact on practice/service user outcomes:

As a direct result of the work completed at the operational meetings by key partners there has been development of initiatives and interventions, this is still work in progress, and is being developed. The multi-agency working and cooperation in this arena has developed and has proven to be very successful. Police colleagues began and continue to disrupt behaviours by visiting potential exploiters that had been identified in the meetings and issuing warnings. There was a method of passing on intelligence to police colleagues that would ensue that it was picked up and actioned. C&F identified a need for interventions and released a member of staff on a pilot scheme to complete this work with our most vulnerable young people. Education and health colleagues were instrumental in sharing information and supporting the meeting.

As a direct result of the sign up to this for all agencies and the individual agency work, this has resulted in hotspots for exploiters being identified and activities interrupted or disrupted. It was always understood that this was a short term initiative and that next steps would need to be planned and actioned across all services, with multi agency cooperation, input and interventions.

Referrals to Early Help and Support

Referral numbers fluctuate month to month. The expected range is 21-25 per month; the range has been 0 – 43. The last quarter saw more consistent referral figures (28 in January 2022, 29 in February). School holidays impact referrals, with schools being the main referrer to the service. It

is thought there has been an impact of COVID on referrals and it is anticipated this will settle over the coming year.

Referrals into Children and Families

The average anticipated target range for referrals to children and families is 78 per month. This has fluctuated across the year but has seen an overall decrease to be in line with the target. Some issues were identified around threshold relating to referrals from agencies that would have been better served in early help. Further discussions have taken place with individual agencies and workshops have taken place with health and education colleagues around appropriate referrals and threshold. Audits of referrals into the service took place in November/December 2021 to further assure that the threshold issue was not one within the initial response team in children's services, and to consider the effectiveness of the multi-agency discussions and workshops regarding referral routes and thresholds

The number of re-referrals into the service have been reducing over quarter two and three. The monthly rate in this area has been inconsistent and still remains outside of target range but is now going in the right direction. In quarter four, around 30% of referrals were re-referrals.

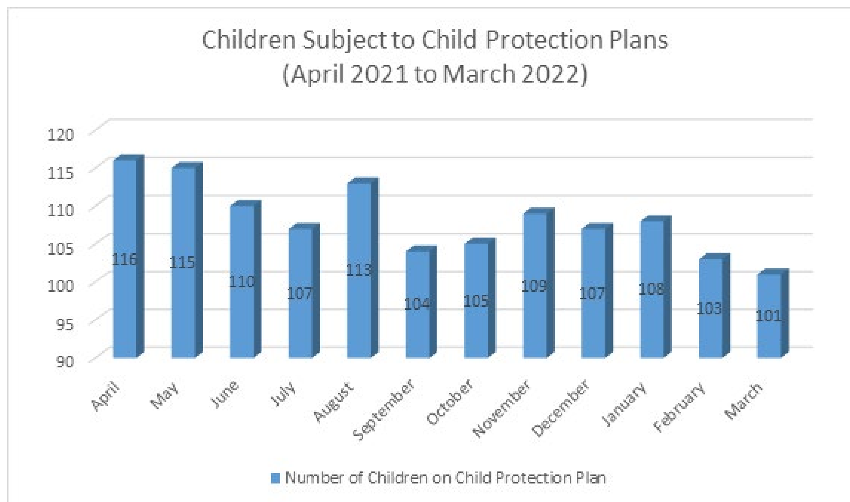
A multi-agency audit is currently underway in respect of threshold regarding referrals, quality of information provided within Multi-Agency Referral Forms (MARFs) and re-referrals to identify any thematic issues in respect of these..

Assessments

The number of assessment completed in timescale has been inconsistent, this has been due to factors around COVID-19, which include both family and staff availability due to illness, which has impacted on social workers ability to actually visit families, see children and complete assessments. Percentage of assessments completed on time increased over quarter two and three between 80 to 85% for Children with Complex Needs (CWCN) assessments and 89% of S46 assessments. This has decreased again over quarter four whereby the significant spike in COVID cases following the festive period has impacted across the service as a whole due to staff and family sickness and availability.

Child protection planning

The number of children subject to child protection plans have ranged during the last year between 116 (April 2021) to 101 (March 2022).



COVID-19 and the restrictions had an impact on capacity, given the high number of conferences during this time, which reduced the timeliness of conferences being held. Delays were always kept short however and the reasons examined and reported on monthly by the Senior Independent Reviewing Officer (SIRO) to senior management in Manx Care.

Participation of families at conference has been consistently good and a conference will only proceed without a parent/carer present in exceptional circumstances; everything will be done to accommodate parent's attendance.

Children's contribution to conference has remained consistently good with the role of the Children's Rights Champion (CRC). When consultation has not occurred this is due primarily to a lack of parental consent for the child to be seen by the CRC; this is something which is monitored in the unit and if themes arise regarding consent support is sought from our social work colleagues to promote the role of the CRC with families. There has also been some impact due to the CRC's absence from work. When absent, alternative means to consult with children are sourced (e.g. another involved professional being asked to seek the child's views).

In recent years the Safeguarding and Quality Assurance Unit has worked to promote parents right to appeal the outcome of the Child Protection Conference. In the past year three appeals have been made against the outcome and have progressed to a multi-agency appeal panel. Two were not upheld although learning was noted in one regarding strengthening the decision making of the conference and this was examined within an IRO development session. The third appeal was upheld and the conference was subsequently re-run and the outcome was overturned.

A multi-agency audit was undertaken in February 2022 to understand threshold for child protection conferences. This audit found that the threshold criteria was, on the whole, appropriately applied at initial child protection conferences. There were some challenges regarding threshold for cases that had been subject to planning for a significant time and actions agreed to address these. There will be a re-audit later this year to understand the impact of these actions.

Learning from both have been in respect of the need for more frequent assessments to understand impact of the plans and for strengthening the multi-agency decision making within the conference meeting. This learning has been disseminated internally and shared with multi agency partners.

Looked After Children

The number of Looked After Children (LAC) has gradually reduced from 90 (May, November and December 2021) to 79 (March 2022). The main factor causing the decrease is a number of LAC have become adults.

There has been a decrease from last year of children placed within families (which includes mainstream fostering, placements with wider family/friends, adoption or placement with parents) from 75% to 66%. The remaining 34% of LAC are within a residential placement. This change has been the impact of availability of foster placements and the increase in use of residential placements for children in response to this. A recruitment strategy is underway to resolve this.

- Participation in LAC reviews

Participation of children/young people in their review process has been consistently good throughout the year. The IROs work hard to encourage children's participation and attendance at their reviews; as a minimum their views are sought.

MASM

14 individuals have been subject to the Managing Allegations Strategy Meeting (MASM) process in the last year. 12 of these that have concluded to date, 6 allegations were substantiated, 4 unsubstantiated and 2 concluded to be unfounded. Onward referrals have been undertaken in respect of those substantiated, including to the Disclosure and Barring Service in some instances.

The process has identified some safeguarding vulnerabilities for the Island due to a number of professions being unregulated and when regulated, the regulatory bodies not having jurisdiction on the Island.

There is ongoing work by the Safeguarding Board to develop the current MASM procedure and process.

Adult Safeguarding – Social Care

Background:

With the advent of Manx Care on 1 April 2021, a stage has been reached in conjunction with the restructure and development of Adult Social Care where decisions need to be made on the future of Adult Safeguarding within Manx Care, and what realistic options are available to ensure we have in place safe working practices that are sustainable for the workforce.

Key Priorities:

- There will be a move towards a different model of delivering Safeguarding support within Adult Social Work. The preferred option identified in the 2021 Options Appraisal recommends that all Social Workers are trained in order that they can identify and respond appropriately to safeguarding concerns. All Social Workers will be undertaking safeguarding responsibilities

- To complete a dataset of key areas for Adult Safeguarding the team has begun by collating manual statistics collected from safeguarding concerns at the front door. This was initially due to the fact that the system was not capturing all of the information needed nor was it offering meaningful data. Safeguarding Adults is now a much improved position, having collated information manually, and these are screened monthly at Key Performance Indicator (KPI) meetings and a narrative is being established to report to the Executive Board. However, there continues to be a need for the recording system to accurately reflect data both in terms of what has occurred, to ensure quality assurance and forecasting of future resource requirements.

Key Challenges and Key Achievements:

1. Safeguarding cases required a process of auditing and management. Safeguarding Officers have now been given the responsibility to open referrals and also upload their own work to the Rio recording system. A system of quality assurance has been brought to the process. The Initial Referral Discussion (IRD) Hub was established to promote interagency discussion and is chaired by the DL. This has worked well in terms of commitment on attendance and case discussion being very high on the agenda for stakeholders. However in terms of **Safeguarding Together** this forum does not always feel effective. Some stakeholders appear reluctant to take on actions nor were many actions being recorded or timescales given. The role of the Planning Meeting (Enquiry – stage 2) in the Adult Safeguarding process appeared to have been lost and instead of being recorded as a Planning Meeting was recorded in case notes. This created difficulties in trying to establish statistics on enquiries and outcomes of same which then meant that responses were automatically not hitting the appropriate timescales (1, 2, 5 working days). There were also concerns about not adhering to Caldicott Principles particularly when there were case sensitive issues, such as those involving staff members, that did not need to be discussed in the wider arena.
2. A triage system has been implemented since November 2021 whereby all Safeguarding concerns are screened on receipt of the referral, prioritised and responded to. The IRD is cancelled when there are no Safeguarding concerns to be discussed and any appropriate parties will be included in the information gathering process or enquiry stage. Complex cases are still discussed which require, where necessary, MDT information sharing/action but these are now being recorded as Planning Meetings on the recording system. Adult Safeguarding are making efforts to identify patterns, themes and learning outcomes from safeguarding concerns and enquiries undertaken. Multi agency referral forms (MARFs) were not being included in the statistics but now are. Staff are developing triage charts documenting screening outcomes. The need to demonstrate multi-agency approaches to Safeguarding is recognised, this was a recommendation from the Multi-Agency Review of Adult Safeguarding (2020) by Sylvia Manson. The team is in a stronger position now that it has returned to documentation which better serves them in recording activity and highlighting where service improvement is needed.
3. The impact of only having two Social Workers undertaking Safeguarding the last year continues to be an area of challenge. Duty is fast paced and at times intense. Staff continue to also attempt to manage caseloads during these periods. There has been an element of agency worker backfill, the need for permanency posts across Manx Care is high on the agenda for the Social Care Leadership team.

4. Within each team all post qualifying social workers with two years' experience will be trained to become Safeguarding Officers and undertake investigations, and so expertise will be developed over time. When looking at the overall benefits of having this model in place, it allows for expansion of a specialism whilst continuing to retain Safeguarding as 'everyone's business' approach. These specialist workers will hold high risk and complex cases but also be involved in providing coaching, training and guidance to other Social Workers within the team. This will be essential as the team moves forward from having a dedicated specialist team. This approach will also work within realistic time scales. It may not be possible to train every qualified Social Worker to an appropriate level of competency immediately.
5. It is planned in the future to be at a stage where every Social Worker is at a level that there no longer needs to be a defined risk/skills approach, but cautious optimism must be utilised initially as Safeguarding duties will be new for many social workers on the Isle of Man, even for those who have been qualified for some time. Team Managers will be trained to chair meetings creating greater resilience for the Safeguarding process.

Evidence of impact/likely impact on practice and service user outcomes:
The information below highlights the performance data captured by Adult Social Care throughout the reporting period.

Data indicates that the Adult Safeguarding Team received 432 Safeguarding Concerns from 1 April 2021 to 11 March 2022. Out of those, 278 were referrals, 100 were Multi-Agency Referral Forms (MARF's) and 47 were requests for information and advice.

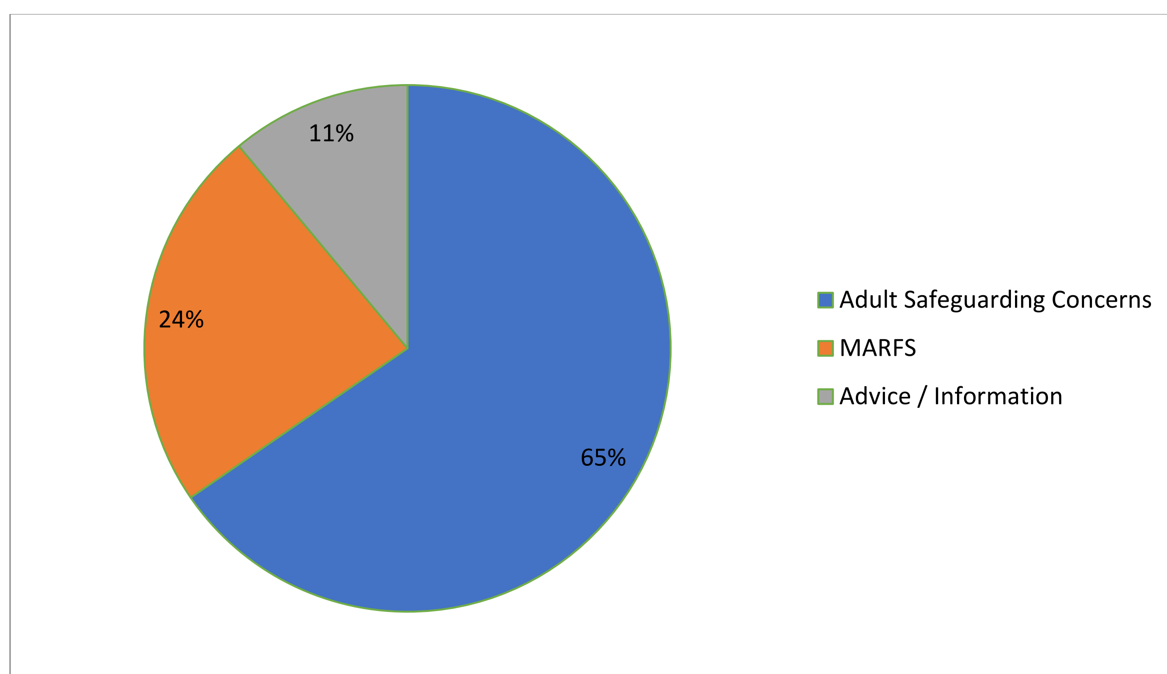


***Fig. 1** – pie chart showing the breakdown of referrals received by the Adult Safeguarding Team*

The number of referrals received to the Adult Safeguarding Team has slightly increased. These statistics were gathered for this report before the month of March had ended therefore it is likely that the figures will be slightly skewed and not accurately reflect the full year (3 weeks short).

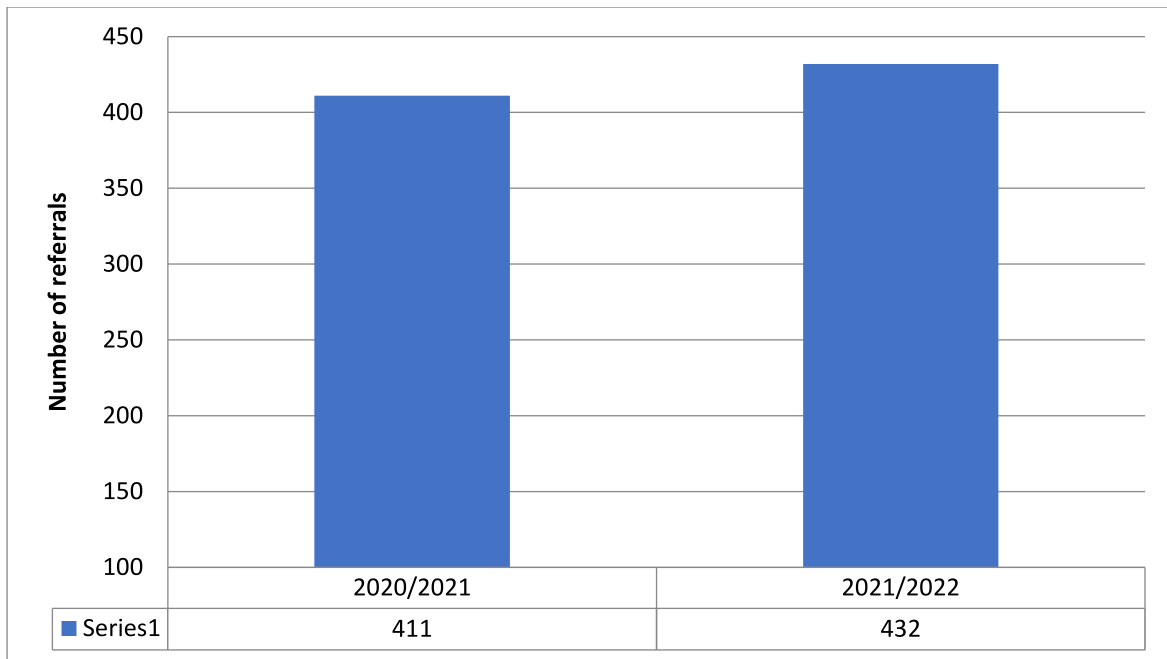


***Fig. 2 -** Number of referrals received by the Adult Safeguarding Team compared 2020-2021 and 2021/2022.*

In terms of abuse categories the three main types of abuse consistently continue to be; Neglect (84), Physical abuse (69) and Financial abuse (42). Psychological abuse accounted for 33 referrals, Sexual abuse (28) and Domestic Abuse (5). Institutional abuse accounted for 5 with only one Human Trafficking referral and Female Genitalia Mutilation (1). Digital abuse received no Safeguarding referrals. This highlights the need for raising the profile of these types of abuse and securing training to meet this demand.

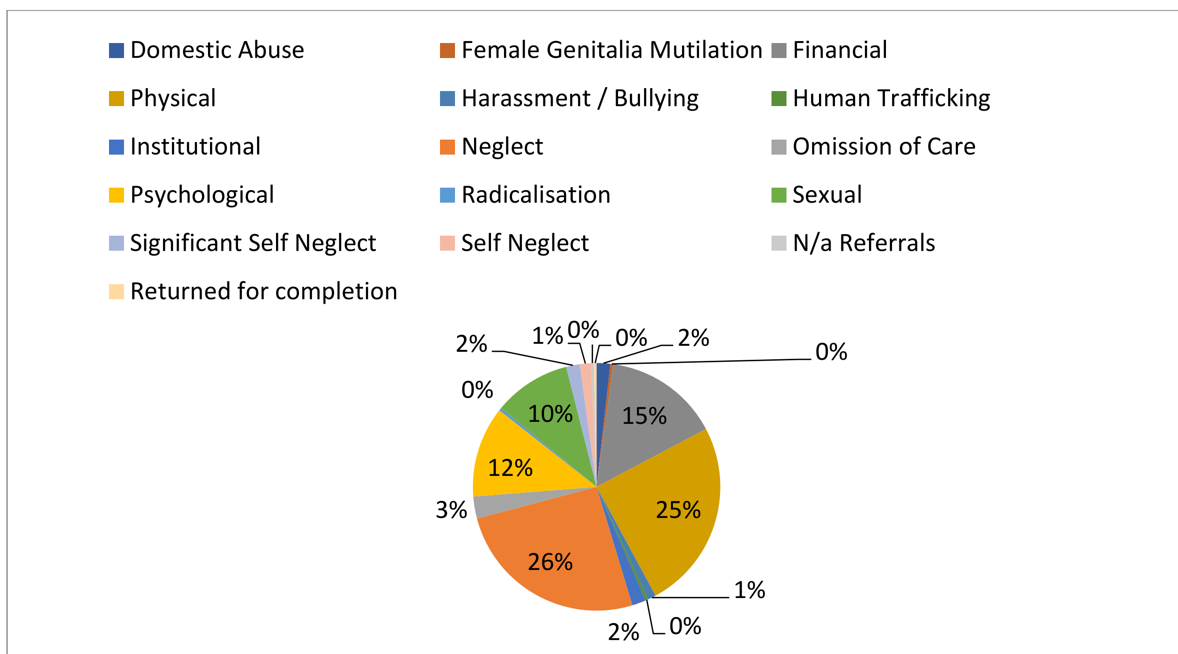


***Fig 3 -** pie chart breaking down categories of abuse*

In respect of the MARFs, 78 did not identify any possible abuse, but MARFs are recognised as an invaluable source of information for Adult Safeguarding. During welfare visits police have access to our most vulnerable adults in the community and serve as a means to ensure that these people are being seen and offered support as appropriate. Even if information is simply logged it starts to develop a chronology of events that may warrant future intervention. Quite often these individuals are signposted to other services within Manx Care.

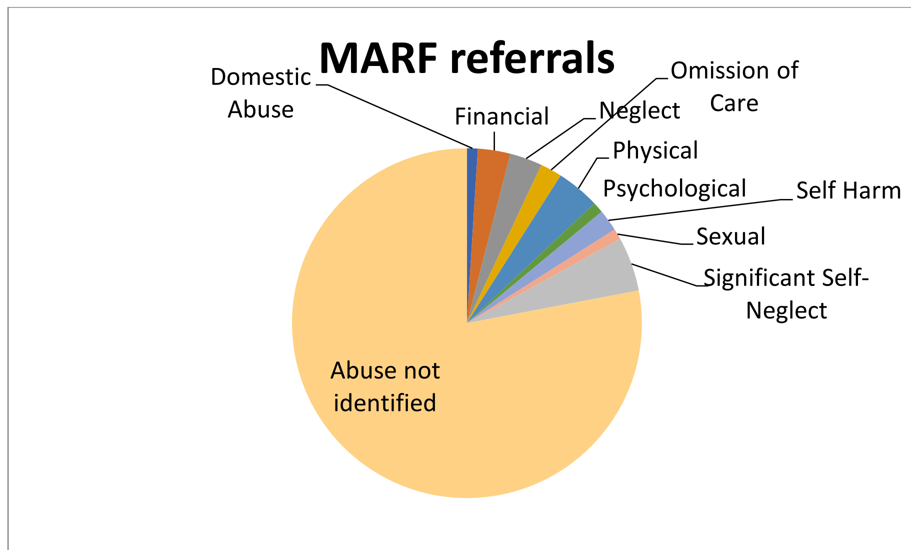


Fig. 4 – *categories of MARF referrals received by the Adult Safeguarding Team*

In terms of referral source it is interesting that the highest referrers is Manx Care's own Social Work teams (45) and Learning Disability Services Day Care Providers. This serves as extra weight to the proposal of embedding the Safeguarding role into the general Social Work role as services are already involved and can offer consistency of care through the Safeguarding journey. Health are the next highest referrers, with 20 being received by Community Health, 10 from Noble's A&E Services and 17 from Noble's wards, however these numbers still seem too low for the Isle of Man population and need further scrutiny.

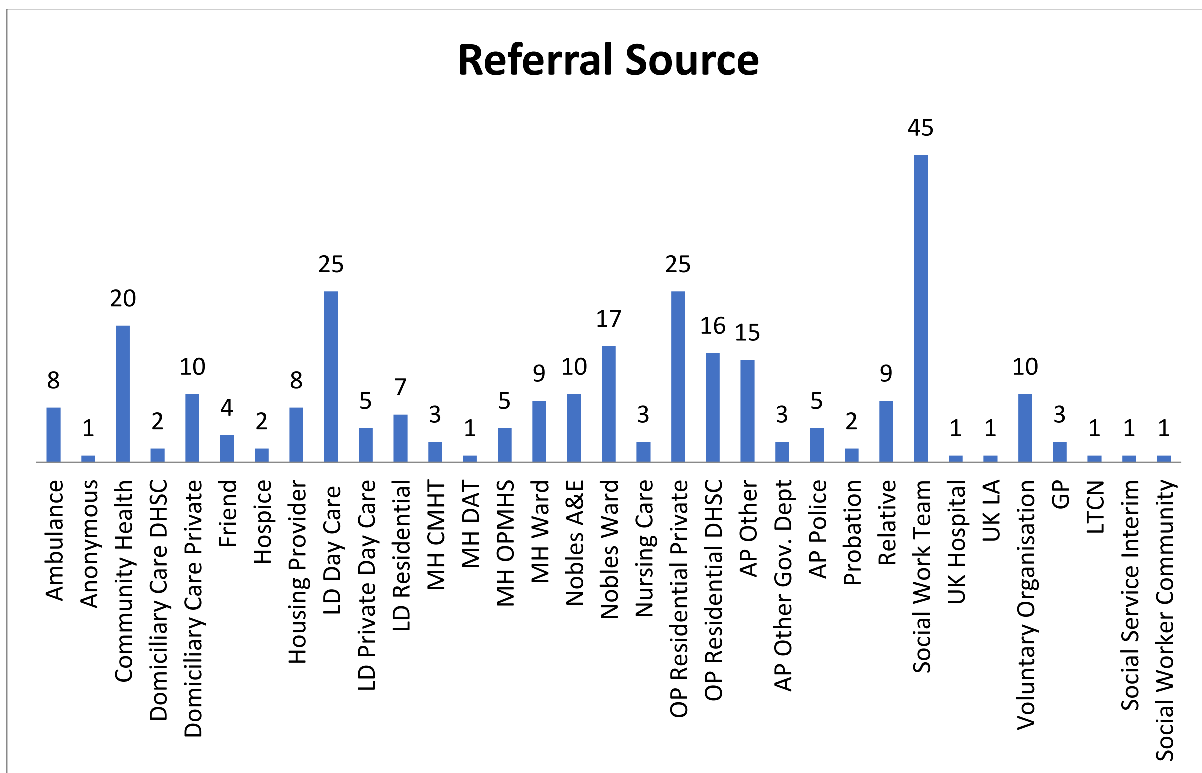


***Fig. 5.** - graph depicting the breakdown in the referral source to the Adult Safeguarding Team*

In terms of the general understanding and awareness of safeguarding, we need to better engage the public in the Safeguarding process. Of the safeguarding concerns received in the last year only 15 were from the public; 9 were from relatives and 4 from friends. None were received from people themselves. It is positive that safeguarding officers take referrals over the phone or by email to minimise distress and the public are not required to fill in a referral concern form.

As a service, need is trying to be anticipated. What can be seen from the statistics reported is that Manx Care needs to consider distribution of resources in respect of self-neglect cases and in preparation for the implementation of the Domestic Abuse Act 2020. The new Sexual Abuse Referral Centre (SARC) pathway has also seen a slight rise in the amount of referrals received and it is hoped that awareness of this provision will continue to rise.

There is a cluster of **self-neglect cases** sat with the Coroner's Court. This has led to the Safeguarding Board requesting information on how we work together to manage such cases. The Adult Safeguarding Team are constantly reviewing these with a critical eye and also an MDT approach through Planning Meetings. A Risk Assessment Tool has been introduced and Management Action Plans on cases identified as high risk are being completed.

Any evidence of capturing the voice of service users and their families:

Making Safeguarding Person (MSP) continues to be completed at the point of referral. However this is not always being completed at closure or the optimal stage.

Auditing of work by the designated lead has revealed that MSP records are not as personalised as the team would aspire to and don't fully capture the safeguarding journey such as how safe the client feels at each stages of the process or what they are doing to keep themselves safe.

Also there is no voice recorded where the client is assessed as not having capacity. The adult safeguarding team believes that this is not good enough and therefore aims to capture the ascertainable wishes and feelings of their service users prior to losing capacity or if/when this is regained. The team also understands the importance of decisional and executive capacity and how this can be better captured within data sets by incorporating best interest paperwork/checklists into the electronic documentation.

Closure letters were not always being sent out or referrers advised of why a referral was inappropriate/not being progressed. This has been readdressed and closure letters are to be sent to both the referrer and the service user for transparency. The safeguarding team also plans to send service user feedback forms in every closure letter in order to capture their views of the service and how it can be improved.

The safeguarding team has held two learning forums in order to understand, in collaboration with partner agencies and how to better improve practice. Feedback from these forums which included a GP, Registration & Inspection, private care providers, the Older Peoples Mental Health Service, and Manx Care Health was that this was an invaluable tool to be reflective on practice, determine how agencies can better communicate with one another and engage in the safeguarding process alongside the service user.

Future work:

- The DL has been involved in the workshop on the implementation of the new Domestic Abuse Act 2020. As a result the team has been asked to input key activities that have been considered from this area and any major risks that could impact on the delivery of these. One area already identified is the likelihood that adult safeguarding concerns will increase and the potential resource implications as a result of this.
- The DL has also attended a work stream on the review of the Isle of Man Multi-Agency Public Protection Arrangements (MAPPA) and also look to introduce the Multi-Agency Risk Assessment Conference (MARAC) process.
- The Managing Allegations Strategy meeting (MASM) Policy was enacted recently and offered the opportunity to review the draft policy which will need to be ratified moving forward.
- Safeguarding staff have been preparing for audits by CQC and Sylvia Manson (Independent Reviewer) in April 2022. Progress has been made on the previous Sylvia Manson review, however there are still areas to be developed.
- Single Agency Level 3 Safeguarding training to be devised and rolled out across all Manx Care. Staff have previously not been trained at the correct level.
- Plans to have safeguarding supervision embedded into adult safeguarding across Manx Care.

Health Safeguarding

Background:

The post of Head of Safeguarding for Children & Adults in Health Services was established as a new role in Manx Care in 2021. In terms of changes, this year has seen the transition from a Designated Nurse for Safeguarding Children to an organisation wide (Manx Care Health) Safeguarding Lead covering the whole age spectrum. There is a Named Doctor and a Designated Doctor for Looked After Children (LAC).

Governance – Policies, Procedures, Pathways, Audit:

1. Reviewed and updated Sudden Unexplained Death in Childhood (SUDIC) Policy in conjunction with other agency leads (despite the remit and responsibility for SUDIC remaining with Children and Families Safeguarding).
2. Developed new Medical Pro-forma for SUDIC.
3. Updated 'Was Not Brought Policy' (WNB). This Policy recommends the use of the phrase Was Not Brought (WNB) when working with children rather than Did Not Attend (DNA).
4. Worked with new Forensic Examiner/SARC (Sexual Abuse Referral Co-ordinator) lead to review sexual abuse referral pathway.
5. At request of Chief Executive Officer (CEO) developed a pathway for 'Child presenting with Mental Health Crisis' also a recommendation from Child J Serious Case Management Review (SCMR).
6. Pathway for referral for Child Protection medical examinations reviewed and updated in conjunction with Designated Doctor.
7. Maintained data for child protection medical examinations for submission to Safeguarding Board.
8. 2 Audits have been completed – Routine Enquiry (Domestic Abuse) and Safer Sleep.

Peer Review/Peer Supervision:

1. Regular monthly ongoing of Royal College of Paediatrics Child Health (RCPCH) standards, child protection peer review meetings based on an agreed terms of reference.
2. All Health Visitors and Staff Nurses have safeguarding supervision regularly.

Education and Training:

1. Updated training package and provision of induction training to Foundation level doctors.
2. Updated training presentation as part of Island wide multi-agency training programme (January 2022).
3. Training for GP trainees provided (Level 3 Safeguarding Children)
4. Training for ED doctors provided (Level 3 Safeguarding Children)
5. Paediatric Peer Teaching on Perplexing Presentations (based on updated 2021 RCPCH guidance) over 2 sessions.
6. Paediatric Peer Teaching on learning from Non-Accidental Injured 'NAI' in under 1s (role of the father).
7. Level 3 training (7.5 hours) weekly to capture 1000+ health staff.

Education:

1. Training by Centre of Expertise on Child Sexual Abuse (Intra-familial sexual abuse). Recommendation from SCMR.

Reviews:

1. Involvement at all stages of Child J serious case review (following from direct clinical care involvement).
2. Family K on-going.

Individual Peer Support and Supervision:

1. Regular advice to General Practitioners and other healthcare professionals-telephonic/e-mail/face to face
2. Regular peer support to all colleagues undertaking child protection medical examinations
3. Support and advice to colleagues in other specialities
4. Support/supervision to colleagues attending court as professional witnesses.

Challenges:

Sir Jonathan Michael report has flagged up what colleagues in safeguarding have raised for several years, i.e. the poorly integrated electronic patient/client records are a significant barrier to safe integrated care and this is particularly important risk in safeguarding.

1. Lack of appropriately trained workforce.
2. Within the Paediatric team the long-term difficulty in recruiting doctors at both Consultant and Speciality Doctor level is an on-going challenge in terms of delivering a reliable, sustainable, safe and efficient service. This impacts safeguarding as much as any other speciality area in paediatrics
3. Lack of continuity in key leadership roles in all agencies.

Achievements:

1. Emergency Department (ED) alerts on for all children on Child Protection, Contextual Safeguarding and Looked After Children (LAC).
2. Transition of LAC Caseload into the SG team.
3. Established duty safeguarding children's team.
4. Supported with future implementation of the MASH.
5. Evaluation template for all LAC.

<u>Mental Health</u>

Within the mental health service a multi-agency panel meets weekly which is chaired by the Adult Safeguarding Lead, with Police, Ambulance, OPMHS, District Nurses and Community Mental Health in attendance. All referrals into the service are discussed with the exception of urgent referrals as they have already been processed. There is a plan to change the format of the meetings as they don't always meet the purpose.

The current risks are assessed as a workforce not being adequately trained, their workforce has a mandatory training policy of level 3 Safeguarding training; closer links with the Named Nurse for Safeguarding are needed; the reporting system RiO does not have a specific option to choose for safeguarding; and relevant safeguarding statistics are not captured. To mitigate these risks the team discusses cases as part of a multi-disciplinary team discussion and with the safeguarding lead and the clinicians discuss with a manager or the senior leadership team.

Drug & Alcohol Team (DAT)

A Drug and Alcohol professional for families has been recruited within the past 12 months, whose role is to work with patients with those who have social care involvement, forming part of the child protection groups and review conferences. There is a Drug and Alcohol Young Person's Worker within the service who works with young people and their associated network.

Should any DAT professional have concerns in respect of exploitation or abuse, they are aware to refer to Children's & Families Social Work. The DAT Young Person's Specialist has highlighted concerns regarding sexual and financial exploitation to Social Services for certain individuals during past 12 months.

Professionals within DAT are aware of the process for referring safeguarding concerns via a multi-agency referral form and can also utilise internal multi-disciplinary team for case discussion. Within the DAT team, there are a number of professionals with safeguarding and child protection backgrounds.

The Isle of Man Constabulary

Having realigned internal practices IOM Constabulary believes they have an accurate picture of the vulnerable people on the Isle of Man.

Children: Initially when comparing data to that held by Manx Care there were discrepancies so the complex abuse meetings held by police and partners were not as effective as they could have been. Working in partnership the issues have since been ironed out. An algorithm has been created and utilised every 6 weeks to identify the young people most at risk, who are rated to assist with decision making and prioritisation. During that same week a partnership meeting is held when all individuals are discussed and a collective decision is made. From this meeting came the concept of Operation Yarrow, a police initiative where all young people in the highest risk category have a response plan with a police owner, who is required to adopt a problem solving approach to the problems faced by the young person.

To-date:

- 16 young people have been through Operation Yarrow.
- Work remains ongoing with seven individuals
- Of the nine that have been completed (with whom a problem solving approach is being taken), two were finalised as the young people were being investigated for criminal offences, the remainder were closed as the level of risk to them was reduced or risky behaviours improved. This should be seen as being a success.

Work that has developed from this has been:

- The Harbouring Notices and Child Exploitation (CE) Notices which are issued to the perpetrators of CE, are held on the relevant profiles of those concerned.
- The Exploitation Awareness Notice which are to be delivered to the parents of the Amber group of young people the police are starting to become aware of.
- Intelligence collection, the templates and guide have been circulated to all partners to ensure the intelligence is submitted and the provenance of the intelligence is captured.

This has developed further and led to a more joined up approach with schools with a clear structure in place internally and a dedicated Sergeant. This is shared externally with schools. The IOM Constabulary has now been invited on two occasions to share their thoughts and vision with school leaders, which has been well received.

Specialist neighbourhood police officers deliver a consistent standard across the Island from packages prepared by experts which complement the policing strategy. Work is both scheduled and bespoke to assist with additional complexities that arise within schools i.e. Team Around Schools (TAS) where a few young people were causing a large problem. This was addressed through the joint working.

There is additional work afoot under as set out below.

- As networking grows so does the IOM Constabulary's involvement with other teams and partners. E.g. Multi-Agency Police Protection Unit (MAPPU) now hold regular meetings with St Christopher's regarding their Looked After Children to support them, where recently a drugs dog was provided for an issue they raised with the Isle of Man Constabulary.
- Recognising exploitation with young people is a risk, so they have undertaken to raise awareness with various partners by providing safeguarding inputs at hotels, with door-staff and license holders and pubs.
- This isn't just about young people but vulnerability adults and adolescents. So in an attempt to replicate the work we have commenced around Op Yarrow, we have devised a role within MAPPU 'Adult Intervention Management' where the proposals will be presented to the Chief Inspector to outline how this will be managed.
- Restorative Justice has been discussed by many and with training planned the Police decided to own this and drive it through as the evidence base to support this work.
- To-date 20 mixed partner agencies were afforded the opportunity to do a one day training in Restorative Justice (RJ) to see how this could influence their working in their agencies. Of the 20, 9 went on from police, prison and probation to complete the three day course. This enables them to complete RJ on lower level offending. However with the high enthusiasm, commitment and relationship building this had led to one of the highest profile prisoners in prison being considered for RJ and plans are underway to make this happen.
- Multi-Agency Public Protection Arrangements (MAPPA) was a key challenge several months ago but by going over the recommendations as highlighted in the Gillian Fairley report with partners this has resulted in the police working closely with probation/prison who have now taken the lead to implement a root and branch review of the MAPPA training and process. This has now taken place and training and a restructure is due to be put in place very soon.

- Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) inspected the police and during the preparation a review the safeguarding training was undertaken. This directly led to a requirement for all Police employees to complete E-Learn Vannin Safeguarding training commensurate to their role which is managed by the Organisational Development (OD) department.

The delay in domestic abuse legislation has meant it is difficult to define through our recording methods victims and offenders and in particular those who are repeat victims or indeed repeat offenders.

To mitigate some of this the police has worked incredibly hard to maximise all opportunities for reporting, creating Safer Spaces – in Shoprite, Tesco, pharmacies - where individuals can seek support and assistance. The police domestic abuse officer trained partner agencies to help in identifying potential domestic abuse warning signs, these included Manx Utilities, Manx Telecom and those seeking election in the September 2021 House of Keys general election.

All of this was supported by media releases at key times.

More recently twenty mobile phones have been secured which can be provided to victims with all supported policies in place for the effective management of them. Collaborative work is underway with Housing Matters, a not for profit organisation, to try and assist, where possible, to house domestic abuse victims. A firmer structure is being progressed with the Department of Home Affairs, which will form part of the work being done on the new domestic abuse legislation.

All partners have complimented the Isle of Man Constabulary on work so far, particularly around Op Yarrow and the work in Schools.

Through the Safeguarding Board the police have been intrinsically involved in the evolvement of a multi-agency safeguarding hub (MASH), which will lead to co-location. This will ensure that partners come together on a daily, weekly and monthly basis to manage the risk of exploitation around our young people and the management and support of them.

Home Affairs

The different services that sit within the Department of Home Affairs each have a vital role to play in contributing to, and leading the way in the safeguarding of vulnerable adults and children on the Isle of Man.

The Department has published a Delivery Plan which outlines how the Department will achieve the targets and goals set out in the Island Plan, as well as supporting the strategic objectives of a secure, vibrant and sustainable future for our Island. The plan details objectives which the Department aims to achieve within individual timescales.

The Sexual Offences and Obscene Publications Bill received Royal Assent in July 2021. This legislation modernises existing sexual offences legislation and introduces new protections for children and young people from online harms, including grooming and sexting. It also extends the range of sexual offences, providing more protection to children and victims of sexual violence.

The Department has published implementation plans for both the Domestic Abuse Act 2020 and the Sexual Offences and Obscene Publications Act 2021 and aims to have both Acts fully in place by Autumn 2023. The Department has also appointed a new Domestic Abuse Strategic Co-ordinator who took up post in February 2022 to support this work. A key challenge is to ensure the effective implementation of both of these pieces of legislation, including training, services and pathways and to address this DHA continues to work closely with all members of the Safeguarding Board.

The Department is also committed to finalising stakeholder feedback and the publication of the Domestic Abuse Strategy by July 2022.

The Department continues to work with the Department of Health and Social Care and Manx Care on the development of a local Sexual Assault Referral Centre (SARC), which has now secured capital and revenue funding. The SARC will give an end to end, local service for adult and child victims of sexual assault.

The services that sit within the Department of Home Affairs continue to work hard to review and improve safeguarding processes.

The Fire Safety team in the Fire and Rescue service continues to prioritise fire safety inspections for vulnerable people, particularly those who are identified as hoarders. Additionally, a Station Officer has been identified within the Service to liaise initially with the Police and ultimately Social Care to review the process for dealing with vulnerable referrals from operational crews and outside organisations, the first meeting of which took place on Wednesday 9 February 2022. The Fire Safety team will also in time be undertaking a restructure of the teams within Fire Safety so as to take an enhanced, community based and proactive approach to safeguarding in the future.

The Prison and Probation Service continues to work to reduce risk with those who perpetrate crime against vulnerable people. The Department has invested in the development of two Victim Liaison Officers who support victims of serious crime and offer Independent Sexual Violence Advisor services to victims of sexual offences. Additionally, all Prison and Probation clients are assessed as part of the Level of Service Case Management Inventory (LSCMI) assessment. This assessment provides the Prison and Probation Service with a solid understanding of what the risks associated with a client's offending are, a client's needs in relation to social and personal circumstances and importantly, highlights issues such as self-harm and self-neglect. This assessment is reviewed every 6 months. The Prison and Probation service also work to support the most vulnerable people in the Justice system on their release from prison and in the community. Funding has been secured for a new Workshop facility which will provide support for the development of construction skills, and also increase resettlement day release opportunities. A key challenge is the release of "lifers" from detention and their management in the community. To address this Prison and Probation are ensuring the effective provision of Electronic Tagging and have introduced new licence conditions to manage offenders in the community, and they are working with Safeguarding Board Members to strengthen public protection arrangements. The Department is revising its MAPPA processes and procedures which it has identified as a key risk to safeguarding vulnerable people

Education, Sport and Culture

The Department of Education, Sport and Culture (DESC) has continued to work collaboratively with the safeguarding partners, in the capacity of a reporting agency but also contributing to a range of work streams and developments across the partnership.

DESC adheres to and upholds the understanding that '*Safeguarding is Everybody's Business'*. Each of the 32 primary and five secondary schools have a 'designated safeguarding lead'. This is always a senior member of staff, and most often the head teacher or deputy head teacher taking the lead responsibility for child protection and safeguarding issues within their own setting.

Termly 'Safeguarding in Education' sessions continue to be held on a termly basis and allow designated safeguarding leads to come together and participate in workshops, receive updates from the Safeguarding Board and look at learning from recent local SCMRs and national reviews. This year workshops have been held on the exploitation of children, Professional Curiosity and most recently the new Safeguarding Board Information Sharing Guidance and Protocol.

DESC have developed and are rolling out a Safeguarding audit (drawing on the NSPCC Safeguarding and child protection self-assessment tool) to ensure that schools are meeting their safeguarding duties. The audit has been developed to enable DESC to satisfy itself that safeguarding practices in schools are continuing appropriately. Senior officers from DESC are carrying out the audits with schools, examining and triangulating a range of evidence including discussions with front line practitioners and children. In order to further strengthen our internal quality assurance procedures for safeguarding, the findings of the audits will then be collated and examined to identify future training and development needs and priorities.

The Child Protection and Safeguarding Officer and Head of Additional Educational Needs have disseminated training on the Safeguarding Board's new Information Sharing Guidance and Protocol to Designated Safeguarding Leads in schools and the further roll out of this training to frontline practitioners is planned.

During the reporting period, the work of an adviser with responsibility for children who are looked after, a similar role to that of the Virtual School Head teacher in neighbouring jurisdictions, has been developed and contributes to safeguarding and has made a positive impact for this group of young people.

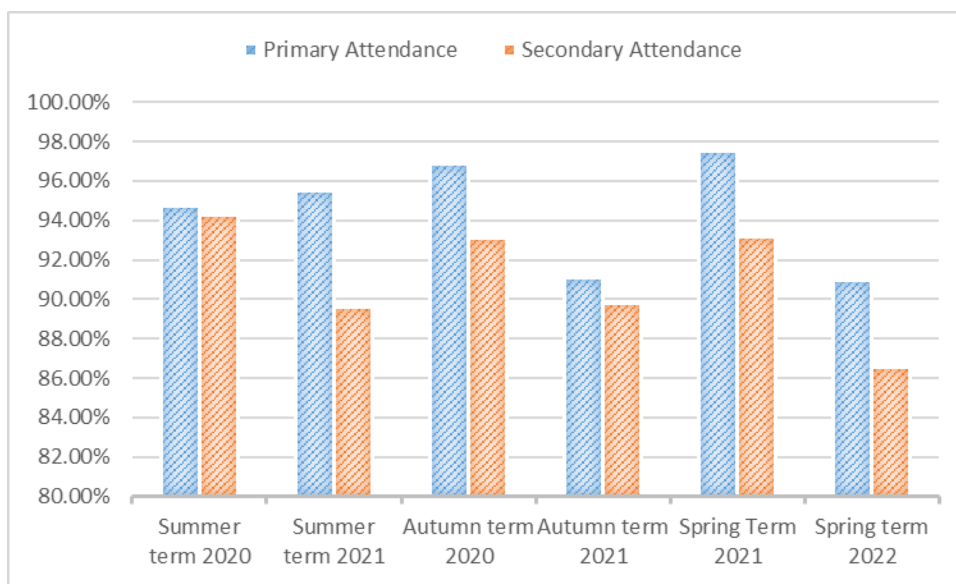
One of the actions from the complex abuse enquiry 2018 action plan was to ensure that schools ensure that regular visitors and contractors were aware of their safeguarding responsibilities when working in these settings. The Child Protection and Safeguarding Officer has worked closely with colleagues in the Department of Infrastructure (DOI), to develop a Safeguarding Awareness document including a code of conduct. This includes face to face awareness sessions allowing staff to raise any concerns and questions. DESC will liaise with the DOI to ensure that staff understand the safeguarding practice guidance and to monitor the impact.

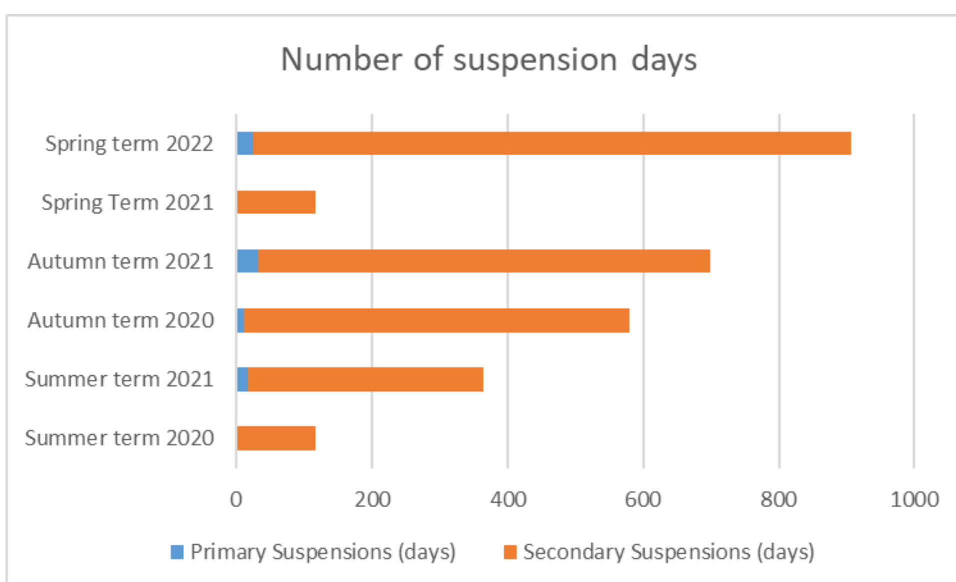
The Education Advice and Support division have piloted a 'team around the school' project to help safeguard vulnerable adolescents within one of the secondary schools. All divisions of DESC have provided support to these young people based on their needs. The culture division have provided

session at the Kensington Arts Centre with young people attending each week as part of an alternative timetable of provision. The centre staff have provided private mentoring sessions in music as well as work experience at the venue.

Manx Sport and Recreation facilitate a coach education programme which includes the provision of UK Coaching Safeguarding and Protecting Children workshops and Level 2 Welfare Officer workshops. During this period the Department has delivered 7 Safeguarding workshops to a maximum of 20 individuals per course and a Welfare Officer course providing opportunities for any individual to update their training and knowledge around Safeguarding, as well as meeting their local and national Governing Body's requirements in relation to Safeguarding.

DESC are concerned about the possible impact of the COVID-19 pandemic on children and young people's wellbeing. Attendance of pupils for the Autumn term of 2021 compared to the same period in 2020 is lower and comparison of formal suspension data shows an increase in some areas.





Referrals to the Education Welfare Service (EWS) have risen sharply with 'anxiety-based school refusal' or 'emotional wellbeing' issues being the most notable reason for referral. In December 2020, the EWS was dealing with 80-90 cases of low attendance, this has now increased to 154 open cases. DESC is currently participating in a wellbeing survey with secondary age students which will provide a more accurate picture of the mental health and wellbeing needs of our secondary students which will be benchmarked against UK data.

Due to an increased awareness of the vulnerability of some young people on Island, as evidenced in Child J SCMR and in feedback from schools regarding exploitation of young people, DESC Senior Officers are working with multi-agency partners to collaboratively develop strategies and operational practices to safeguard this group of vulnerable adolescents.

DESC have experiences similar difficulties to other agencies, such as recruitment, staffing, and resources, making collaborative working difficult at times.

The expected impact of the safeguarding audit in schools is that it will identify priorities for training and development.

The expected impact of the information sharing training is that practitioners across the organisation will be clearer and more confident about sharing information and this will ensure that appropriate information is shared in a timely manner to protect children from harm.

The expected impact of the team around the school pilot is that it will safeguard the young people involved by motivating them to attend schools and positively engage in activities. Early indications show good improvements in the self-awareness, interpersonal and social skills of the young people involved.

Individual schools continue to work proactively by participating in safeguarding related aspects such as anti-bullying week and safer internet day. Individual schools obtain young people's and families wishes and feeling on a range of subjects as part of their normal working practices.

DESC will continue to roll out information sharing guidance and protocol to all teams within DESC at a level commensurate and proportionate with roles and responsibilities.

Continue to develop single agency training in line with emerging issues and themes and findings from Serious Case Management Reviews.

Children in Care:

The school attendance for primary aged children in care is broadly in slightly better than rate of other primary aged children. The school attendance for secondary aged children in care is below that of other secondary pupils by 6%, which is slightly worse than last year where the difference was 4% but is in line with the previous year where the difference was 6.6%. Lockdowns will have affected attendance as well as other factors.

Suspension rates have increased for the whole secondary school population and this increase is mirrored for children in care. The majority of suspensions for secondary aged children in care are for pupils in Key Stage 3 (Years 7 to 9).

Safeguarding Board Finance

In the financial year 2021/2022, the Safeguarding Board budget was £244,576 and spend against budget came in at £266,961. As reported in previous years, the majority of the spend was staffing costs, including the independent chair costs.

The Board had to overspend its budget, due to the need to complete or commence three Serious Case Management Reviews and to undertake work as outlined, as required by its statutory functions. The Board is not funded to undertake these reviews, due to the inability to predict when they may be required and there is an agreement for Cabinet Office to meet any additional costs as necessary.

Future plans

In 2022-2023 the Board will continue to drive forward the work to ensure it achieves its agreed business priorities and implement the recommendations and learning from SCMRs to improve practice.

Key work planned to meet the priorities:

Working together to effectively safeguard vulnerable adolescents

- Finalise work on the new risk assessment tools and working protocol to improve how professionals work to protect young people from exploitation
- Complete the Vulnerable Adolescent Strategy
- Launch the new Strategy, Protocol and Tools via a multi- agency Conference
- Finalise a training programme to increase workers confidence in identifying and working with exploitation

Ensuring an effective multi-agency safeguarding response for vulnerable adults

- Develop a Safeguarding Strategy for vulnerable adults that articulates the pathways for dealing with concerns
- Develop a Self-Neglect Strategy, working protocols and training programme
- Develop a programme of awareness raising around adult safeguarding to improve recognition and referrals
- Develop a comprehensive multi-agency safeguarding adults training programme

Work to meet the overarching priorities:

- Complete work to ensure a full suite of multi-agency safeguarding policies and procedures for children and adults
- Develop a Quality Assurance and Scrutiny Framework that will provide assurance about practice and provides the Board with information about the impact of its work

- Develop a multi-agency dataset with exception reporting for adults and children which will provide essential information regarding safeguarding practice issues which may identify further development areas and capitalise on areas of good practice.
- Implement any outstanding recommendations from SCMRs
- Ensure an appropriate multi-agency safeguarding training programme for both adults and children based on the newly developed competency framework and training needs analysis
- Improve communication about the Board's work and dissemination of key safeguarding messages via further improvements to the Board's website, engagement with the media, quarterly newsletters and events to share learning
- Develop an engagement strategy that ensures the voice of service users, their families and carers is at the heart of the Board's work and informing practice improvements and priorities

The Board member agencies would like to sincerely thank the staff across all organisations, sectors and communities that have contributed to the work of the Board this year. We welcome feedback about how to improve safeguarding practice and better protect children and vulnerable adults from abuse and harm. The Board can be contacted at safeguardingboard.co@gov.im

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