SAFEGUARDING BOARD
ISLE OF MAN

The Isle of Man Safeguarding Board

Board Response to Serious Case Management Review – Child N

This Serious Case Management Review (SCMR) relates to a serious incident leading to a young child being presented at hospital and needing emergency treatment. The Board note that the findings from this review provide an insight into local systems and practices when a child is born to young parents with their own significant vulnerabilities, which may indicate that a child could be at risk of significant harm and parental neglect.

This SCMR was commissioned in 2022 by the Isle of Man Safeguarding Board in line with the 2019 Safeguarding Together Guidance and Safeguarding Board Act 2018. The Board commissioned Nicki Pettit, an experienced independent reviewer and safeguarding expert to complete this SCMR.

The review process consisted of agencies providing reports of their involvement with the family and two practitioner events. This process is supported by a Panel of independent senior staff from involved agencies who can provide necessary context on organisational policies and practice.

The agencies involved in the process were:

Isle of Man Constabulary

Department of Education Sports and Culture

Manx Care- Health

Manx Care – Mental Health.

Manx Care – Children & Families.

This Board response will focus on the learning and recommendations only, as the not share any of the case details to respect the family's right to privacy and prevent any identifiable information being shared.

The report and its recommendations were agreed and accepted by the Isle of Man Safeguarding Board. The Board believe that the actions identified to address the recommendations will improve how agencies work with children and their families in similar circumstances. The learning briefing has been published by the Safeguarding Board along with this Board response.

The review identified a number of key learning points:

- Where there are known or knowable parental vulnerabilities, such as mental health issues, a history of abuse or neglect, care experience, substance misuse, concerns about anger management and violence, or learning difficulties. There needs to be information sharing at the pre-birth stage, robust consideration of the impact on a baby, and a focus on that child, including pre-birth, alongside the offer of support.

- Practitioners, their managers, and agencies need to ensure that they are aware of and promote the legislation and expectations regarding information sharing where a child may be at risk. Professionals need to be clear about what is required, even if there is a lack of parental consent. Any disputes or concerns in this area need to be discussed with a manager. Isle of Man procedures clearly state that ‘effective sharing of information between professionals and local agencies is essential for effective identification, assessment and service provision’ and that ‘fears about sharing information should not stand in the way of the need to promote the welfare and protect the safety of children’.
- There is a need to seek, share and consider information about a baby’s father and their role in a family, and to include them in assessments and plans in respect of their child. Those working with adults need to ensure that they consider what is known about the father (or mother’s partner) and share this with professionals responsible for the child if there is anything that may indicate a risk. They should always Think Family.
- Professionals need to effectively consider the information available to them to fully understand a child’s actual and likely future lived experience, including utilizing multi-agency meetings to share information and consider the impact on the child.
- Professionals need to challenge themselves and others if practice is parent focused. This is particularly a risk when a parent is young and has significant vulnerabilities of their own.
- Issues such as parental mental health or domestic abuse, or incidents of child neglect tend to reoccur, so an incident lead approach should be avoided, with consideration given to the impact of the issues on a child over time
- Inconsistent or poor engagement with professionals by a parent needs to be considered, including seeking to understand the impact on a child of a lack of meaningful engagement and what might be stopping full engagement - which may include pressure from others due to domestic abuse, or fear of a child being taken into care.
- The Isle of Man is a relatively small place, and many professionals are often working with families where there is a personal connection, and this can potentially lead to a conflict of interest. Agencies and professionals must be transparent about this issue, be honest with families and other professionals, and use supervision or management consultations to both explore and resolve this complex issue.

Recommendations

The review recommends that the Isle of Man Safeguarding Board:

- ➢ Considers how it can ensure that there is a change of culture on the Island regarding the need to always share available information that could mean a child is at risk, regardless of parental consent.
- ➢ Considers transparently and proactively what needs to happen to ensure that professionals are supported to work in an environment where their professional and personal knowledge and relationships may overlap.
- ➢ Should work with its partner agencies to develop and implement a neglect strategy and associated tool kit to help staff better understand the lived experience of the child.
- ➢ Considers adding Working Effectively with Fathers and Non-Birthing Partners as a thematic focus area in its business plan, which should lead to a review of practice, procedures, and policies.
- ➢ Asks all agencies to consider how they can ensure that professionals identify the need for a referral for a pre-birth social work assessment and how they will ensure that there is an

improvement in the quality of written referrals that identify the parental vulnerabilities which may pose a risk to a baby

- All the agencies working with adults, including those in the criminal justice system, to provide assurance that they will 'think family' when required.

Immediate Actions Taken to Address the Learning and Recommendations.

There have been a number of actions already taken to improve systems and practice namely:

- Manx Care – Health Safeguarding team have developed a multi – agency pre-birth protocol aligned with the Safeguarding Board Multi-agency Pre-birth procedures and a Maternity Service safeguarding policy along with a domestic abuse policy.
- The Safeguarding Board have agreed that a duty to share information for safeguarding purposes will be added to the Safeguarding Act 2018 and work to facilitate this has commenced.
- The Safeguarding Board have undertaken further promotion of the new Pre – Birth Procedures and flowchart, through a series of briefings.
- Manx Care – Health Safeguarding team have revised the Enhanced Care Pathway to ensure that absent partners are captured in the information gained and any adverse childhood experiences and risk factors are noted.
- Manx Care Health Safeguarding team now ensure that all GPs are invited to strategy meeting and outcomes are shared with all relevant agencies.
- Manx Care Health Safeguarding team have developed a Vulnerable Adolescents pathway bespoke to the age group and vulnerabilities, which is an enhanced version of the previous Vulnerable Women's pathway
- Manx Care Health Safeguarding team have commissioned safeguarding supervision training for midwifes, health visitors and school nurses, and a bespoke standalone supervision policy for both adults and children which will ensure practitioners capture "Think Family".
- The Health Visitor lead has introduced a practice directive that all staff must declare to line managers if they have a personal connection to a service user / patient.

The Safeguarding Board has developed a detailed action plan based on the recommendations, and the progress of actions will be monitored and assurances about progress sought from partner agencies. The impact of required changes to practice will also be tested and assessed using the Board's Quality Assurance and Scrutiny Framework.