GD2024/0124

SAFEGUARDING BOARD
ISLE OF MAN

ANNUAL REPORT 2023/24

Independent Chair's Introduction

Welcome to the Isle of Man Safeguarding Board Annual Report for 2023/2024, which covers the performance for the year 01 April 2023 to 31 March 2024, my third year as the Independent Chair. I have continued to see good evidence of collective multi-agency partnership working, focused on improving practice with children and their families and vulnerable adults, the details of which are outlined in this report.

My role as the Independent Chair is to receive assurance about safeguarding practice from the agencies and to ensure effective joined up multi-agency work. Also, to independently scrutinise the standard and quality of safeguarding practice for children, young people, and vulnerable adults, to ensure they are protected from abuse and harm. The Independent Chair can never be the sole provider of feedback, reflection or challenge, and the Board are continuing to develop a culture of "high support" and "high challenge", to ensure a culture of continuous improvement. This will be enhanced through development sessions for the Board planned to coincide with new Independent Board Members appointments in 2024.

My first two years as the Independent Chair concentrated on ensuring the necessary conditions were in place to promote safe and effective practice, such as appropriate policies and procedures, a comprehensive multi-agency training offer, effective sub-groups, and work plans to drive forward key work. Also, a Quality Assurance and Scrutiny Framework, that allows the Board to receive assurance and evidence of impact. This is the bedrock required to create the conditions for effective joined up safeguarding practice across all agencies. This year centered on really testing the quality and impact of practice through a robust scrutiny process and driving forward key pieces of multi-agency improvement work arising from the findings of scrutiny and Serious Case Management Reviews.

This year's Safeguarding Board Conference focused on Self-Neglect and formally launched the Self-Neglect Strategy and procedural guidance, following the publication of the Serious Case Management Review – A Thematic Review of Self-Neglect. The focus of the conference was on awareness raising about the importance of using the new tools and pathways to improve practice and how to work effectively with self-neglect to achieve impact. The family of one of the

individuals who sadly lost their life due to self-neglect, were central to promoting messages about the importance of working closely with families and carers, and understanding the challenges of having a family member who is self-neglecting. Their powerful messages at the conference and subsequent training highlighted the importance of the voice of service users and carers being at the centre of all the Board agencies work.

As outlined in this report, there have been several audits of practice and a performance dataset is now providing helpful intelligence on areas that may require support or improvement. In addition, I have led two detailed pieces of scrutiny using the agreed methodology laid out in the Board's agreed Quality Assurance and Scrutiny Framework. These focused on evaluating the impact of work to improve basic multi-agency safeguarding practice with vulnerable adults and evaluating the impact of the Vulnerable Adolescents Strategy and working protocols on safeguarding adolescents from exploitation and harms outside the home. The summary of the key findings is outlined on pages 14-17.

This year the Board have also published learning from two Serious Case Management Reviews, Child N and Child O, both of which involved serious harm to children locally. The key messages and details of work to address the findings is detailed on page 18 of this report. As a result, the Board are working with agencies to develop a Neglect Strategy, to help facilitate the recognition of and response to neglect. A toolkit for professionals will also be developed to support best practice, to ensure agencies improve outcomes for children and young people at risk of neglect locally.

In previous Annual Reports, I have reported that one of the most significant barriers to effective safeguarding practice locally has been information sharing. Despite a new Board information sharing protocol, practice guidance, a myth busting leaflet, podcast, and the reinforcement by senior leaders of the importance of sharing information where safeguarding concerns exist, it has been clear barriers remain. The Board agencies have therefore proposed an amendment to the Safeguarding Act setting out a legal duty to share information for safeguarding purposes. Alongside this, the Board have regular briefing sessions on information sharing and are ensuring this is covered in all training.

This year Board agencies have continued to experience staffing changes including at senior levels, and this has impacted on the membership of the Safeguarding Board and its sub-groups. Despite the challenges, member agencies have remained committed to ensuring that work on the Board's agreed priorities continues to move at pace, and as this report evidences, there has been significant progress on a number of pieces of work to improve multi-agency safeguarding practice.

Finally, I am happy to report that I have agreed to remain as the Independent Chair moving forward, as I am keen to continue to work with the Board agencies to celebrate good practice and focus on necessary improvements. My focus will be on ensuring progress on the agreed priorities in the new business plan and evaluating the effectiveness of current practice and its impact on outcomes for local citizens. I look forward to continuing to work closely with professionals, leaders, and politicians across the Island to ensure island residents are protected from abuse and harm.

Lesley Walker

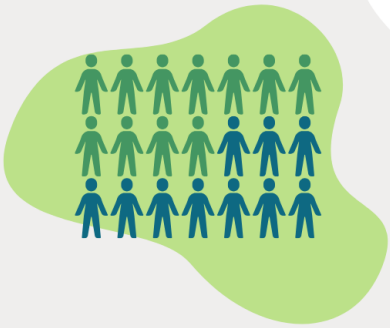
Ms Lesley Walker

Independent Chair

Isle of Man Context

Isle of Man in Numbers

Population



84,069 inhabitants
49.6% born on the Isle of Man
38.2% born in the UK
2.8% born in Asia
2.3% born in Africa
1.9% born in Republic of Ireland
1.9% born in Europe
3.3% others

Housing figures

43,881 live across 4 towns
16,414 live across 4 village districts
23,774 live across 16 parish districts

Population Split

There are 15796 children (under the age of 18) with
11,298 registered at school
44,875 are economically active
20,651 people are retired

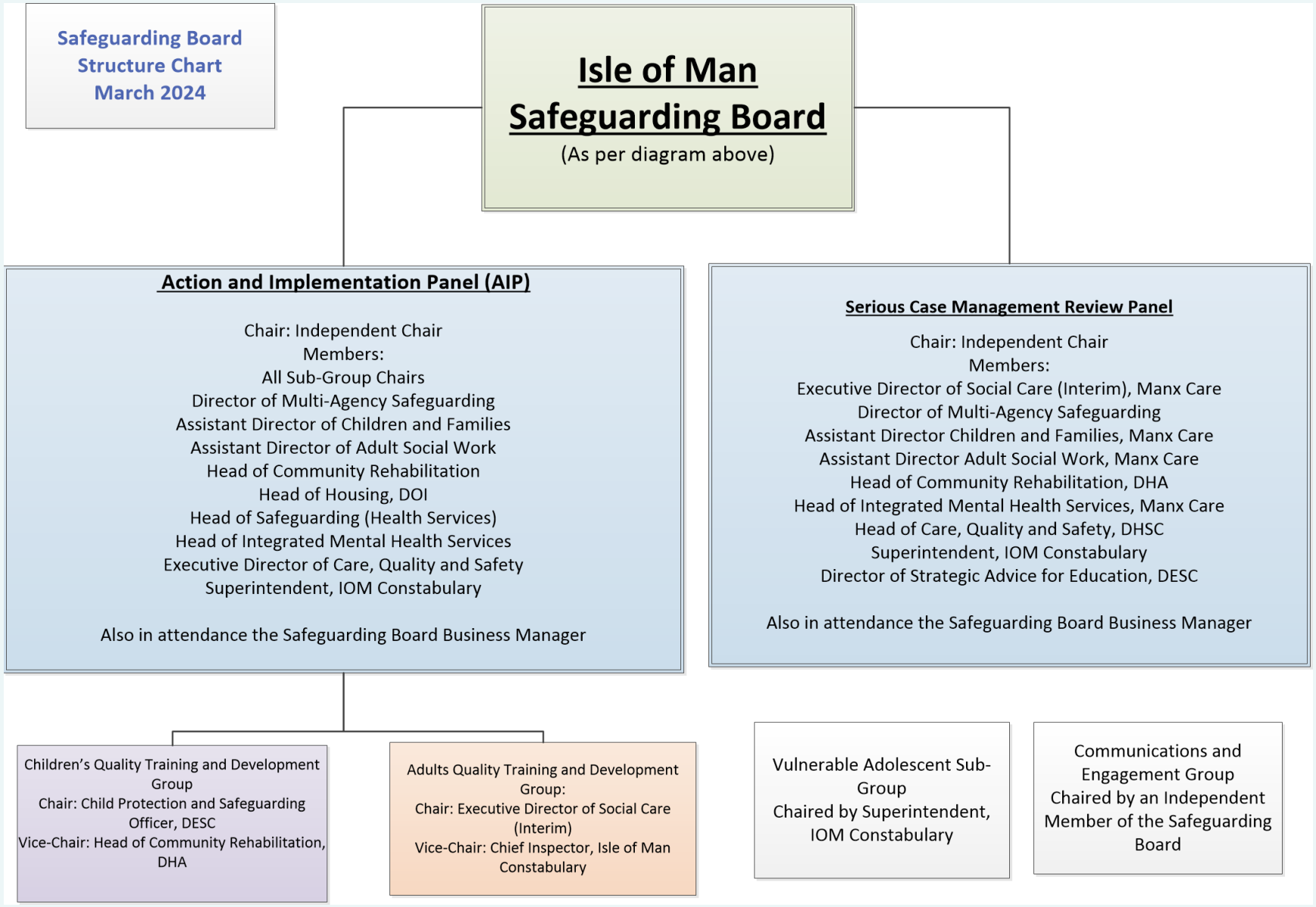
Cost of Living

Average weekly earnings
£902
Average house price
£381,060

O Land of our Birth
O Gem of God's earth
O Island so strong and so fair;
Built firm as Barrule,
Thy throne of Home Rule,
Makes us free as thy sweet mountain air

The Safeguarding Board

The Isle of Man Safeguarding Board is a partnership of key safeguarding agencies across the Island


Safeguarding Board Structure Chart March 2024
Isle of Man Safeguarding Board
(As per diagram above)
Action and Implementation Panel (AIP)
Chair: Independent Chair
Members:
All Sub-Group Chairs
Director of Multi-Agency Safeguarding
Assistant Director of Children and Families
Assistant Director of Adult Social Work
Head of Community Rehabilitation
Head of Housing, DOI
Head of Safeguarding (Health Services)
Head of Integrated Mental Health Services
Executive Director of Care, Quality and Safety
Superintendent, IOM Constabulary
Also in attendance the Safeguarding Board Business Manager
Serious Case Management Review Panel
Chair: Independent Chair
Members:
Executive Director of Social Care (Interim), Manx Care
Director of Multi-Agency Safeguarding
Assistant Director Children and Families, Manx Care
Assistant Director Adult Social Work, Manx Care
Head of Community Rehabilitation, DHA
Head of Integrated Mental Health Services, Manx Care
Head of Care, Quality and Safety, DHSC
Superintendent, IOM Constabulary
Director of Strategic Advice for Education, DESC
Also in attendance the Safeguarding Board Business Manager
Children's Quality Training and Development Group
Chair: Child Protection and Safeguarding Officer, DESC
Vice-Chair: Head of Community Rehabilitation, DHA
Adults Quality Training and Development Group:
Chair: Executive Director of Social Care (Interim)
Vice-Chair: Chief Inspector, Isle of Man Constabulary
Vulnerable Adolescent Sub-Group
Chaired by Superintendent, IOM Constabulary
Communications and Engagement Group
Chaired by an Independent Member of the Safeguarding Board

Priorities

The Safeguarding Board agreed two key practice priorities and three overarching priorities and areas for necessary focus in the Business Plan. There has been significant work undertaken by the Board's subgroups - Children Quality Training & Development group, Adult Quality Training & Development group, Communication & Engagement Group, Vulnerable Adolescent Working group aligned to the agreed priorities. The key highlights are:

Priority 1: Working together to effectively safeguard vulnerable adolescents

- Delivered a multi-agency training offer for child exploitation and contextual safeguarding in support of the new working protocol and tools.
- Promoted several media campaigns to raise awareness of exploitation signs & indicators and how to raise concerns about a child or young person.
- Multi-agency plans were implemented to manage the risks to victims and from perpetrators, relating to sexual & criminal exploitation by organised crime groups.
- Continual promotion of information and intelligence sharing to safeguard vulnerable young people via multi-agency meetings
- Scrutiny event to test out and review the impact of multi-agency work aligned to the Vulnerable Adolescent Strategy and Protocol.

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

- Launch of the self-neglect development strategy and multi-agency procedural guidance / pathway at the Board's Self Neglect conference in September 2023.
- Delivered bespoke self-neglect training at various levels to support the new multi- agency procedures & pathways.
- Facilitated multi-agency adult safeguarding training to a variety of agencies & sectors.

- Undertook a number of multi-agency audits regarding adult safeguarding practice which demonstrated a significant improvement in service delivery and agencies working together.
- Scrutiny event undertaken to test out the quality of adult safeguarding practice within the multi-agency arena.

The subgroups have also undertaken work aligned to the following overarching priority:

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

Each of the Boards subgroups have provided assurance reports on the work completed aligned to the priorities above and via evidence within their work plans.

Quality Assurance & Scrutiny

The Board developed and introduced its Quality Assurance and Scrutiny Framework in October 2022, which sets out the processes to be used by the Board to gain assurance about the effectiveness of safeguarding activity for children, young people, and vulnerable adults. The overall aim is to ensure the very best practice possible in the Isle of Man and that agencies and sectors are working collectively and can evidence the positive impact of their work. There have been several key elements that have been a focus for the Board this year:

- Undertaking multi-agency audits to evaluate the strengths in practice and areas for improvement.
- Independent Scrutiny of Multi- Agency Adult Safeguarding practice to evaluate the impact of agencies work and overall progress against key Board initiatives.
- Embedding learning from Serious Case Management Reviews and tracking progress on the recommendations and actions
- Action planning by agencies to address the areas of improvement identified by agencies in their Organisational Standards Audits

Performance Dataset

The Children Quality Training & Development subgroup and the Adults Quality Training & Development subgroup have continued to review and revise the dataset to ensure that it remains relevant and useful to share identified trends and emerging themes with Board members.

The dataset is a comprehensive collation of metrics that individual agencies collate for internal use and over the number of quarters during this period it has been helpful to track any variance in numbers and present both positive and negative themes and trends.

Each agency represented at the subgroup submit a report to highlight crucial information that the data is showing and share the plans to analyse further and address any issues in order to improve performance and service delivery.

Organisational Standards Audit

The Organisational Standards Audit (OSA) is a mechanism to evaluate and monitor the effectiveness of how agencies safeguarding and promote the welfare of children and vulnerable adults. All agencies represented on the Safeguarding Board completed a self-assessment and provided evidence of how they comply with eight key safeguarding standards in January 2023.

Each agency submitted an action plan to address any identified areas of improvement and the progress has been monitored and support via the Board's subgroups. There has been regular evidence provided of the progress made during this reporting period 2023/24, and where there have been cross cutting themes / areas of development, the groups have explored how these can be worked on collaboratively.

The key improvement themes identified were:

- The dissemination of audit and SCMR findings / learning to frontline staff and the evaluation of impact on practice.
- The analysis and learning from complaints being shared with frontline staff to assist service development.
- Development of service user engagement and participation in consultation processes
- To ensure an appropriate training offer to meet need and mechanism to evaluate impact
- Overall awareness of the Information Sharing protocol and associated documents.

The Organisational Safeguarding Standards Audit will be repeated in 2025, where agency assurance will be sought as to the sustainability of the improvements noted over the two-year period.

Practice Audits

Single agency and multi-agency practice audits are essential to provide insight into the effectiveness of practice, and assurance that it is of the required quality and standard. It also provides a baseline against which to measure and monitor any practice improvements.

In each of the Quality Training & Development(QTD) subgroups, there is a schedule of single agency audits and learning which is shared at each meeting. Agency members participate in taking forward any shared multi-agency learning and also provide respectful challenge during discussions and posing curious questions, when required.

In the Adults' QTD group, a baseline audit of allocated cases was undertaken to evaluate the quality of multi-agency adult safeguarding practice. The audit findings formed part of the basis of the adult scrutiny process, and these are highlighted later in this report.

In the Children's QTD group, two rounds of multi-agency audit were undertaken to evaluate the quality of practice offer to vulnerable adolescents at risk of exploitation and in line with the new Vulnerable Adolescent working protocol. The audit findings informed part of the children's scrutiny process and the findings are highlighted later in this report.

Independent Scrutiny

The Independent Chair provides independent scrutiny and support and challenge, to ensure children and young people and vulnerable adults are effectively safeguarded from abuse and harm. Specific thematic scrutiny is focused on evaluating the impact of multi-agency work on the Boards's business priorities.

This scrutiny uses the Board's agreed process, which consists of analysing and triangulating information from a range of sources, including single agency and multi-agency audits, feedback from service users, carers and families, interviews with frontline practitioners, learning from serious case management reviews, performance data and examples of good practice. The evaluation and analysis developed from this information, identifies what is working well and where improvements are required to multi-agency practice, at an operational and strategic level. The evaluation is then fed into an interactive scrutiny event led by the Independent Chair, involving senior operational leaders and relevant representatives. During the event, those present work together to reflect on the key findings and developing key actions to address areas of practice that require strengthening. This year there has been scrutiny of both safeguarding practice in relation to both vulnerable adults and children and young people.

Safeguarding Adults Scrutiny

Last year the Board had to pause the scrutiny of multi-agency adult safeguarding practice, after concerns were raised during the early evaluation about: clarity of roles and responsibilities across agencies in adult safeguarding cases, clarity about thresholds for referral, lack of feedback to professionals following referrals and at case closure, and the robustness of safeguarding plans. It was agreed that immediate improvement work would be led by the Executive Director of Adult and Children's Social Care and regular assurance reports would be presented to the Safeguarding Board on progress. The Board agreed adult safeguarding practice would be added to the Board's risk register.

The scrutiny process was restarted in September 2023 to evaluate both basic safeguarding practice and ensure that the necessary practice improvements were being implemented. The aim was to develop a comprehensive overview of how partners had worked together in adult safeguarding cases, using an agreed baseline of practice and expectations. The following basic success factors were agreed to support the evaluation:

- Procedures are known about and being followed.
- Risk is identified and responded to in a timely manner.
- Information is shared effectively both internally and between multi-agency partners.
- There is evidence of the voice of the adult and evidence that the lived experience of the adult is understood.
- Multi-agency working has a positive effect on the outcomes for the adult.

The work commenced with each agency partner completing an agency case file audit and then coming together to discuss the findings, to reach an agreed consensus and rate practice. The audit findings report, performance datasets, feedback sessions with frontline practitioners, learning from reviews and evidence of best practice were collated into a scrutiny evaluation report, which formed the basis of the scrutiny pack. This pack was used for reflection and action planning with senior operational managers at the scrutiny event on 14 March 24 and the key

findings, good practice and areas for improvement were drawn together into an Independent Scrutiny Report prepared by the Independent Chair.

Overall, the scrutiny report identified that practice improvements in relation to adult safeguarding had been made across all agencies, but especially by the Adult Safeguarding Team. Collaborative working had also improved and there was good evidence that this is leading to improved outcomes and a positive impact for service users. A number of examples of good practice were highlighted with strong evidence of high levels of engagement with services users by all agencies and evidence of Making Safeguarding Personal in all of the audits. The following key areas for improvement were identified:

- The need to promote a culture of professional curiosity which is supported by reflective supervision and training.
- Standard operating procedures for the Adult Safeguarding team must be progressed to include, chronology use and case recording, including the need to record supervision decisions..
- Further single-agency and multi-agency review and audits of the safeguarding planning process should be undertaken, to ensure the planning stage record is sufficiently and proportionally detailed, including actions and to evidence that plans are recorded and shared.
- The Adult Quality Training and Development sub-group of the Board to develop a proposal to support improved understanding of consent.
- AQTDG must seek assurance that the Adult Safeguarding Team is consistently providing feedback on the outcome and response to safeguarding referrals.
- Multi-agency Chronology Practice Guidance should be developed by the AQTDG for use in all adult cases. The Adult Quality Training and Development sub committee of the Board will ensure that the work plan for the coming year details action in response to all recommendations and findings in the Scrutiny report.

The Adults' Quality Training and Development Sub-Group (AQTDG) will ensure that the work plan for the coming year details actions in response to all recommendations and findings in the Scrutiny report and will report progress to the Board. Further scrutiny of adult safeguarding practice is planned later in 2024, when the Board will be evaluating the impact of the work undertaken to improve the response to self-neglect following the publication of the Thematic Review of Self-Neglect.

Safeguarding Children's Scrutiny

The focus this year in relation to children's scrutiny, was on evaluating the impact of partners work in relation to the exploitation business priority. The Vulnerable Adolescent Strategy and Procedural Protocol and tools were launched at the Conference in October 2022, and the Board were keen to evaluate the impact of the strategy by assessing the way partners practice in order to provide assurance that vulnerable adolescents are being kept safe from harm. It was agreed to use a set of agreed success factors under the four pillars of the strategy, namely Prevent, Pursue, Protect and Disrupt, to support the evaluation.

In line with the normal scrutiny process two multi-agency practice audits were planned and commenced in September 2023. The audit findings report, observations of key meetings, interviews with a random cohort of families, performance data, feedback sessions with frontline practitioners, learning from reviews and evidence of best practice were collated into a scrutiny evaluation report, which formed the basis of the scrutiny pack. This pack was used for reflection and action planning with senior operational managers at the scrutiny event on 6 March 2024, and the key findings, good practice and areas for improvement were drawn together into an Independent Scrutiny Report prepared by the Independent Chair.

The commitment to and focus on safeguarding vulnerable adolescents locally had improved, compared to the position when the Child J Serious Case Management Review report was published in 2021. There was evidence of collaborative working and good multi-agency working relationships, which are critical when working in the complex and ever evolving area of exploitation. Agencies had also committed additional resources, for example an exploitation support worker and a safeguarding health exploitation lead. Moreover, during this period

agencies had committed to setting up a Multi-Agency Safeguarding Hub pilot (MASH) and considered how the Daily Exploitation Meetings (DEMs) could work effectively alongside the pilot.

The scrutiny process highlighted some good practice and the need to share examples of the types of interventions working most effectively in tackling exploitation. However, it also highlighted the need for a range of actions to improve practice with young people and their families where there are identified risks of exploitation. It again raised the need for a cross Island Early Help Strategy, as a way of preventing those most vulnerable to this type of abuse from being harmed. This includes children who have suffered early trauma or who have identified vulnerabilities including neurodiversity. The need for a comprehensive Early Help Strategy was identified in the Child J SCMR published in 2021 and although there is a commitment to develop this, there is limited evidence of progress to date.

Scrutiny identified some immediate areas for improvement especially the need to reset practice in line with the agreed operating protocol. This reset workshop will take place in April and the Independent Scrutiny findings and recommendations will be presented to the Board for sign off and agreement in relation to the way forward. The findings and recommendations if accepted by the Board, will form the basis of a detailed workplan for the Board's Exploitation Subgroup. This group will also be focused on developing an Exploitation Strategy that also concentrates on vulnerable adults and will need to ensure that there is sufficient focus on young people transitioning into adult services, as this is a particularly vulnerable phase.

Serious Case Management Review Panel

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

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

The Board has completed two SCMR's in this reporting period, however neither of the full review reports have been published due to the sensitive nature of the circumstances. Summary learning briefings will be available.

The two SCMR's Child N and Child O concerned young children under the age of two with near-miss incidents where medical interventions prevented serious injuries or death and had similar identified learning for professionals.

The learning focused on the importance of sharing information pre-birth when there are known or knowable parental vulnerabilities such as mental health issues, a history of abuse or neglect, care experienced parents, substance misuse, and concerns about anger management and violence. The importance of serious consideration of the impact of parental issues on a baby, including pre-birth, alongside offering an appropriate level of support.

The reviews highlighted the need to promote the welfare and safety of young children and focus on their likely or lived experiences; and the importance of professional challenge if practice appeared overly parent focused and reliant on parental self-reporting. Also that robust consideration is given to assessing risk or potential impact when parents refuse to give or withdraw consent to share information or engage with assessments.

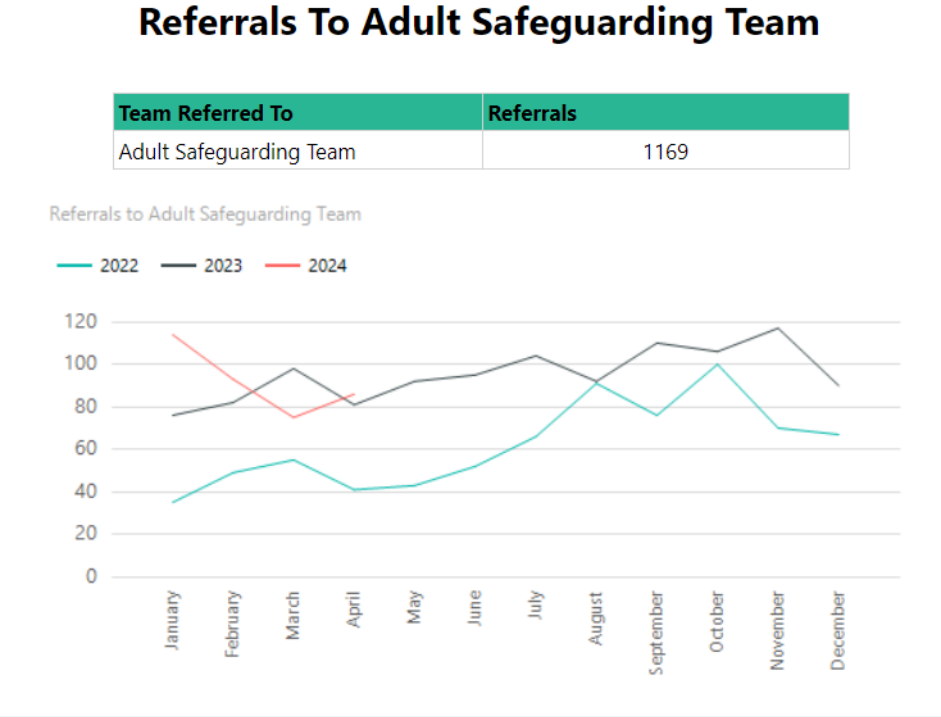
Both reviews highlighted the need for professional confidence in knowing when and how to share information and have a good understanding of information sharing guidance and legislation.

Safeguarding in the Isle of Man

Adult Safeguarding

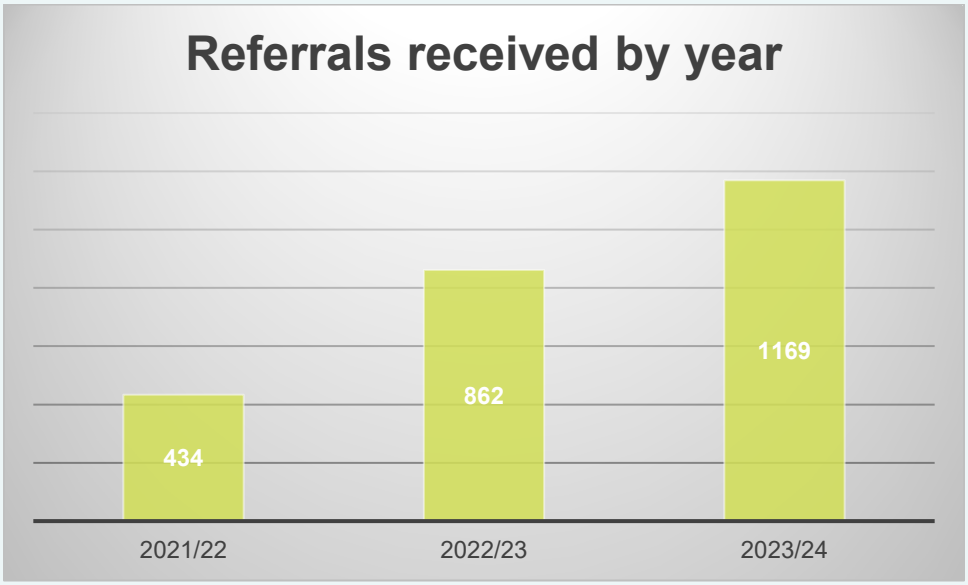
During this reporting period, the Adult Safeguarding Team (AST), in Manx Care, managed a significant increase in referrals in the autumn of 2023. This is likely to have been an impact of the launch of the Self Neglect Policy and Guidance which was informed by the Thematic Review on Self Neglect. Total numbers show an increase in referrals to 1169 from 862 in the previous year.

The chart below shows the number of referrals in comparison with previous years:



The table below highlights the increase in referrals since 2021/22 and demonstrates an approximate increase of 155% in the yearly referrals to the team. This could be due to a myriad of reasons including better public awareness of Safeguarding issues; the promotion of the Adult Safeguarding Board website and training opportunities available; the impact of the staff in the

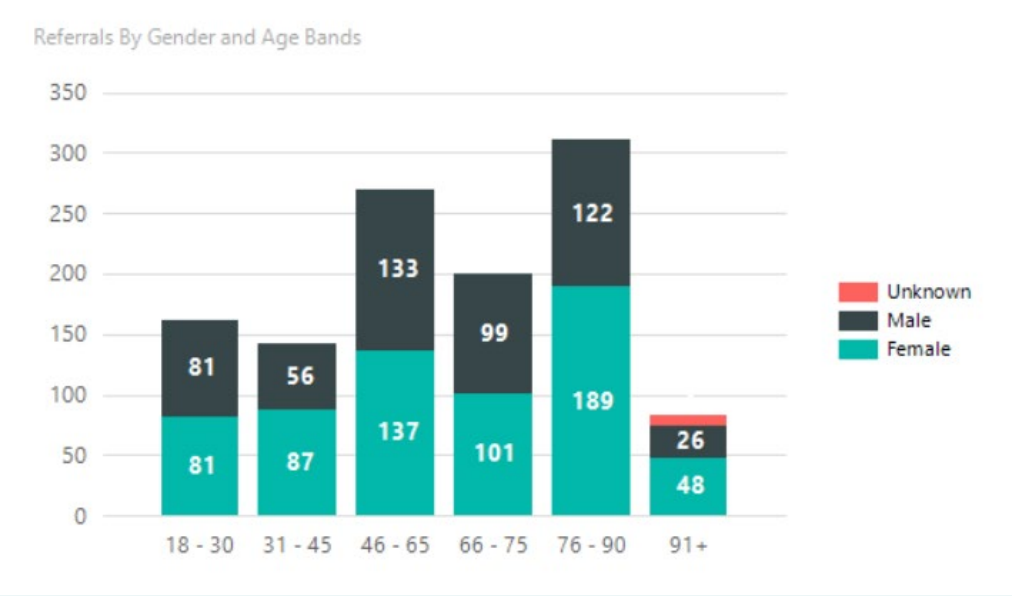
health safeguarding team etc. The Adult Services review and self-neglect thematic review have also had a direct impact on the increase in referrals. This was particularly noticeable following the official launch of the new self-neglect procedural guidance in September 2023.

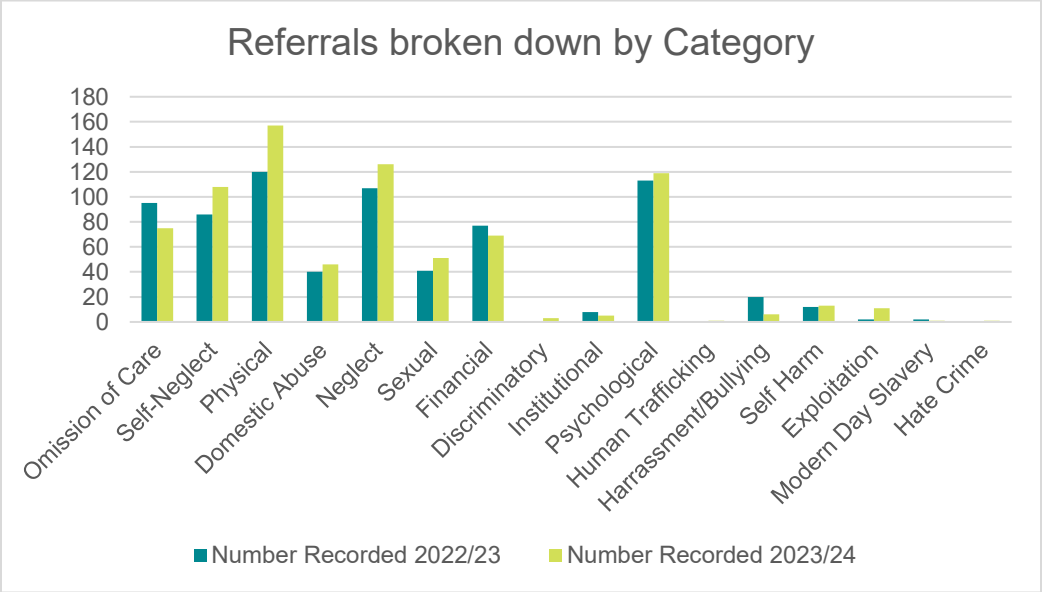


The team have also received a significant number of inappropriate referrals where a social work referral would have been the most appropriate route to assess and identify need and complete care planning to meet that need. However, all referrals which do not meet the threshold for safeguarding case work are passed across to the lead professional/agency to co-ordinate a multi-disciplinary response.

Referrals by age and gender are shown below, with the highest referral rate being in the 76–90-year-old cohort, closely followed by 46–65-year-old group. In the previous reporting year, the highest referral cohort was 66–75-year-olds. It is likely that the increase in referrals in the 46–65-year age group relate to the increase in self-neglect referrals to the team. In most age groups female referrals are higher than males.

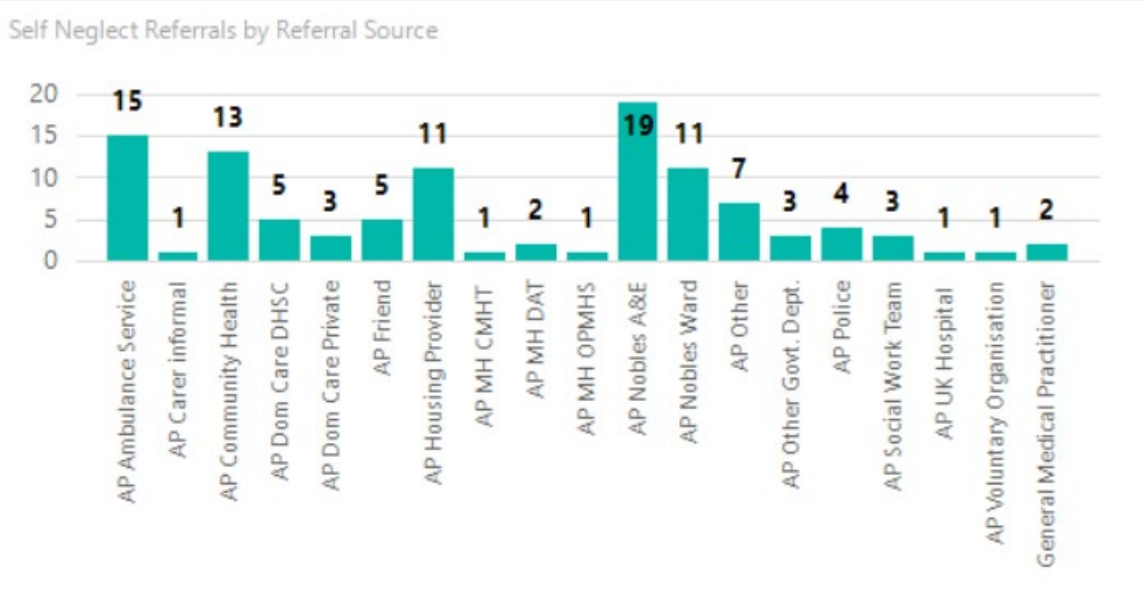
In terms of abuse/harm types the team are seeing substantial increases in many areas of abuse as evidenced by the table below:





Self-neglect by referral source:

The awareness of self-neglect concerns has increased across many agencies and the table below breaks down referral source for self-neglect matters:



Re-referrals to Adult Safeguarding were 190 for this reporting period. The level of re-referrals as a proportion of overall referrals has remained stable throughout the period. This indicates a degree of consistency in decision making in the service.

The Four Stages of Safeguarding

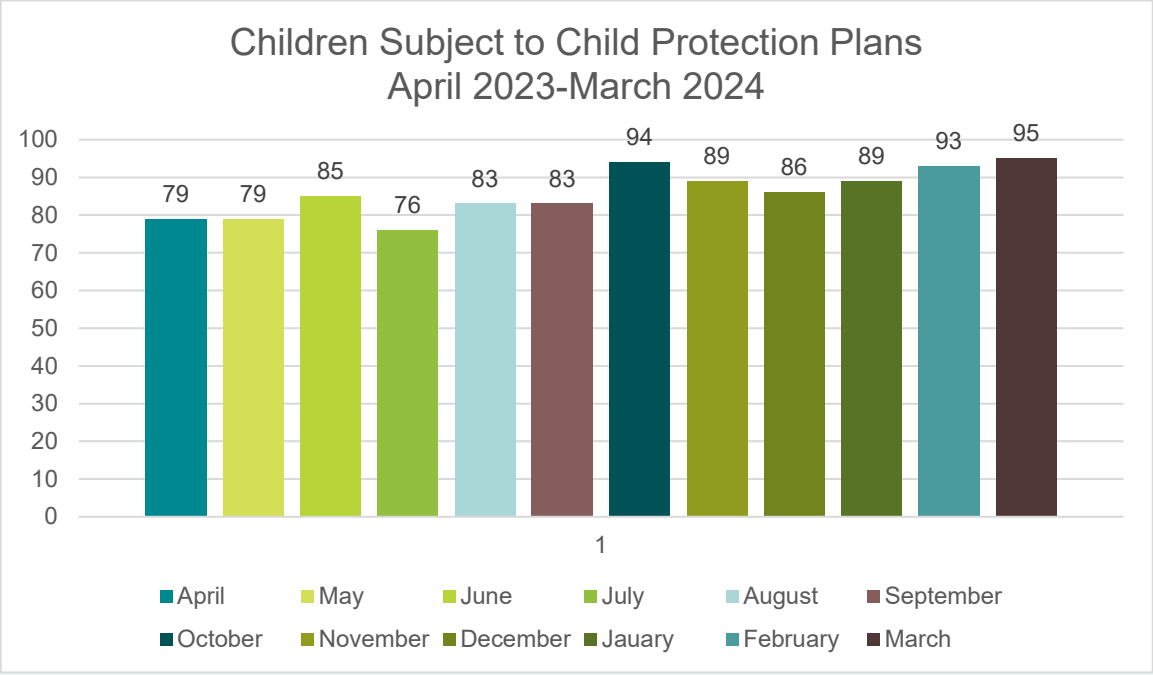
- Stage 1 – Raising Adult Safeguarding Concerns
- Stage 2 – Enquiries
- Stage 3 – Safeguarding Plan and Review
- Stage 4 – Closing the Safeguarding Enquiry

In terms of the four stages of Safeguarding only 16 Case Conferences (Stage 3 – Protection Plan) were held this year which is positive and in line with the value base of the new Adult Protection policy and procedures, which is service user led and focused on outcomes rather than process. A large majority of cases can be supported through protection plans which are implemented at the planning stage which is more proportionate to the level of risks and is person led.

Contacts and referrals:

The increase in contact numbers from March 2023-March 2024 (155 to 215) has been due to a change in recording of contacts on existing cases within Children and Families. Previously contacts were not added on to open cases and any significant information was added as a case note which we found was easily missed whereas a contact is not. When a contact is made to the service this is for information only, if there is a need for more work or enquiries to be completed then the contact will be progressed to referral stage to enable this to take place. Referral numbers have however remained relatively consistent across the year. The low number of contacts resulting in no action or information and advice over the year is indicative of an improvement in the quality and appropriateness of referrals (MARFs) being received by Children and Families. This is thought to be due to the new multi-agency working arrangements developed this year with the Multi-Agency Safeguarding Hub (MASH) which began in June 2023.

Child Protection planning:

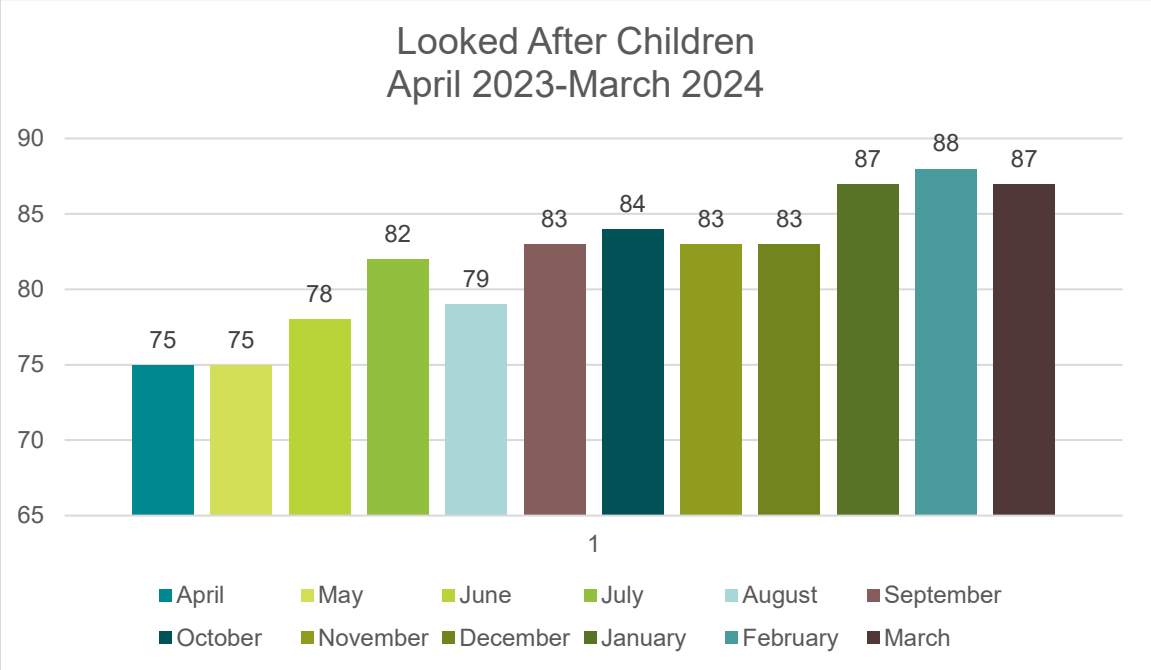


There has been a significant increase in the number of children subject to child protection plans from March 2023 (79) to March 2024 (95). This increase has been due to a high number of initial

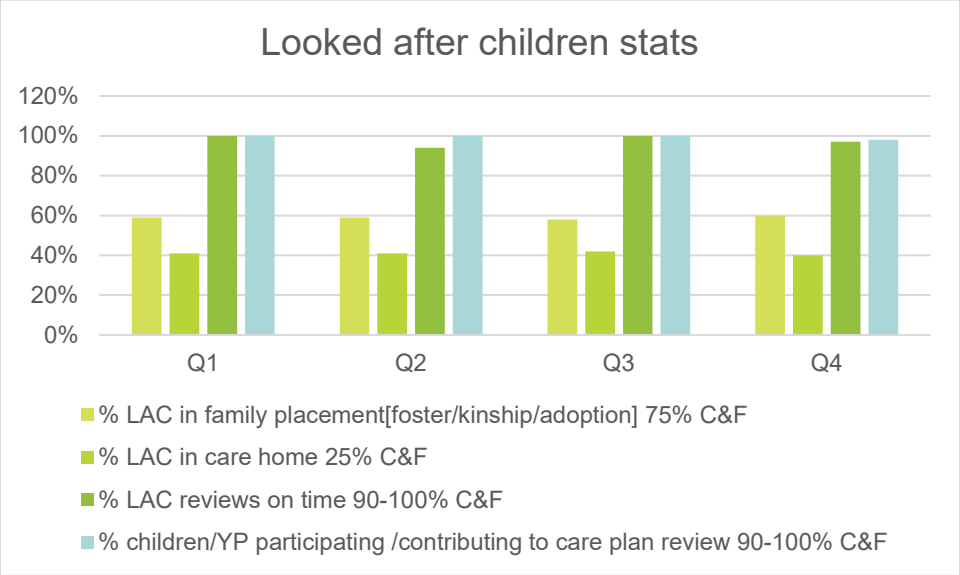
child protection conference requests from January – March 2024 (33 children). Audit activity is occurring to understand the cause for this and a mechanism for scrutiny of ICPC requests by the Group Managers is being introduced as an interim measure to ensure the correct application of threshold. Audits did show that the application of threshold for initial child protection case conference was not always robust, which did result in requests for the plan at the 3-month review. The Group managers now have sight of cases being progressed to Initial Child Protection Conference (ICPC) and review the threshold for these cases to ensure it is appropriate.

There has been a decrease in the number of children subject to child protection plans for longer than 15 months; in March 2023 this was 11 children (7 families), March 2024 this number was 7 children (2 families). This data suggests a reduction in drift in child protection planning.

Looked after Children:

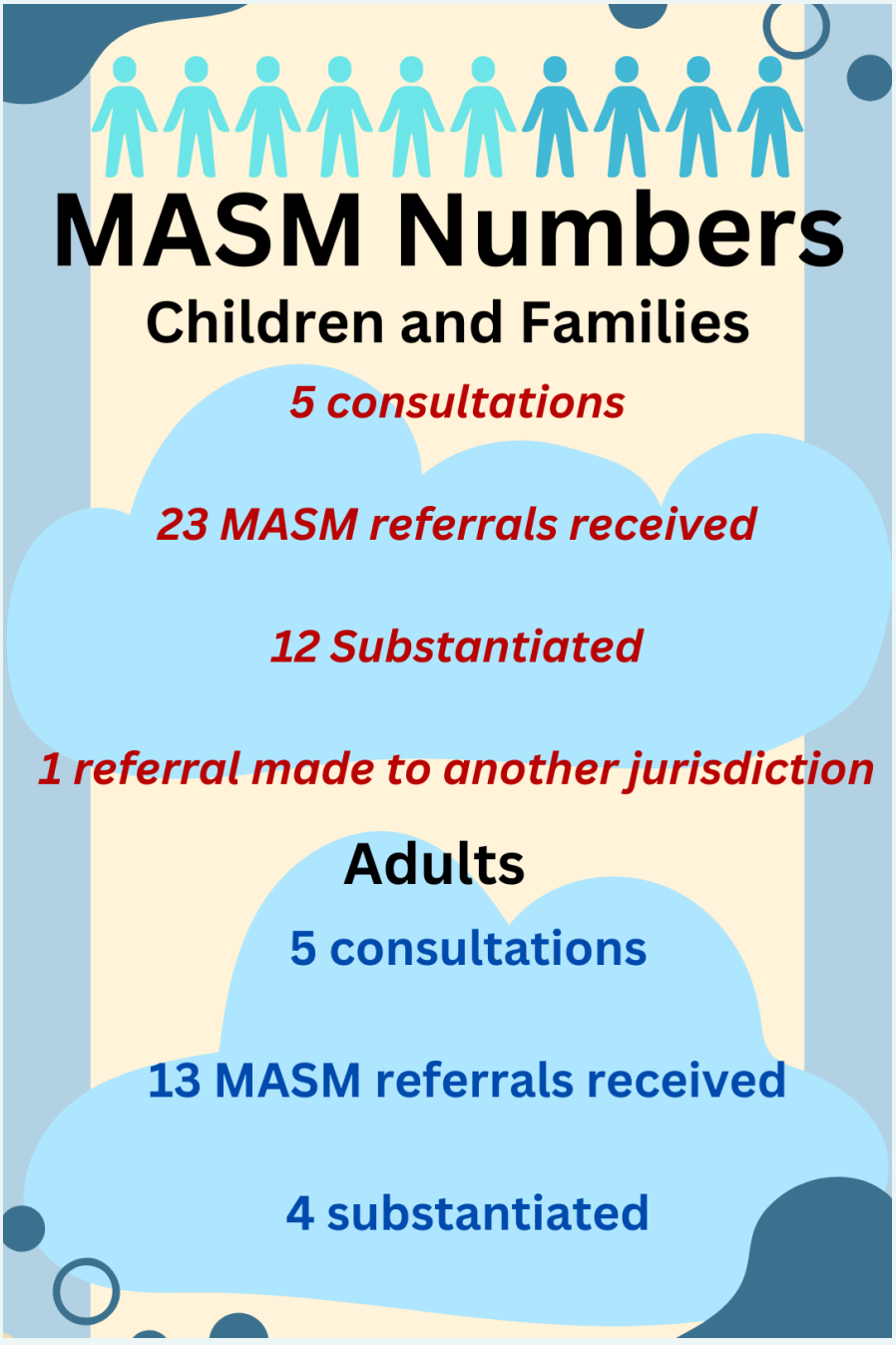


The slight increase in numbers of Looked After children in January was contributed to by a large sibling group (4 children) being accommodated due to their parents' bail conditions. Looked After numbers have remained relatively consistent across the year and in comparison, with previous years. During this reporting period the Edge of Care service was implemented and this initiative has seen children return to or remain at home where it is safe and appropriate to do so



There has been a reduction of the number of Looked After Children identified to be at risk of criminal exploitation to 5; no children were identified at risk of sexual exploitation. Practice in working with young people at risk of exploitation is currently being scrutinised by the Safeguarding Board to evaluate the effectiveness and impact of multi-agency interventions .

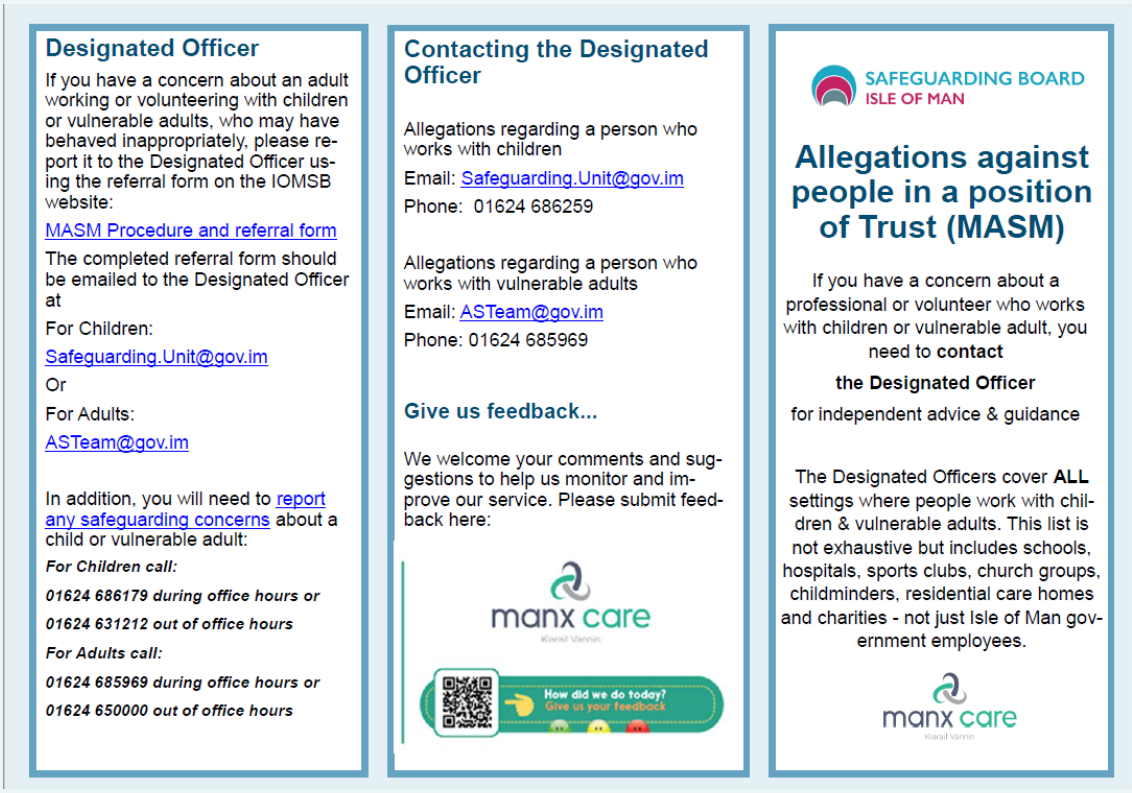
MASM–Managing Allegations against a person working with children & vulnerable adults procedure.



The MASM procedure is a coordinated process following allegations made about people considered to be in a position of trust in organisations and setting providing services to children and vulnerable adults and provides oversight of those robust multi-agency investigations of risk.

This mechanism is used to ensure that all agencies are providing a safe service and explore all issues relating to conduct, risk and potential abuse / harm to children and adults. The Board's dataset includes data pertaining to MASM activity to provide assurance regarding the management of allegations against people within a position of trust, following the Knottfield enquiry into institutional abuse.

The new joint procedure for children and adults MASM with bespoke referral forms was introduced in February 2023; and this has been supported through MASM awareness training aimed at all agencies and sectors where professionals (employed or volunteers) are working in positions of trust. There has also been an information leaflet designed to be distributed to a variety of settings which provides clear guidance and expectations on how allegations against those in a position must be dealt with



Designated Officer

If you have a concern about an adult working or volunteering with children or vulnerable adults, who may have behaved inappropriately, please report it to the Designated Officer using the referral form on the IOMSB website:

MASM Procedure and referral form

The completed referral form should be emailed to the Designated Officer at

For Children:

Safeguarding.Unit@gov.im

Or

For Adults:

ASTeam@gov.im

In addition, you will need to report any safeguarding concerns about a child or vulnerable adult:

For Children call:

01624 686179 during office hours or

01624 631212 out of office hours

For Adults call:

01624 685969 during office hours or

01624 650000 out of office hours

Contacting the Designated Officer

Allegations regarding a person who works with children

Email: Safeguarding.Unit@gov.im

Phone: 01624 686259

Allegations regarding a person who works with vulnerable adults

Email: ASTeam@gov.im

Phone: 01624 685969

Give us feedback...

We welcome your comments and suggestions to help us monitor and improve our service. Please submit feedback here:

manx care

How did we do today? Give us your feedback

SAFEGUARDING BOARD ISLE OF MAN

Allegations against people in a position of Trust (MASM)

If you have a concern about a professional or volunteer who works with children or vulnerable adult, you need to **contact**

the Designated Officer

for independent advice & guidance

The Designated Officers cover **ALL** settings where people work with children & vulnerable adults. This list is not exhaustive but includes schools, hospitals, sports clubs, church groups, childminders, residential care homes and charities - not just Isle of Man government employees.

manx care

Training

This report year has been busy with developing and delivering core training and hosting specialist safeguarding courses, ensuring that the Board was able to offer a comprehensive training offer as a priority.

The training schedule is circulated widely across government departments, Manx Care, schools and third sector agencies and available on the Safeguarding Board website. In addition, we regularly promote upcoming courses to managers within targeted agencies and sectors and advertise forthcoming courses and spaces available on the Safeguarding Board Facebook page.

On-Line Level 1 Safeguarding Training – Adult & Children

The Its Learning and eLearn Vannin platforms continue to be an important part of the Board's training offer. It provides a good level of basic training in both child safeguarding and adult safeguarding, which can be completed within two hours approximately. It can be accessed on the eLearn Vannin platform within government and Its Learning platform for those who do not have access to a government email address.

In addition, the Board provided additional learning at the annual conference in September which launched

the Self Neglect Strategy and Procedural Guidance, and a number of interesting presentations regarding various professional agency experiences of working with self-neglect issues. There are further details about the conference in the section below.

Future Planning

The planning process for the training offer of 2024/25 has begun, which will include a core training programme based on the analysis of Partner agency's Training Needs assessment, along with bespoke and specialist training recommended by Serious Case Management Review authors and based on multi- agency audit findings.

There are many different learning opportunities being planned where partner agencies can share experiences relating to specific topics, such as professional curiosity workshops; Lunch & Learn webinars to offer practitioners an hour online session discussing a variety of topics; regular sessions with teams and services to promote key messages and learning from Board activity with a wide variety of services/sectors.

There will also be further learning opportunities offered in the next year's Safeguarding week for children and adult services, where various activities and workshops will be facilitated to raise awareness of safeguarding topics and experiences.

Safeguarding Board events 2023/24

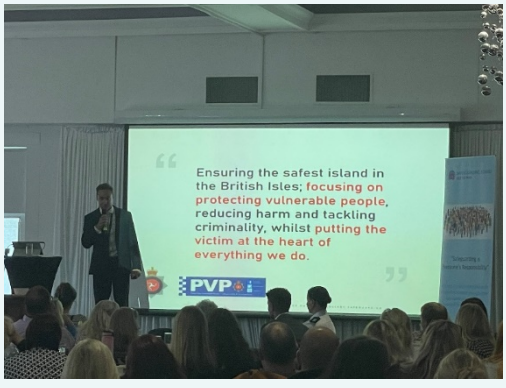
The Board hosted two big events during the reporting period – the first ever joint adults & children safeguarding week in November 2023 and the Self Neglect conference in September 2023.

Self-Neglect Conference

The Board hosted the Self-Neglect Conference in September 2023 to launch the Self Neglect Development Strategy, Procedural guidance and pathway.

The conference was attended by 124 delegates across government departments, Manx Care and third sector agencies. The guest speakers were Sylvia Manson and members of Andrea's family – (Andrea, not her real name, was one of the people who had died due to self-neglect and whose circumstances formed part of the thematic serious case management review).

The conference covered a variety of topics relevant to working with people who self-neglect including capacity & consent, self-neglect & the Mental Health act, which was presented by representatives from partner agencies. There were presentations from a number of agencies sharing their experience of vulnerable adults who self - neglect along with a recorded interview with Andrea's family to share their personal journey regarding her life with self-neglect and the impact of events following her death.



The conference has been well received and delegates shared the event was very engaging and informative.

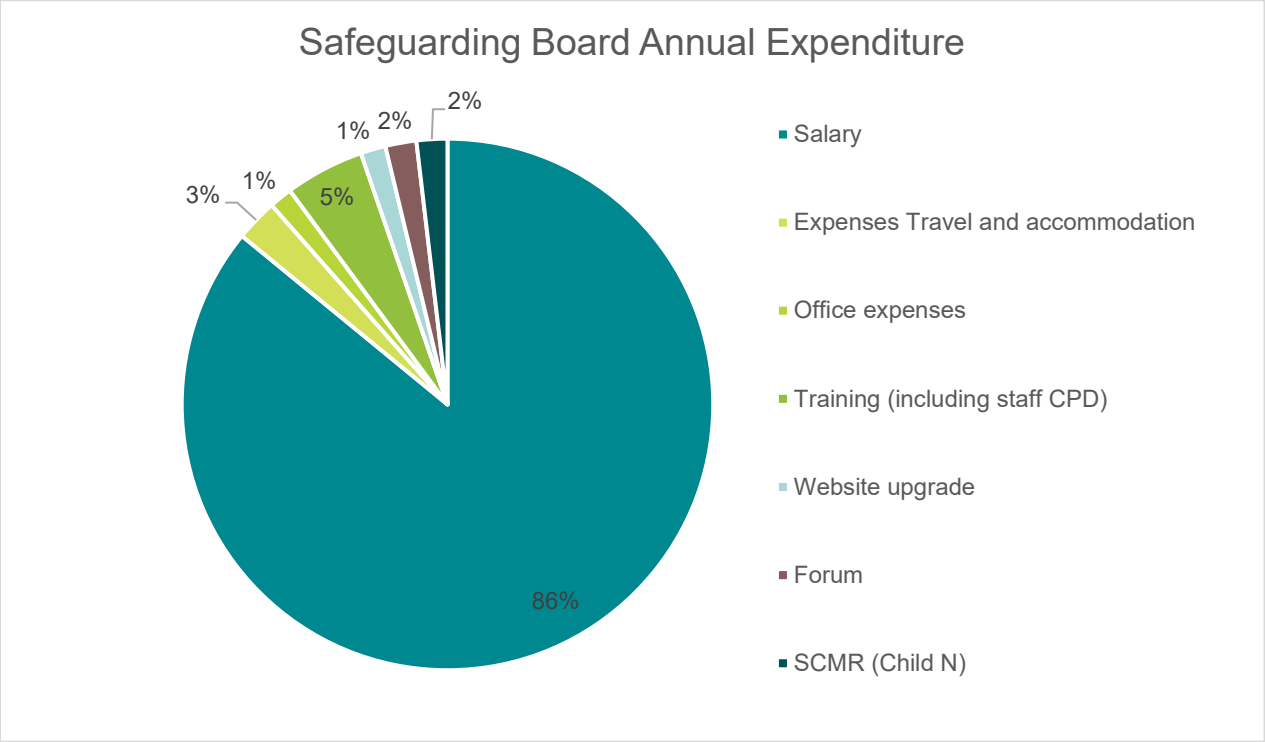
Safeguarding Week

The board hosted the first Safeguarding week for children and adults across the Island during the week of 20 to 24 November 2023. As a multi-agency partnership, we agreed an ambitious plan to promote and raise awareness of various safeguarding topics facilitated by government departments, police, schools, voluntary organisations, faith sector and charities. The activities included a podcast by the Constabulary, events and pop-up activities.

Some partner agencies collaborated on activities which added to the richness of the offer. Events were offered to the community and others bespoke to practitioners from a variety of agencies and services.

There were 27 individual sessions delivered covering topics such as trauma informed practice, safeguarding in churches, keeping sport safe in the community, adult safeguarding, impact of self-harm in families, mental capacity and eating disorders, learning from adult and children reviews, domestic abuse, feeling safe in the community including 'Ask Angela' Campaign. Along with advice sessions and pop ups regarding housing issues, financial abuse, children safeguarding and exploitation.

Budget



Future Plans

The Board had another busy year and achieved significant progress against the agreed multi-agency priorities in the business plan, as evidenced in this report. This year has been more focused on both ensuring and evaluating the quality and impact of multi-agency-practice. It will be important that further in-depth analysis and evaluation of the impact of work on the agreed priorities, and progress on identified areas of practice improvement continue at pace in 2024/25.

Following an evaluation workshop, the Board agreed a new vision and a set of business priorities for 2024-2027. These reflect areas identified through; performance data, local intelligence and audit, Serious Case Management Reviews and findings from scrutiny that identified further improvement. The agreed priorities are:

- Ensuring effective multi – agency safeguarding practice for vulnerable adults.
- Safeguarding adolescents from risks and harm outside of the home.

- Improving the multi-agency response to childhood neglect
- Embedding learning to improve practice.

Each priority will be owned and driven by one of the Board sub-groups or a specific task and finish group and progress will be regularly reported to the Board.

Board members are committed to improving the voice and input of service users, their families and carers in 2024/25. Alongside this, they have committed to involving a wider range of agencies and sectors in the work of the Board and enhancing the involvement of practitioners in practice improvement.

Next year's annual report will highlight the progress made against each of the new Business Priorities.

The Board would like to thank staff across all sectors and communities that have contributed to the work of the Board. We welcome feedback about how to improve safeguarding practice and protection for our children and vulnerable adults.

The Board can be contacted at safeguardingboard.co@gov.im