Isle of Man Safeguarding Board

Child J-SCMR

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Who is Child J?

Child J is a younger sibling in a fairly large family and has had an allocated social worker since just before they had reached the age of eight years old.

They had been the subject of safeguarding procedures periodically for over six years which started when they were only seven. The child protection planning for them between 2014 and 2019 was because of the emotional impact on them due to their father being convicted of an offence, domestic abuse and family dynamics, an extended private law proceedings for custody and parental access. When they were stepped down from a child protection plan, support continued through a child with complex needs plan until they were accommodated under section 25 CYPA 2001 in October 2019.

Child J's life was felt by professionals to be complex, chaotic and emotionally challenging. Child J became involved in drugs. They were deemed as "beyond parental control" and were regularly missing from home and was becoming increasingly more violent. Matters came to a head when they overdosed and was admitted to hospital and transferred to Intensive Care. As they recovered, they assaulted care staff and police officers and subsequently was remanded into the care of the department and had time in a secure unit.

It was also equally complex and difficult for those professionals trying to work with Child J and how difficult this was for their social worker trying hard to help and safeguard them. Over a 6-month period Child J attended the Emergency Department (ED) at hospital on six occasions due to theirs or others violence and drug and alcohol abuse and on the last occasion in February 2020 suffering serious consequences from the overdose.

Why was the SCMR carried out?

The purpose of a SCMR is to establish whether there are lessons to be learned from the case about the way in which local professionals and organisations work together to safeguard children, identify what needs to be changed and as a consequence, improve inter-agency working to better safeguard and promote the welfare of children.

On 4th March 2020, the Isle of Man Constabulary made a notification to the Independent Chair of the Isle of Man Safeguarding Board, for consideration of a Serious Case Management Review (SCMR) in respect of a child aged 15 referred to as Child J. Reports from the agencies involved with Child J were requested and received.

These reports identified concerns both about them and wider systems and resource implication issues in relation to children in similar situations.

The Terms of Reference raised three specific themes for the review to examine. These are now analysed in turn, taking account of the information provided to the review. This analysis by the review author and panel members reports and assessments has raised further learning themes for consideration.

Learning Themes from Terms of Reference

a) How adverse childhood experiences can impact on a child; potentially making them more vulnerable to exploitation.
b) Understanding risk to Child J including the events February/March 2020.
c) Contextual safeguarding.

The critical areas for exploration by agencies through this SCMR are:

How Adverse Childhood Experiences[1] can impact a child; potentially making them more vulnerable to exploitation -

It is clear from the analysis that Child J experienced several ACEs, from which they were undoubtedly suffering trauma. This made them more likely to have life-long issues in relation to their health and wellbeing and use coping strategies that involve risk taking behaviours, criminality, and suffering from mental health issues. Early in their life living in an abusive household including the violence they witnessed appear to have strongly impacted on them to date. It was clear from the practitioner event that they felt almost all of Child J's issues in adolescence, stem from their early childhood. They didn't know who to trust in order to seek help from them.

There is not in place a multi-agency approach to training professionals to better understand Adverse Childhood Experiences and how to identify them. The Isle of Man Constabulary have rolled out some basic training to their personnel and the Education Department have added some information into their single agency Level 1 and 2 training. The Children and Families Service have started rolling out trauma informed practice training, highlighting the impact on brain development. More recently, this training has started to be offered to the multi-agency arena, but it is stated will take some time to be embedded. This needs to form part of ongoing work requiring a practice change to ensure that professionals understand what it means in practice and when attending incidents and households, what they should be doing differently and ensuring good quality information to other partners regarding risk.

There may have been moments in their life when Child J might have been open to engage and make changes to their behaviour. Some professionals call this moment a 'reachable moment', or in Education a 'teachable moment'. In the National Child Safeguarding practice review panel's report on safeguarding children at risk from criminal exploitation (March 2020) it calls this a 'critical moment'.

The review author believes that there were 'reachable moments' for Child J which were not apparent and thereby acted upon. The education psychologist was a person in Child J's life who did seem to be actively trying to help positively to 'reach Child J'. The education psychologist at the practitioner event agreed there were a number of times what this report is describing as 'reachable moments' for Child J. The education psychologist and others were keen to point out that a key to preventing future cases like Child J is to ensure that agencies intervene early.

[1] The ACE Score https://www.adversechildhoodexperiences.org.uk/

Understanding Risk to Child J

Child J's long involvement with social workers revealed a childhood of domestic abuse. In August 2018 Child J suffered physical chastisement from their father, which their father has never taken responsibility for.

The key lines of enquiry in this review relate to questioning how agency intervention might have been improved to disrupt Child J's progress in their adolescent years to illicit drug use and criminal exploitation. Questions are raised about whether a more coordinated and trauma focussed multi-agency approach supported by a contextual safeguarding policy and procedural framework could have disrupted this progress at an earlier stage in Child J's life.

Child J was a vulnerable child who spent their early life in what was a difficult home environment but within which as a younger child they managed not to present with overt signs of distress. They experienced significant childhood trauma and demonstrated distress when their life was disrupted by their father being arrested and sent to prison. A range of therapeutic approaches were taken to deal with this emotional distress and increasing anger and aggression but none of these were effective in preventing a spiral of drug taking and criminal exploitation. It is not clear how the therapeutic approach was formulated and whether this was based on Child J's individual assessed needs resulting from their adverse childhood experiences. This raises questions as to whether CAMHS advice within the process from an earlier stage would have helped. The review author fully understands the difficulties with capacity within CAMHS that may have impacted on the obtaining of this advice.

Child J as already stated in this report experienced complex and fractured family dynamics and conflict between their parents. This trauma, modelling and lack of parental guidance led them to struggle to understand and regulate their own emotions. The outward experience to professionals of this is an angry and sometimes violent young person at times when they felt out of control. Drugs for Child J have been for them an escape and a coping strategy. Through their associates in the community, they became criminally exploited. They were fearful of unknown adults to which "debts" were owed and they was unable to trust adults in the professional network around them. Child J could have learnt this behaviour towards professionals from their father. Child J experienced years of professional involvement with few positive changes being achieved to improve their life experience. Child J was criminally exploited and there were insufficient multi-agency policy and procedural frameworks to respond effectively to this.

On a positive note, Child J has had a consistent network of professionals available to support them. Each of these professionals were aware of the risks for them regarding drug use and were expressing their concerns regarding potential exploitation. The focus of all interventions was however directly with Child J with the emphasis placed upon them to stop using drugs and to break free of these criminal associations. The social worker, team manager and youth justice worker all were aware there were wider contextualised safeguarding concerns occurring and all were trying to address these within the resources and frameworks available to them. Without a multi-agency procedural framework to manage the risks however these plans often functioned in isolation and there was lost connectivity regarding what was known and no analysis of what this meant for Child J. There was limited analysis of whether the risk

was escalating for Child J in regarding their drug taking and intervention was more reactive for day-to-day issues and an acceptance that this drug use was "the norm". The use of the processes available to the allocated social worker, and the lack of procedural frameworks for these processes, meant there was often information missing from key agencies and limited multi-agency ownership of the risk for Child J.

This feeling of frustration for professionals has been created by the limitations of what they could do within their individual roles to keep Child J safe from using drugs and the associated risks they were identifying for them. They also felt the multi-agency network placed the responsibility upon them and this feeling is validated by the lack of a legislative, strategic, or procedural framework on the Isle of Man to give the multi-agency group the guidance and strategies to respond to and manage criminal exploitation. At the practitioner event a number of individuals in particular the police and the DAT young people worker said they were all willing to engage in information sharing however due to lack of a formal framework for contextual safeguarding this was not happening on a consistent and regular basis.

The outcome of an off-Island placement for Child J cannot be known. It is known that there were several challenges regarding professionals engaging Child J and whether they would have "bought in" or accepted the placement is questionable based on what is known and that the risks externally were not on the Isle of Man but in the UK. It must be considered if in fact it would have increased the risk of exploitation as key adults involved in drug trafficking to the Isle of Man are based in the UK. Alternative provisions or plans were not explored at the time and this contributed to crisis management becoming the pattern of intervention.

A large piece of work in the IOM was undertaken in 2016 which developed a Child Sexual Exploitation (CSE) Practitioners Strategy and Toolkit, which was signed off by the then Safeguarding Children's Board. Various forms of training were rolled out, but each agency interpreted the use of the toolkit differently and it did not become consistently used and was not a success. Contextual Safeguarding was first identified by a Department of Education Sports and Culture (DESC) lead as being an emerging area that all agencies should recognise and agree a joined up multi-agency approach and that exploitation needed to be considered wider than just sexual exploitation. Recognition of contextual safeguarding and the establishment of a contextual safeguarding framework within child protection at an earlier stage may have prevented the situation with Child J occurring by offering alternative interventions.

There has been some progress that the review can update on as training in methods of behaviour de-escalation is being rolled out for health workers in the front line of managing young people with challenging behaviours to reduce the need for police involvement in such cases. The school nurses now provide a "Listening Service" at each High School and programmes to upskill them in DBT (Dialectical Behaviour Therapy) are being stepped up to enable more widespread support at an early stage for children and young people presenting with emotional and behavioural problems. The DAT Young Person's worker will be placed within the CAMHS service which will strengthen the dual diagnosis focus of the role and the CAMHS manager is reviewing the policy and practice for sharing reports in the context of multiagency working.

In relation to the events that occurred in the hospital on end of February, beginning of March concerning Child J and another two children, work has been carried out led by the consultant paediatrician and there is a proposed SOP to assist consistent practice across Manx Care for a 'Child presenting to ED with a Mental Health Crisis Out of Hours'. It was clear that this incident was not a 'one off,' but is still occurring on a regular basis and urgently needs adoption of the SOP by all agencies.

Multi-Agency work around contextual safeguarding

Contextual safeguarding and its links to risk taking behaviours and sometimes criminal exploitation has been discussed in operational forums and initiatives considered. However, there is no overarching policy to develop contextual safeguarding and collectively agencies have been slow to respond. The issue needs to be better understood and developed by professionals and agencies. There is a reluctance or concern of some agencies, particularly in Health and Social Care, around the legal basis for sharing information on individual young people to elicit connectivity between the individuals and community events or incidents, without a policy and procedural position.

There is an understanding of contextual safeguarding however it was not until the events in the hospital at the end of February 2020 when Child J had been discharged from hospital and into police custody that there was a meeting held using the current complex abuse procedures to consider the wider community risks, including other children who may be at risk or who may have posed those risks. This emphasises the priority need to have in place an agreed multi-agency contextual safeguarding framework.

DfE guidance Working Together 2018 says that:

> *"As well as threats to the welfare of children from within their families, children may be vulnerable to abuse or exploitation from outside their families. These extra-familial threats might arise at school, from within peer groups, or more widely from within the local community. These threats can take a variety of different forms from online safety, exploitation, sexual, by criminal gangs and organised crime groups to the influences of extremism leading to radicalisation and trafficking. Assessments of children in such cases should consider whether wider environmental factors are present in a child's life and are a threat to their safety and/or welfare. Interventions should focus on addressing these wider environmental factors, which are likely to be a threat to the safety and/or welfare of a number of different children and adolescents who may or may not be known to local authority children's social care."*
> *"For practitioners, this means that to undertake effective safeguarding with adolescents, we must extend our knowledge and analysis of the risks and dynamics within the family home and begin to include the risks and dynamics within peer groups, schools, neighbourhoods and communities. Adolescents experiencing harm from CSE, gangs, HSB, and missing episodes are mostly likely to be at risk in within these wider While extending the approach to include an understanding of these contexts, we need*

to continue to work with families to understand the push and pull factors in adolescent lives."[2]

The complex abuse procedures (in the absence of a contextual safeguarding of vulnerable adolescent strategy) should have been used earlier. This lack of uniting individual children's needs with the wider community risks has at times meant that Child J's needs were only looked at in relation to their risks in their family. Whilst it is undoubtedly Child J's family issues that have precipitated their emotional wellbeing and risk-taking behaviours, it is also essential that their reliance on peers as a support network, the risk of exploitation and use of drugs needs to be considered to gain a full insight into the life of Child J and the risks to their safety.

Data Protection, GDPR and adhering to processes have been reasons cited for being unable to address contextual or community safeguarding issues. The Safeguarding Act, 2018 brought about the introduction of the duty to safeguard which has enabled better information sharing than previously as it became a basis to share information by all those who are the "Relevant Bodies" as defined within the Act. Better information sharing may have prevented the situation with Child J escalating to a critical level. The Safeguarding Board needs to ensure there is clarity of the information sharing agreement it has currently in place. Professionals must also be enabled to prioritise meetings on vulnerable individuals as there were opportunities to share that were missed due to non-attendance of key professionals. Any review by the Safeguarding Board of its information sharing should ensure that it contains an information sharing pathway for contextual safeguarding.

What did the SCMR find?

Child J had definitely experienced a high number of Adverse Childhood Experiences in their life. It is important for the safeguarding partnership to understand what they were and work using a trauma informed approach to work through them to help Child J or other similar children in the future.

A key piece of learning from Child J is, that if professionals had been able to work with them much earlier to alleviate some of this adverse childhood trauma, they may have been able to divert and disrupt offending patterns and behaviours. The review author believes that there were 'reachable moments' which did occur for positively altering the life journey from offending and being at risk of criminal exploitation for Child J and although spotted the professionals involved were not able to effectively act on them. The learning for professionals is ensuring that when these 'reachable moments' occur professionals are flexible and able to capitalise on them. Examples of 'reachable moments' are Child J's relationship with the educational psychologist, when their paternal grandfather died, the first time they were arrested and the first time they went into care.

The review author believes that there were other 'reachable moments' for Child J which were not apparent and thereby acted upon. The education psychologist was a person in Child J's life who did seem to be actively trying to help positively to 'reach Child J'. The education psychologist at the practitioner event agreed there were a number of times what this report

[2]Department for Education (2018) Working Together to Safeguard Children. 'A guide to inter-agency working to safeguard and promote the welfare of children.' July 2018

is describing as ‘reachable moments.’ He and others were keen to point out that a key to preventing future cases like Child J is to ensure that agencies intervene early.

The key lines of enquiry in this review relate to questioning how agency intervention might have been improved to disrupt Child J’s progress in their adolescent years to illicit drug use and criminal exploitation. Questions are raised about whether a more coordinated and focussed multi-agency approach supported by a contextual safeguarding policy and procedural framework could have disrupted this progress at an earlier stage in Child J’s life. An increased effort at early intervention would have helped in Child J’s case and would help greatly with other similar children now and in the future.

The multi-agency working groups on developing strategies to work effectively with challenging and complex adolescents using a contextual safeguarding approach are critical in improving the lives of a proportion of vulnerable young people on the Isle of Man who are at higher risk of being drawn into risk taking and ensure that this does not continue as a ‘rite of passage’ into adulthood. It is imperative that children and young people’s mental health services (including substance use support) are accessible and that professionals in this field become part of the overarching plan around a young person and not an add-on. There is an opportunity to improve the adolescent experience of some young people, but any strategy needs supporting and endorsing throughout all the agencies.

Identified Learning Themes:

- Child J’s adverse childhood experiences.
- Multi-Agency working and information sharing
- Contextual Safeguarding

Recommendations to the Isle of Man Safeguarding Board:

5.0 Recommendations

The Individual Agency management reviews have identified learning and recommendations for their agencies which agency’s will action and should be monitored by the Safeguarding Board. Both the police and education IMRs recommendations look at the work of the multi-agency partnership and could benefit from examination for any internal learning by their panel members. The review makes some additional recommendations as detailed below, the implementation of these will assist the Isle of Man to deal more effectively with similar circumstances in the future resulting in the improved safety and welfare of children who are at risk.

Recommendation 1 (Priority Recommendation)
a) The IoM Safeguarding Board to establish with partners a multi-agency strategy and procedural framework for contextualised safeguarding and exploitation. This should ensure it includes an information sharing protocol.
b) The IoM Safeguarding Board to consider adopting a vulnerable adolescent service strategy.

Recommendation 2 (Secondary priority recommendation) The IoM Safeguarding Board should seek assurance from partners that an early help strategy is being considered and developed to intervene early in the lives of children similar to Child J. This early help strategy should include a professional framework to improve professional's knowledge and understanding of the impact of Adverse Childhood Experiences implement that understanding in response to children and young people; and for professionals to provide a trauma informed response.
Recommendation 3 a) The IoM Safeguarding Board should ensure that learning is provided that highlights to professionals the importance of identifying and acting on a 'reachable moment' for a child at risk of CCE. b) This should include assurance from the safeguarding strategic partners that they have systems and structures in place through them working as a multi-agency team with joint responsibility to be able to capitalise on this moment.
Recommendation 4 a) The IoM Safeguarding Board should support the implementation of the proposed standard operating procedure for a 'Child presenting to ED with a Mental Health Crisis Out of Hours' this would help to ensure there is in place actions to deal with similar situations in the future. b) The Hospital should consider the allocation of a room to be used for similar scenarios in the future. c) Consideration of alternative security arrangements put in place rather than the use of police officers. d) The Police to consider the use of de-escalation and conflict resolution training for officers.