Isle of Wight Safeguarding Adults Board

Annual Report 2024-25

Isle of Wight
Safeguarding Adults Board

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Welcome from the Executive Group

Ensuring that safeguarding arrangements are considered for vulnerable persons is a fundamental part of modern policing and one that Hampshire and IOW Constabulary takes very seriously. It involves effective working across all of our police departments as well as strong partnership working with other statutory and non-statutory organisations; overseeing and supporting that work are Safeguarding Boards such as our own IOW Safeguarding Adults Board.

IOW policing takes an active part within the board through local policing representation where we can influence local activity and performance encouraging sharing of best practice such as problem solving and training opportunities. We also have representation from our specialist police departments in Public Protection who have expertise in many areas of safeguarding for vulnerable adults ensuring that they share information with the right organisations to protect the public.

Through collaboration with other members of the SAB we are able to understand and mitigate the risk of harm for people exposed to a range of challenges ranging from domestic abuse, mental health, neglect, and criminal exploitation.

As the Area Police Commander for the IOW, I will continue to be an active member of the SAB to ensure that those organisations charged with delivering safeguarding for the vulnerable across the island are supported in that aim.

Supt. Robert Mitchell, Isle of Wight Area Commander, Hampshire & Isle of Wight Constabulary

As a statutory safeguarding partner, NHS Hampshire and Isle of Wight Integrated Care Board (HIOW ICB) provides both financial support and expert safeguarding leadership to the Isle of Wight Safeguarding Adults Board (IOW SAB). This ensures that safeguarding arrangements across the Integrated Care System (ICS) are robust, effective, and well-integrated into the wider health and care landscape.

NHS HIOW ICB maintains formal representation on IOW SAB executive and board meetings and all of the subgroups through its corporate safeguarding team. This team plays an active role in shaping and delivering the Board's strategic priorities, demonstrating a strong commitment to partnership working. The close collaboration between the IOW SAB, NHS HIOW, and Hampshire Constabulary supports the co-production of safeguarding strategies that incorporate a healthcare perspective and drive improved outcomes for adults and their families.

Through ongoing leadership, collaboration, and a strong commitment to continuous learning and improvement, NHS HIOW ICB has significantly contributed to safeguarding adults across the ICS. These efforts ensure that safeguarding remains a central consideration in both health service delivery and system development.

NHS HIOW have supported the development and achievement of the IOW SAB's business priorities and workstreams which support health and partner organisations by promoting a coordinated, system-wide approach to adult safeguarding. These priorities align frontline practice with clear, consistent guidance and processes for practitioners to follow.

This collaborative approach positively impacts adults and their families, fostering a shared ethos of quality improvement across partner organisations. A mature, expert multi-agency network underpins this work, bringing together professionals committed to preventing harm and abuse and enhancing services for children, young people, and families.

Fiona Holder, Safeguarding Director, Hampshire & Isle of Wight Integrated Care Board

As a statutory partner of the Isle of Wight Safeguarding Adults Board (IOWSAB), the Isle of Wight Council remains firmly committed to collaborating with our partners and local communities to protect adults at risk and promote a culture of safety, dignity, and respect across our communities.

This Annual Report reflects the collective efforts of our multi-agency partnership to strengthen safeguarding practice, respond to emerging risks, and embed learning from lived experience. It highlights the progress made in 2024–25, including the development of new protocols, delivery of impactful training, and the introduction of innovative approaches such as the Unexpected Death Protocol and the rotating chair model.

The Council has played a central role in supporting the Board's strategic priorities, particularly in areas such as workforce development, data analysis, and quality assurance. We continue to lead and contribute to key subgroups, ensuring that safeguarding remains a core focus across all services and that our frontline teams are equipped with the knowledge and tools they need to respond effectively.

This year's report also demonstrates the value of strong local leadership, shared accountability, and a commitment to continuous improvement. As we look ahead to the development of the 2025–30 strategy and the first All-Age Conference in 2026, we remain dedicated to working collaboratively with our partners to ensure that adults on the Isle of Wight are supported to live safely, free from abuse and neglect.

Laura Gaudion, Strategic Director of Adults Social Care and Housing, Isle of Wight Council

What is the Isle of Wight Safeguarding Adults Board

The Isle of Wight Safeguarding Adults Board (IOWSAB) is a partnership of organisations, that work together to protect adults who may be at risk of abuse or neglect. These adults might be elderly, have disabilities, or face other challenges that make them vulnerable.

The Board's role is to:

- Coordinate safeguarding efforts across services.
- Review serious cases to learn and improve.
- Develop policies and training for professionals.

Whilst, the Board does not deliver services directly, it monitors, supports, and challenges the organisation that do, ensuring safeguarding is a priority and that lessons are learned when things go wrong.

Safeguarding means protecting a person's right to live safely, free from abuse and neglect. It's about making sure people, especially those who may be more vulnerable, are supported to live safely and with dignity.

The Board includes senior representative from a range of organisations, and these are split into statutory partners, who are legally required to be part of the Board and non-statutory partners, who are invited because of their role in safeguarding and/or their role within the community.

The IOWSAB has three statutory partners, who make up our Executive Group, who act as the part of the Boards governance:

- Isle of Wight Council
- Hampshire & Isle of Wight Integrated Care Board
- Hampshire & Isle of Wight Constabulary

Governance is about how the Board is run, who makes decisions, who checks that things are working properly, and how different organisations work together to keep adults safe. Good governance helps make sure the Board is effective, accountable, and focused on the right priorities.

In the past, the Board was led by an Independent Chair**,** someone not connected to any local organisation. Their job was to lead meetings, make sure everyone had a voice, and keep the Board focused on its goals. This helped ensure fairness and independence.

After the Independent Chair stepped down, the Board reviewed other ways of working. It chose a new model that includes:

- Independent Scrutineer: This person does not lead meetings but instead acts as a "critical friend." They look closely at how the Board is working, ask challenging questions, and make sure the Board is doing what it says it will do. Their role is to provide honest feedback and help improve how safeguarding is delivered.
- Rotating Chairing by Senior Leaders: Instead of one permanent Chair, senior leaders from our statutory partners now take turns chairing meetings. This means more people

are actively involved in leading the Board's work, and it helps build stronger partnerships and shared responsibility.

The benefits of the New Model include:

- More Challenge: The Scrutineer can focus on asking tough questions and checking progress, without having to run meetings.
- Stronger Local Leadership: Senior leaders are more involved in driving change and making sure actions are followed through.
- Shared Ownership: Different organisations feel more responsible for safeguarding outcomes.
- Fresh Perspectives: Rotating chairs bring new ideas and approaches to each meeting.

The IOWSAB has three specialist subgroups that sit underneath the main Board, they focus on specific areas of safeguarding and are chaired by a senior professional.

The Workforce Development Subgroup ensure staff working across all organisations, are trained and confident in safeguarding adults. The Safeguarding Adult Review Subgroup oversees reviews of serious cases where an adult has died or been seriously harmed due to abuse or neglect. The Quality, Assurance and Performance Subgroup check how well safeguarding is working across the partnership by reviewing data and undertaking audits.

Alongside our own Subgroups, the IOWSAB engage with numerous other local, regional and national forums, including:

Isle of Wight Health & Care Partnership	Isle of Wight Community Safety Partnership	Isle of Wight Domestic Abuse Partnership Board	Isle of Wight Childrens Safeguarding Partnership
National Safeguarding Adults Chairs Network	Adult Social Care Stakeholder Board	National Safeguarding Adults Board Managers Network	SE Regional Board Managers Network
4LSAB Housing Subgroup	4LSAB Policy Subgroup	4LSAB Health Subgroup	4LSAB Fire Safety Development Group

Each subgroup meets regularly and produces highlight reports which are presented to the Board who use this information to make strategic decisions, approve new policies and commission further work. The Board may give instructions or feedback to the subgroups, creating a continuous cycle of learning, action and improvement.

Where to go for Advice or Support

If you are worried about yourself or someone you know, you can:

- contact the Adult Safeguarding Team on **(01983) 823340** during office hours
  (out of hours call 01983 821105)

- email safeguardingconcerns@iow.gov.uk

If you think someone is in immediate danger, call the police on 999.

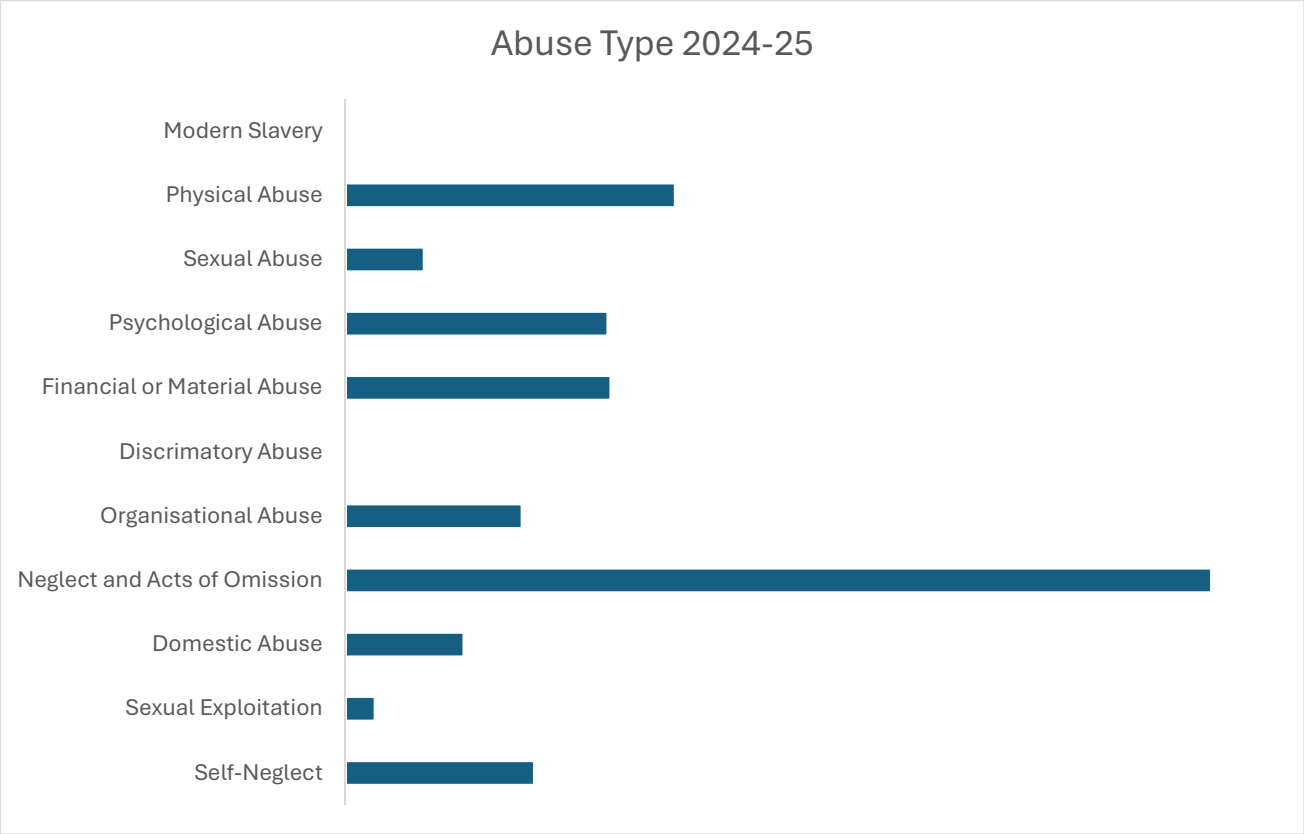
For concerns relating to domestic abuse, please see the Domestic Abuse Referral Pathway

For concerns relating to children, please see the information here from the IW Safeguarding Children Partnership.

What the data tells us

The Isle of Wight Council collates data on the safeguardig referrals it recevies.

Most safeguarding referrals relate to concerns about negelct and acts of omissions (37%), this means people weren't getting the care or support they needed. Other common concerns included physical abuse, where someone was hurt or harmed, finananical abuse, where someone was exploited financially and psychological abuse, where someone was emotionally harmed or manipulated.

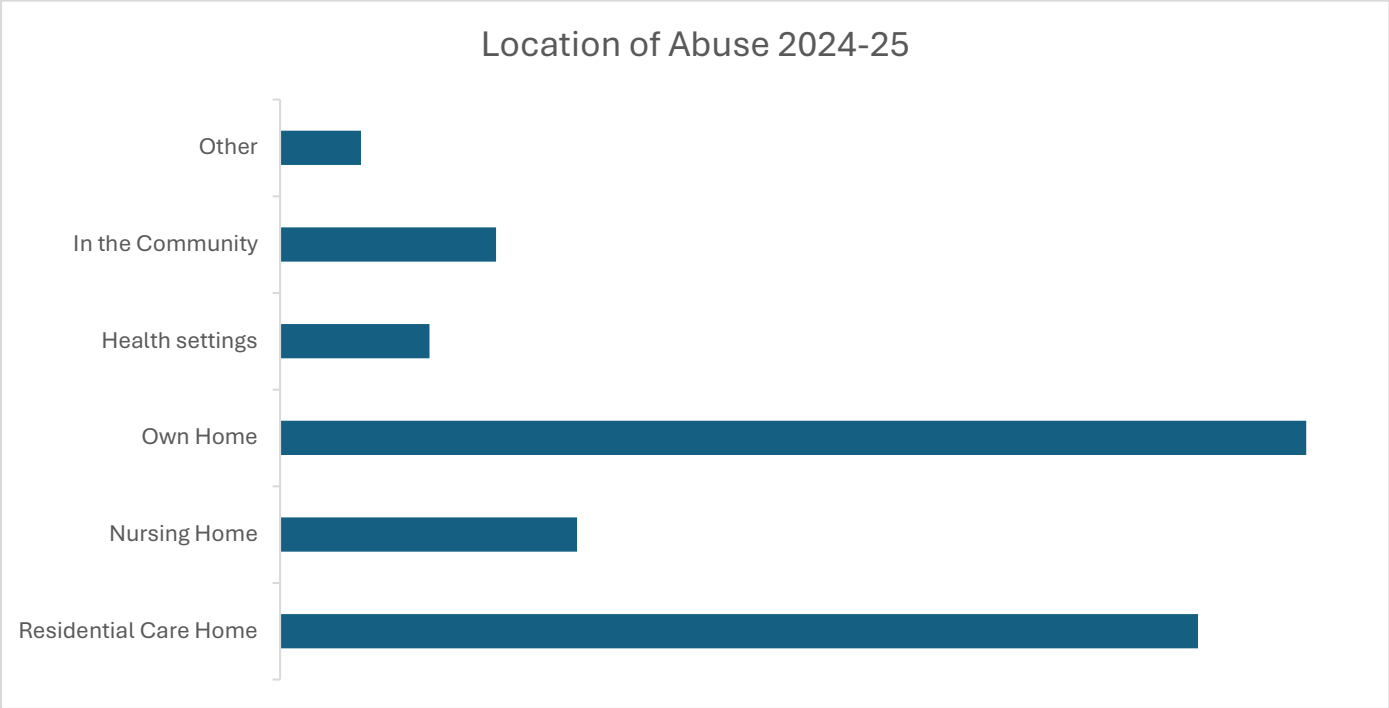


The data also shows low referrals for some types of abuse, suggesting that these are rare, but it could also mean that they're not being reconigsed or reported.

The data is showing that more work is needed:

- with care providers to promote good practice
- to encourage a culture of openness and support professionals and the public to speak up when something feels wrong
- with community groups to understand barriers to reporting
- to understand gaps in learning for frontline staff

The referral data also tells us that abuse is most commonly happening in people's own homes (35%) and residential care settings (30%), this means that two-thirds of all abuse is happening in places where people live.



Whilst the data shows that a significant number of safeguarding concerns arise in residential care settings, this reflects that these environments are closely monitored and shows a positive sign of vigilance and accountability. Residential care homes are often home to people with complex needs, which means they are more likely to be involved in safeguarding processes, not necessarily because harm is happening more often, but because staff are doing the right thing by raising concerns early.

Strategic Plan 2024-25

The IOWSAB is legally required to publish a strategic plan, this is part of its duties under the Care Act 2014.

In simple terms:

- The strategic plan is like a roadmap. It sets out what the Board aims to do to help keep adults safe from abuse and neglect in the local area.
- It explains the main priorities, what actions will be taken, and how organisations will work together to protect adults at risk.
- Publishing the plan means making it publicly available, so that everyone can see what the Board is doing and hold it to account.

Why Is This Important?

- It helps make sure that everyone is working towards the same goals.
- It shows that the Board is being open and transparent about its work.
- It gives people a chance to understand and get involved in safeguarding in their community.

The 2024-25 Strategic Plan highlighted three new priorities:

Building and strengthening connections

Quality Assurance and Embedding Learning

Prevention and Early Detection

In 2024-25, the Board has:

- ✓ Delivered a local multi-agency safeguarding conference
- ✓ Created a wider communication network, increasing the reach of the Board
- ✓ Created new Learning Briefs to disseminate learning from local lived experience
- ✓ Developed a review schedule to ensure local policies and procedures are kept up to date
- ✓ Completed multi-agency audits
- ✓ Created a dedicated space for feedback on people's experience of safeguarding activities on the Island
- ✓ Created an Unexpected Death Protocol to review all local deaths and identify learning at the earliest opportunity

Safeguarding Adult Review (SAR) Subgroup

A Safeguarding Adult Review, or SAR, is a form process that takes place when an adult with care and support needs has died or been seriously harmed, and there is a concern that organisations could have worked better together to protect them. The emphasis is on learning lessons to improve how organisations work together to keep people safe in the future.

Under the Care Act 2014, every Safeguarding Adults Board must carry out a SAR when the legal criteria have been met. The Board also has the power to carry out reviews in other cases where it believes there are valuable lessons to learn.

In 2024/25, the SAR Subgroup looked at 12 individuals who had sadly died and whilst none of which met the legal threshold for a full Safeguarding Adult Review, the group felt that two cases still had important lessons to offer.

To explore these, the group held reflective workshops, bringing together professionals from different organisations who had been involved with the individuals concerned. They talked openly about what happened, what went well, and where things could have been done better, especially around how organisations worked together.

From these discussions, the team created learning briefs, short documents that summarise the key lessons. These were shared with partner organisations to help improve how services work together to protect adults in the future.

A common theme in the referrals we received in 2024/25 is that the individuals involved often have poor mental health. This tells us that mental health challenges are playing a significant role in the situations where people are at risk of harm or neglect. For the Board, this means we need to think carefully about how mental health services are working with other organisations, and whether people are getting the right support at the right time. It also highlights the importance of making mental health a key part of our safeguarding work and planning.

Unexpected Death Protocol

In 2024, a new process called the Unexpected Death Protocol was introduced on the Island. This means that professionals from Health, Social Care, and the Police now meet regularly to look at all unexpected deaths that happen locally.

This joined-up approach helps to:

- Quickly spot cases where something might have gone wrong or where more learning is needed.
- Review how different services were involved, and whether anything could have been done differently.
- Share important information that helps other teams and services improve their work.

One example of how this has made a difference is the discovery of a rise in deaths among people experiencing homelessness. Because of this, a special review was launched to look more closely at the issue and find ways to improve support for this vulnerable group.

Glen, a 72-year-old veteran, experienced long-term homelessness after his discharge from the Navy, living intermittently across the UK mainland, Isle of Wight, and Crete.

Despite health concerns, Glen had minimal engagement with local health services and declined multiple offers of temporary accommodation from the Local Authority Homelessness Team. Concerns about his deteriorating mental and physical health were raised in mid-2023, but he consistently declined support.

Tragically, Glen was found deceased in January 2024, in a field without shelter.

Key Learning

- Importance of clear and reflective recording of practitioner actions and interactions.
- Need for supervision and escalation when interventions are not accepted.
- Consideration of adverse weather conditions and organisations responsibilities when supporting homeless individuals.
- This case highlights the complexities of self-neglect and the challenges in engaging individuals who decline support, reinforcing the need for professional curiosity, multi-agency collaboration, and robust safeguarding practices.

'Ms L', an adult with cerebral palsy and complex communication needs, experienced prolonged abuse and neglect while living in Southampton before relocating to the Isle of Wight. Despite having mental capacity, Ms L relied heavily on carers and family members for daily support and communication. Between 2015 and 2020, nine safeguarding concerns were raised, yet responses were limited and often failed to engage Ms L independently.

Ms L moved to the Isle of Wight in 2020 where further concerns emerged, including deteriorating health and neglect. Organisations assumed others were acting, leading to delays in intervention. Ms L was eventually hospitalised in a severely malnourished state. For the first time she was spoken to independently and disclosed the abuse she had suffered. Following recovery, Ms L now lives in a safe and supportive environment.

Key Learning

- Coercive Control - adults with communication barriers must be supported to express their views independently, without undue influence from carers or family.
- Continuity of Care - transfers between local authorities must include full safeguarding histories and assessments of new environments.
- Persons in a Position of Trust - concerns about carers/family members must be clearly recorded & addressed through structured multi-agency safeguarding processes.

Multi-Agency Risk Management (MARM)

What is MARM?
MARM stands for Multi-Agency Risk Management. It is a way for professionals to work together to help adults who are facing serious risks, especially when those risks do not meet the legal requirements for formal safeguarding under the Care Act 2014.

Learning and Support
On the Isle of Wight, the MARM Co-ordinator offers training to all local organisations and services. This training can be done in person or online, and it is flexible, whether it is for one-person, new staff, or larger teams, it can be tailored to suit the needs of each group.

Sharing Information
The MARM Co-ordinator has shared information about how MARM works at local events, including the Isle of Wight Safeguarding Adults Board Conference and the Residential and Nursing Homes Forum. They also run regular "Lunch and Learn" sessions throughout the year, which cover topics like what MARM is and how to lead a MARM meeting.

Keeping Track and Improving
In March 2025, a central system was set up to keep track of how MARM is being used. This helps make sure that organisations understand and follow the process properly. It also helps identify areas where more training or support might be needed.

Want to Know More?
If you would like more information about MARM, you can contact the MARM Co-ordinator at: **MARM@iow.gov.uk**

Sarah Cooke,
MARM Co-ordinator

Workforce Development Subgroup

Over 80 professionals have accessed learning and development opportunities provided by the IOW SAB, from a range of organisations, including:

- Domestic Abuse Services
- Hampshire & IW Constabulary
- IOW NHS Trust
- Adult Social Care, Isle of Wight Council
- Southern Housing Group
- Wight Homecare
- Childrens Social Care, Isle of Wight Council
- Mountbatten Hospice
- Carers IW
- Hampshire & IW Integrated Care Board
- Vectis Housing Association
- Community Safety Partnership
- Island Healthcare
- Argyll House Surgery
- Barnardo's
- West Wight Sports Centre
- Healthwatch IW

Key learning events have included:

Multi-Agency Risk Management (MARM) – A Brief Overview

- Hosted by the IOW MARM Co-ordinator, these sessions provide an overview of the 4LSAB MARM framework, including protocol and eligibility

4LSAB Fire Risk and Vulnerability Training

- Hosted by Hampshire & IW Fire and Rescue Service, providing an overview of the 4LSAB Fire Risk Framework, highlighting the vulnerability matrix and advocating the Safe & Well service.

Windows of Opportunity

- Hosted by Making Connections IW, the session provided professionals with the knowledge and skills to understand the risk continuum, effectively engage with adults at risk, and identify concerns early to provide appropriate support.

IOW SAB Conference 2024

On 18th September 2024, the Safeguarding Adults Board held its first conference in five years at Northwood House in Cowes. Around 100 people came along from over 30 different organisations, showing just how important it is for different services to work together to keep people safe.

The event featured powerful drama-based case studies from AftaThought, a training company that uses live performances to bring real-life issues to life. These focused on key local concerns like fire safety, homelessness and multi-agency risk management.

Local speakers also shared their insights, and attendees had the chance to visit information stalls during the breaks.

The conference gave the Board a valuable opportunity to strengthen partnerships, share learning, and explore new ways of working together to protect vulnerable adults

I REALLY ENJOYED THE DAY AND FOUND IT VERY USEFUL. THE ACTING WAS PARTICULARLY POWERFUL AND BOUGHT MANY OF THE ISSUES TO LIFE... THE NETWORKING WAS ALSO REALLY USEFUL TO LEARN AND SHARE. MANY THANKS FOR A GREAT CONFERENCE 😊

Thank you for an informative and thought-provoking day. The actors were brilliant and at times really impacted me emotionally.

National Safeguarding Adults Week 2024

National Safeguarding Adults Week happens every year and is run by the Ann Craft Trust. It's all about raising awareness of important issues that affect adults who may be at risk and encouraging safer ways of working. In 2024, the four local Safeguarding Adults Boards, Hampshire, Isle of Wight, Portsmouth, and Southampton, worked together to host a series of events open to all partner organisations. These events covered a wide range of topics and were well attended, giving people the chance to learn, share ideas, and strengthen how we all work together to keep adults safe. Sessions were recorded and are available on the IOW SAB's website

Learning events included:

- Mental capacity and legal literacy
- Self-neglect and hoarding
- Professional boundaries
- Criminal exploitation
- Professional & organisational learning

Quality, Assurance and Performance Subgroup

A key function of this subgroup is looking at how safeguarding is working on the front line, to do this, they carry out reviews (called audits) to learn more. Audits matter because they help make sure that safeguarding is working as it should. They allow the Board to look closely at real cases and check whether people are getting the right support, whether professionals are working well together, and whether policies and procedures are being followed. Audits can highlight what's going well and where things need to improve. This gives the Board confidence, or "assurance", that frontline services are keeping adults safe and helps identify changes that could make safeguarding even stronger.

In 2024/25 the Quality, Assurance and Performance Subgroup completed two audits:

The first audit looked at how well the Multi-Agency Risk Management (MARM) framework is being used. It showed that the framework helps professionals share information and gives individuals a chance to meet the people supporting them. However, it also found that when professionals don't attend meetings, it can negatively affect the person at risk, so there's a need for better commitment from all partners.

The second audit focused on people who are hard to engage. This was a difficult area to explore, but it highlighted some key barriers, like not having access to phones or computers, or not feeling confident using them. It also showed that where and when meetings are held can make a big difference, and that many people prefer to meet face-to-face rather than online or by phone.

These findings help the Board understand what's working and where improvements are needed, so that safeguarding support can be more effective and inclusive.

Looking Ahead

In the next financial year, the Safeguarding Adults Board has some important plans to help improve how we protect vulnerable people

2025-30 Strategy

- We're creating a new 5-year plan to guide our work. It recognises that many organisations are going through changes and challenges. This strategy will help us stay focused and steady during uncertain times.

2026 All Age Conference

- In 2026, the Island's Safeguarding Adults Board, Children's Safeguarding Partnership and the Domestic Abuse Partnership Board, will host a joint conference for the first time. It will bring together professionals who support people of all ages, to share ideas and focus on helping whole families.

Data Dashboard

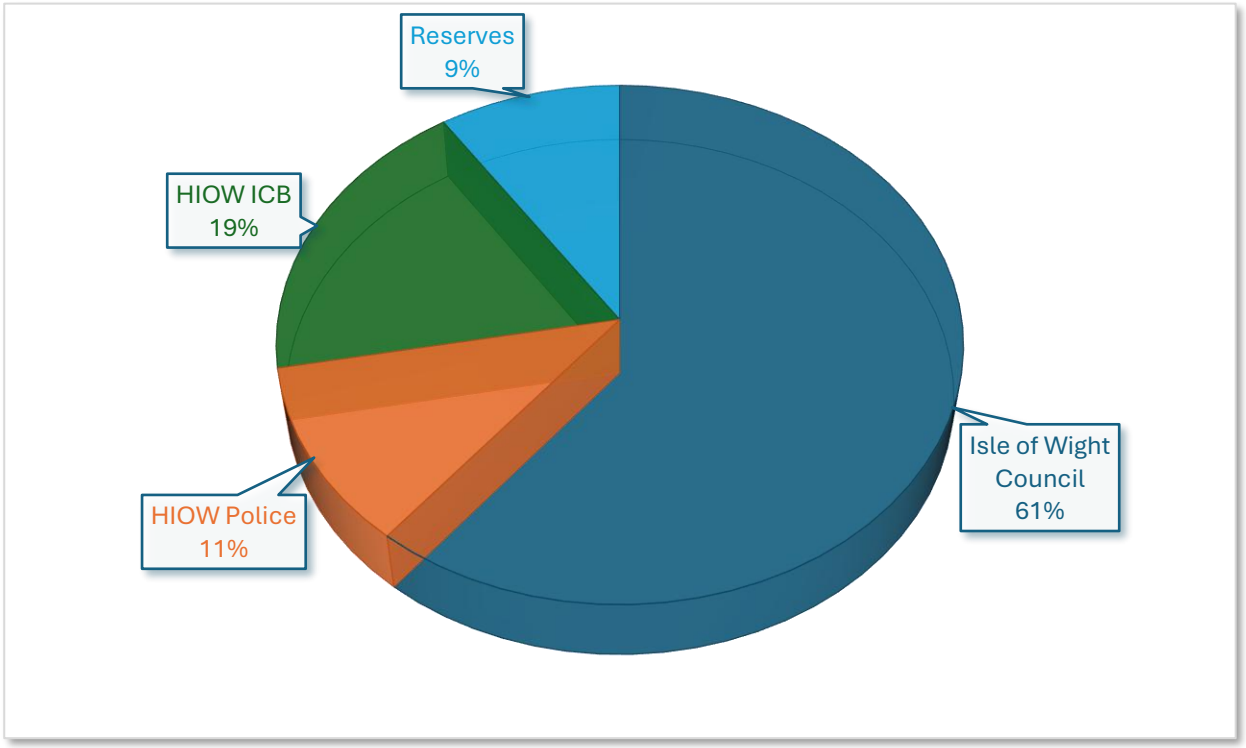
- We're building a new digital dashboard to help us spot patterns and trends in safeguarding work. It will also show how the Board's actions are making a difference.

New Independent Scrutineer

- The Board have decided to replace the position of Independent CHair with a new role called an Independent Scrutineer. This person will help make sure the Board is doing a good job by asking tough questions and offering honest feedback.

Financial Summary

In 2024/25, our statutory partners funded the work of the Board as follows:



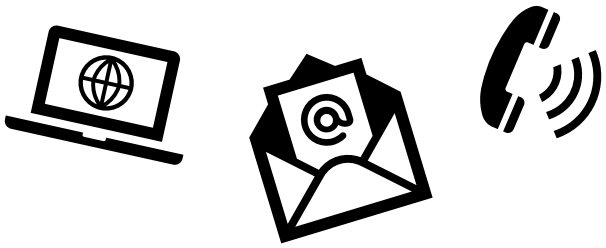
Contact Us

We welcome contact from anyone wanting to find out more about this report, or the work of our Board.

Email: LSAB@iow.gov.uk

Phone: 01983 821000

Website: www.iowsab.org.uk



To access the Isle of Wight Safeguarding training programme, visit our website's Events page.

For more information on the Board's safeguarding resources, including policies, guidance and learning briefs, visit our website's Resources page.