



Top Tips for Safeguarding

Identifying and responding to suspected or reported harm/abuse.



1. **If you suspect or witness harm or abuse, or it is reported to you,** immediately report it to your Safeguarding Coordinator or, if you work for CrossReach, your line manager. Report serious abuse directly to the police.



The Church of Scotland
Safeguarding Service

2. **Get advice:** contact the Safeguarding Service, 0131 240 2256, Mon - Fri., 9am - 4.45pm.



3. Put **'protecting the person'** at the centre: what is best for them?



4. **Abuse?** - 'If it doesn't look, sound or feel right it probably isn't right.'



5. **Label it.** What type of harm has occurred or is at risk of occurring?



6. **4Rs:** Recognise, Report (see 1. above), Record and Refer.



7. **Don't keep** a disclosure of abuse **secret** - there are limits to confidentiality. The Data Protection Act 1998 allows this.



8. Has an **offence** been committed?



9. **If in doubt refer** to the police or social work service - no one agency has a monopoly of safeguarding expertise.



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10. **4Ws**: immediately after a safeguarding event record 'Who, What, Where and When'?



11. **Consult** - what are the wishes of the child or adult at risk?



12. If you were a **relative** what would you want to happen?



13. **Will this keep?** Do you need to take action today or gather more information first?



14. Look at the **bigger picture** - who else has a responsibility for, or an interest in, the person?



15. '**The public interest**': who else could be at risk?



16. What is the **reputational risk** for the Church/service provider? This is always secondary to the needs of the person (see 3. above).



17. **How and why?** After, review the context: line-management, staff training, risk management, information sharing etc...



18. ...and **apply learning** from the particular case to the whole service.



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Guidelines

1. This is the **key message** for all safeguarding concerns, activity and training. This applies to historical abuse too - even if years or decades have elapsed.
2. **Safeguarding Service:** if harm is witnessed, suspected or reported you must contact the Safeguarding Service for immediate advice.
3. **VIP:** what action is best for the person harmed, or at risk of harm?
4. **Abuse yes or no?** But this is only the starting point. Don't jump to conclusions. Trust your gut feeling/intuition.
5. **Label it:** call it what it is. For example failing to give a person their medication, or giving them a double dose in error, is not just bad practice it is neglect i.e. an act of omission. Grabbing a person by the arm and pulling them it is not just 'rough handling' it is physical abuse.
6. **The 4 Rs:** recognition is the foundation of good safeguarding. Without it there can be no reporting, recording or referral to social work and/or the police.
7. **Confidentiality:** if a child or adult at risk says they want to share information in confidence, tell them that that you cannot hold on to that information. Don't keep a disclosure secret. You must share it with your line manager or Safeguarding Coordinator. Your professional code of conduct requires this. The Data Protection Act 1998 allows information to be shared without the consent of the person if it is thought that person is at risk of on-going significant harm, a crime has been committed or others are at risk from the same perpetrator.
8. **Crime?** If a crime is suspected, or has been committed, report this immediately to the police.
9. **Referring to the police (Police Scotland) or social work:** even if you are not sure if the crime or serious harm has occurred consider contacting the police or social work. Either or both agencies will let you know if they have an interest in the case. And they would much rather that you contacted them to get their view about a case, than not refer. It is better to defend a decision to refer to the police or social work than to make the case for not referring when later it is found that harm has occurred.
10. **The 4 Ws:** who, what, where and when? This is basic information to *immediately* record after a safeguarding event. Don't investigate – that is the role of social work and/or the police. Too often basic details are missing: exactly who was present, where, what happened and when. The 'what' should include details e.g. not just 'a bruise on the arm' but where exactly on the arm, what colour, size and shape? Who witnessed the event? And get written/typed and signed statements from witnesses as soon as possible.
11. **Consult** putting the person at the centre also involves getting their views about what they would like to have happen. Record this information too.
12. **If you were a relative:** not too sure if harm has occurred? If this was your son, daughter, brother, sister or parent what would your view be? And what would you want to happen?
13. **Will this keep?:** taking time to make a decision involves gathering more information. Consider compiling a chronology: see Safeguarding Handbook 1, June 2011, page 54.
14. **The bigger picture:** again this is about gathering more information and getting the views of others that may have an interest in, or a responsibility for, the care of the person affected.
15. **Public v private:** consider what other children or adults at risk could be at risk of harm. For example, even if the adult at risk does not what any further action taken if the alleged perpetrator also provides care for other service users then there is a public interest in taking action.
16. **Reputational risk:** this is always secondary to the needs of the child or adult at risk. It is about what 'what looks right' from the point of view of the general public and media. It is about doing the right thing and be seen to be taking appropriate action. Taking the right action for the child or adult at risk enhances the good name of the Church too.
17. **How and why?:** this is about looking at the wider context in which harm has occurred. Usually harm is a result of a decisions or choice made by an individual who provides care, support or supervision for a child or adult at risk. But line managers and co-workers have sometimes seen or heard something and know more about the situation than initially apparent.

Also where a member of professional staff or a volunteer has perpetrated harm line managers may have failed in their responsibilities. Similarly the member of staff or volunteer may not have the skills or knowledge to keep people safe e.g. a risk management plan was not in place or they were not supervised or sufficiently trained. Where professional staff have harmed a person the Scottish Social Services Council's codes of conduct will have been breached. This is often grounds for disciplinary action.
18. **Learning:** whenever a situation of harm or abuse has occurred some 'good can come out of bad'. This will only happen if the learning from the particular case is applied to the whole service or activity. An action plan, dates and names of individuals responsible, is required to ensure that this happens. In the most serious situations a critical incident a review is required. This may involve professionals from other agencies too.

