Parish of Emmanuel Church Northwood
Safeguarding Case Studies 2021

Introduction to our Safeguarding Case Studies

At ECN we believe in learning from the past and so post safeguarding case studies on our website to support training and to improve safeguarding within our own church and within other faith organisations locally and nationally. This reflects the spirit and intent described in the **Diocese of London Safeguarding Policy which ECN has adopted at paragraph 3.1.5:**

'Learning from the past

> In recent years, statutory reports and independent reviews into abuse that have involved the Church of England and other faith organisations highlight past errors and significant lessons to be learnt to improve safeguarding. As a Diocese we continue to commit to a journey of truth, healing, learning and abuse prevention.
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> The Diocese is committed to learning from both our own past failings and those of the wider church, by ensuring that lessons learned are used to improve our response to future safeguarding concerns and how we equip and support all those with a role to play in ensuring a safer diocese. In particular we are committed to listening to the views of survivors of abuse so that we can ensure that their voice shapes our future practice.'

Please note that the following case studies have been anonymised and some details changed to protect the identities of those involved.

Case Study A involves a young child

Case Study B involves a vulnerable adult

Case Study C involves an elderly adult who has become vulnerable

The potential audience for these case studies include: church members, church leadership and pastoral workers; other voluntary sector organisations/groups; parents and carers of children and vulnerable adults; social care workers; LADOs; police and community police officers; employers, especially those in the care sector or employment agencies, In fact the case studies are on our website, with the aim of them being available to anyone who wants to know more about how to manage safeguarding concerns and to improve practice.

Case Study A - a young child discloses possible abuse

B is a 3 year old girl who attends Sunday school regularly with her older sister who is 6. Her mother is a single parent who works as a nurse and so grandparents provide lots of support and both girls stay with them often at weekends. The grandparents are long standing members of our church.

One Sunday last summer, during the very hot weather, B came into her Sunday school group tearful and upset which was very out of character. She was dropped off by her grandfather and appeared cross with him, which again is very unusual.

You are her group leader and know her well, so immediately bent down and asked what was what was wrong. B promptly burst into tears. You took her aside and and asked `Whatever if the matter?'

Once she calmed down, she said, 'I hate my grandad. He's really mean to me and makes me sleep in his bed. He wouldn't let me out and I hate him. '

You thought this very perturbing indeed and that it might be a disclosure of potential abuse. Fortunately the Parish Safeguarding Officer (PSO) was in Church that morning and you managed to check with her, before the end of Sunday school. B, by this time was engaging happily with the activities and children as usual, seemingly having forgotten the incident completely.

The PSO, suggested that you should talk to the child's mother who was due to collect her after Sparklers. Despite some reservations, you followed this advice and were surprised when B's mum laughed and said, 'Yes, both girls were being very silly last night and wouldn't settle down to sleep. Their Grandad was up and down all evening to them, my mum says and in the end, he separated them by putting B into Mum's and his bed, until she fell asleep. When I came back from my shift at 11pm, we moved her back into her own bed, but this morning she had not forgotten. B seems to think it is unfair that her sister was not moved as well. She doesn't understand the point was to separate the two of them. My poor Dad, has been in the dog house this morning!'

The explanation was simple, freely given and made sense, precisely because it was the truth. You realised that sometimes a child's disclosure can be misinterpreted.

When you went back to the PSO, later that week, you asked her how did she know that this was going to come to nothing. She said she didn't and that was the point- good safeguarding practice is about listening, asking questions and observing signs and signals.

Case study B - a vulnerable adult

A vulnerable adult X, who does not have mental capacity to make her own decisions and who is supported full time by a care worker, volunteers each week in a church. During the spring of 2018, X and her carer, Y, attend the church as usual and the carer leaves a bag behind by mistake. The next morning other church staff and volunteers discovered the bag and opened it to find out the details of the owner. In the bag was drug use paraphernalia, which the finders took photographs of. They then reported the matter to a member of staff, Z. Z told the vicar and he contacted the LADO.

However, when the vicar went back to Z to ask for the bag or details of the owner, he discovered that the owner had collected it and that no one currently at the church knew the name of the carer, Y, or of the vulnerable adult X.

The vicar asked Z to contact another church member, on holiday at the time who he believed could identify X. He specifically asked for X's surname and contact details. Z received a reply to her message the next day, but because it did not give X's surname or contact details, but instead provided a contact number for X's mother, Z did not pass this information on to the vicar. It was later discovered that this was because Z was unaware that X was a vulnerable adult and therefore considered it inappropriate to share her parent's contact details with anyone. Moreover Z had had no safeguarding training.

The church in question is situated on the borders of three different Local Authorities and without a surname it took the LADOs six weeks to identify X and trace the carer Y. It turned out Y was employed by J, X's mother, from an agency who supplies carers. J has parental responsibility for X and so was informed about the incident as soon as X was identified.

J informed the agency and Y was suspended pending an investigation. Y's initial explanation was that drugs were for medical purposes. The agency asked her to produce a doctor's letter to this effect and informed the social care triage desk in the LA, where their agency is based, that they had suspended Y. Y failed to produce any such letter and did not responded to any attempts from the agency to contact her. After a few weeks, the agency terminated her contract and informed the disclosure and barring service of the circumstances.

Conclusions and Key Learning Points

Thankfully, even after the long delay in identifying X, no harm had come to her. Indeed there was no evidence that Y had ever been under the influence of drugs or done anything inappropriate whilst caring for X. However, this incident, the delays in informing her parent and the fallout from it could have ended very differently. In a united effort to prevent anything similar happening again, J suggested a meeting of all agencies involved. We met three months after the incident to discuss what we could learn and share with other agencies.

The key lessons are listed below:

1. Voluntary groups need to keep contact details of all volunteers, (and if any are vulnerable adults without capacity, their parent or guardian needs listing too). These details need to be kept securely, but available to key personnel in the event of a safeguarding concern.

2. Front of house staff, (such as Z in the church office above), need formal safeguarding training and regular practice discussions within their teams about how to respond proactively and proportionately to concerns. This is actioned.

3. All organisations, but especially voluntary groups need more training about vulnerable adults specifically, and also, to raise awareness that safeguarding concerns override the need for consent to share information under GDPR.

4. All agencies including voluntary groups need to make safeguarding a standing item on their leadership meeting agendas, with the aim of enhancing awareness that safeguarding is everyone's ***active duty*** not just something we pay lip-service too.

5. We need to be assiduous and follow up loose ends ensuring all partners are informed. For example in this case: the employment agency took appropriate action and informed the Disclosure and Barring service about Y's professional conduct, but failed to get back to their LA social care triage team.

6. Multi agency and cross border working is essential to improve our practice across the whole safeguarding landscape, because every organisation's safeguarding practice is slightly different. In order to work better together we need to create transparency and review cases together, however uncomfortable or challenging this may be.

7. Finally we need to be prepared to share our internal review processes and any learning from each safeguarding incident externally via case studies such as this one.

Case Study C - elderly vulnerable adult potentially suffering abuse

A is an 84 year old lady who has resided at a local Residential Home since her discharge from hospital 3 months ago. A is mobile with a Zimmer frame but does get confused very easily, believing she is at her parent's house. A has been a member of the Church for many years and is visited regularly by the clergy and pastoral workers and friends. Her son C grew up within the church family, but no longer attends. However, he communicates with church members who visit his mother regularly.

A's son, C, wants his mother to return home to live with him; however the Care Manager does not feel this would be in A's best interests as C does not work and spends most of his day in the betting shop. Moreover, after his last visit, the care staff noticed some bruising to A's arm. C also reported that some money was missing from his mother's drawer.

A is getting more and more agitated and has tried on several occasions to open the front door which is locked. You are a pastoral visitor from the church and one morning you witness a senior carer restraining A and preventing her from leaving the building. You can see that she is grabbing A's arm and speaking harshly to her.

You raise your concerns with the senior carer who tells you that it is necessary to be forceful with A as she has dementia and you need to make her understand.

You are aware that the senior carer will be in charge in the Registered Manager's absence and are now concerned what might happen, if you speak to the manager and report the incident.

This is a complicated case and you are not sure where to turn for help but are convinced that there is some physical abuse and possible financial abuse occurring. In the end, you decide to approach the Church Parish safeguarding officer who recommends that together you refer this case to social care as you believe A is at risk of abuse.

The PSO also recommends that you tell the Care manager and A's son, C of your concerns. You are reluctant to do this, but follow the advice. C reacts by crying and agreeing he cannot manage his mother's care at home, as she is exasperating and confused.

The care manager undertakes an investigation of the senior worker's treatment of A and recommends further training etc. As a result, A' s care plan is revised and she receives more appropriate care in future, which focuses on supporting her with independence and involves familiar people including her son in her activities. Over time C and A develop a different but positive relationship, wherein they can spend time sharing games and memories together, often with the support of a volunteer from the church. A stops trying to escape and regards the care home as her home.