Southwark Safeguarding Team
Recording casework on CMS

Introduction

Recording is an essential aspect of providing a safeguarding service. It is a tool for:

- Gathering, organising and analysing key information to inform decision making and planning;
- Reflecting upon and analysing information in order to develop and adjust plans;
- Demonstrating openness with service users and evidencing their views and involvement;
- Maintaining accountability within the organisation;
- Transferring information to other agencies.

This document aims to provide a robust set of recording standards which enable safeguarding staff to record information in a clear and consistent manner. The standards apply to existing and new records on the CMS system and any paperwork.

This document sets out a framework for consistent recording methods, underpinned by a common set of values which are to be considered when recording information in any format. This guidance is intended to benefit children, their families, subjects to any concern and others involved in any safeguarding concerns.

Staff are responsible for completing records in a way which is **timely**, **comprehensive** and of **good quality** and must therefore follow this policy. The Head of Safeguarding is responsible for ensuring that their staff adhere to the policy.

References

- Children Act 1989;
- Children Act 2004;
- Freedom of Information Act 2000;
- Caldicott Principles;
- Human Rights Act 2004;
- Mental Capacity Act 2005;
- Information Commissioners Good Practice Guidance;
- Working Together to Safeguard Children;
- Pan Berkshire Child Protection Procedures.

Record Keeping Values

Each case regarding an allegation, disclosure or concern must have an individual electronic case record from the point of referral to case closure. Audio, video and digital records may also be kept.

Appropriate records must be kept of all contact with the individuals involved, including subject, children and their families/carers and a clear case summary and chronology should be maintained.

There must be a consistent approach to all recording and records should be:

- Accurate and concise;
- Up to date;
- Relevant;
- Easy to read and in plain English, with any abbreviations explained;
- Easily understood by the individuals involved.

Consistent recording processes are essential for service planning, decision making and information sharing. Quality recording will assist employees in the following ways:

- Providing documentary evidence of the Archdiocese involvement with an individual case;
- Providing information to assist with analysis, service planning, reviews and evaluation;
- Documenting services/action taken for cases and to individuals;
- Allowing continuity when staff change or are absent;
- Providing information when dealing with investigations or complaints;
- Supporting supervision and with staff development;
- Providing a complete record of actions and service provided.

Good case recording includes a record of:

- work that has been undertaken;
- actions, and reasons for those actions;
- decisions, and reasons for those decisions;
- progress made towards appropriate outcomes;
- views of any subject (and family/carers);
- life history (where appropriate);
- professional assessment and analysis of risk.

All recording must be finalised within **three working days** of the event, unless a specific endorsed procedure includes a different timescale. In the event of a safeguarding matter it must be recorded immediately and reported where appropriate to statutory services. Where possible, children and their families/carers wishes and views and those subject to a concern (including issues around consent) must be noted and it should be evident that they were actively engaged during the activity.

All recording should be evidence based with clear distinction between fact and opinion.

Consideration must be given when recording race, culture, age, disability, gender or sexual orientation and how the needs of the individual have been acknowledged and supported.

Scope

This applies to all case records whether paper or electronic.

The main case recording tool is CMS, where all information and contacts about work with individual referral and cases is recorded. A decision will be made historic regarding paper files in accordance with GDPR.

Recording "The Munro Review of Child Protection"

In the Munro Review of Child Protection, Recommendation 31 says that Ofsted's "new inspection framework should examine the child's journey from needing to receiving help, explore how the rights, wishes, feelings and experiences of children and young people inform and shape the provision of services, and look at the effectiveness of the help provided to children, young people and their families." The current Ofsted 'Framework for the inspection of local authority arrangements for the protection of children' states that the inspection will focus on the child's journey through intensive and extensive case sampling and case tracking.

Due to the case work that the safeguarding team complete, rarely do we have contact with young people directly. When this occurs, our record keeping must consider the above.

Principles

The key principles that underpin good record keeping are:

- **Accuracy**. Entries must be accurate and must distinguish between facts, opinions, assessments, judgements and decisions. Records must distinguish between first-hand information and information obtained from third parties;
- **Clarity**. Recording should be clear and chronological. The reader should not be left with an interpretation of a recording that differs from the author's meaning;
- **Relevance**. Service users' records should not include unnecessary material, messages or notes. Duplicate information should be kept to a minimum;
- **Timeliness**. Entries should be written within three working days of the events actually occurring. **Entries will be recorded by the date of the event, not the date of writing up.**
- **Legibility**. All recording should be written concisely, in plain English and avoid the use of professional jargon;
- **Responsibility**. The management of information is the responsibility of all the team
- **Services Users' Involvement**. Entries will reflect that the views of child(ren), families and the subject have been actively sought and fully recorded. That they contribute their comments where they agree and/or disagree with professional opinion and these are recorded also. The means by which this information is obtained should also be recorded.
- **Care must be taken when recording to ensure that confidentiality and the principles within the UK General Data Protection Regulation and the Data Protection Act 2018 are considered**. Individuals must be confident that information held about them will only be disclosed to others with their consent or when there is a legal duty or power to do so. In practical terms this means that information will be shared with other professionals who are involved in considering and responding to the needs of the individual;
- **Any emails** copied and pasted to 'Case Notes' do not contain information relating to any other service user or any irrelevant communication between the sender and the recipient, including any disagreements between them. Uploaded emails must not take the place of case notes;
- **Confidentiality**. Information will only be kept confidential from a service user for specific reasons e.g.
    - Where disclosure of the information is likely to result in serious harm to their physical or mental health or to that of another individual (including a member of staff);



    - Where disclosure would identify a third party who has not consented to being identified (this does not apply to third parties who have provided information in a professional capacity);
    - Where disclosure would be likely to prejudice the prevention or detection of crime.
- **Consent**. Written consent should be gained from any individual before any personal information relating to them is sought from other sources. However, a service user's consent to disclose their personal information or seek information from other agencies is not required in instances where the law or public interest overrides their right to confidentiality. These include:
    - If there is a concern about an individual's safety;
    - Where the courts have made an order;
    - To prevent, detect or prosecute a serious crime.
- **Sharing of information**. In situations where a request is made to or by another organisation, to share information the decision to share or not to share regarding who made the decision and the reasoning behind this, should be recorded;
- **Staff should include their full name**
- **Where an interpreter** is used this should be recorded, giving their name and whether they were from a contracted service or a named staff member, family member and/or friend;
- **Management oversight must be evidenced**. The line manager should routinely audit files. Relevant sections of the record must be endorsed, and issues of concern of actions identified during the course of the audit recorded on the appropriate record;
- **Recording of decision-making** to highlight the reasons for the decision-making and the decisions made, including assessing risk and why other decisions were not made, should be clear. All of the people who take such decisions should be identified. Every decision arrived at between supervisor and officer, whether in a formal or informal supervision session, must be recorded in the case recording at the time of the decision being made. Managers must also use supervision to ensure that the case record is being maintained in a reasonable state;
- **Anti-discriminatory practice**. All records must demonstrate an anti-discriminatory perspective and must not include any derogatory comments by the author on ethnicity, race, culture, gender, age, religion, language, communication, sensory impairment, disability, family make-up and sexual orientation;

Opening a CMS

On the new CMS system all new cases must be assigned the most appropriate heading for the concern reported-this is under the "Allocating Categories" heading. This will also assist with assessing trends and reporting figures. The role of the individual must also be assigned, so that there is clear identification of role for all those subjects, reporting or victims of concerns. If the case is a priority, the "Priority concern" box must be ticked. It is for the Head of Safeguarding to assign a case it's low, medium or high-risk level. It is also for the head of Safeguarding to assign the case owner. Each case assigned, the officer will receive an email.

The front page should be completed as fully as possible. If the information is not available, the case will not be closed until the front page is completed as fully as possible. Ensure that the case summary identifies the full aspects of the case as known at the stage of recording the case. If the details of the case significantly change, this should be reflected in the ongoing chronology.

All contact, information, analysis, contingency planning etc, should be recorded on the chronology. New headings are required to establish what is being recorded for clarity and ease of reading the CMS records. Full factual details should be recorded, with email information as a back-up. Emails should not be used to describe what has happened.

We must always aim to offer the most supportive and compassionate service from any complainant. However, if feedback is offered or learning gained regarding managing and supporting those that have been harmed, this should be recorded in lessons learnt so that it can be collated and fed back to the team quarterly. Lessons learnt tab can also be used where there are important lessons that the team could benefit from. The Head of Safeguarding on review may also add lessons learnt, throughout the case work and at the closure of any case.

During supervision, tasks may be assigned and these are recorded under the "task" tab. Weekly staff must look at their tasks and ensure that these are being completed and the result recorded to ensure effective management of any case.

Information to be included within the complex casework

Chronology

A chronology is a sequential list of events (including positive changes and achievements) with dates, recording all significant events that will be of specific interest to specific case. It is responsibility of case worker to write up and maintain the chronology. (This will only be completed in our complex case work)

Other relevant information

Chronologies start from the birth (or before birth where there is a significant event such as the death of an older sibling before the child was born, or a pre-birth assessment.) It should include all details of placements and seminary if regarding Clergy/Religious.

The chronology is a useful way of gaining an overview. It should be used as an analytical tool to help understand the impact of events both immediate and cumulative of events and changes on the individual or subject. It can help inform the assessment and decision making. A chronology should be updated regularly

Risk Alerts

Working with an individual may on occasion give rise to the need to record a 'risk alert' CMS. The purpose of a risk alert is to provide a warning, for example about the recorded characteristics, behaviour or circumstances of a child or adult where these might give rise to a risk of harm to our staff or others. Eg-

- Dangerous Pet;
- Persons Known to be Violent; and
- Need to Protect Information.

If you believe that a risk-alert is required, the Head of Safeguarding will make the decision and this will be reviewed 6 monthly.

Confidential Records

There may be some situations in which access to particularly sensitive records must be restricted to proactively prevent them from being accessed inappropriately. In Southwark this will be rarely, but may occur when a senior Clergy member is being investigated. The decision to restrict a record will be made by the Head of Safeguarding.

Case Record Integrity

When information has been entered onto the CMS it should not be deleted. This is because subsequent records will have been written based on, or in the light of, that information and to remove it could render subsequent records incomprehensible. If information has been entered in error or you believe a whole record requires deletion, the Head of Safeguarding must be contacted and they will make any decision regarding deletion

If information needs to be amended or corrected this must be done in a new action and supervised by the Head of Safeguarding. The new note must detail the correct information and reason for case recording being amended.

Audit Forms

If case is audited, there will be a record of this on the file, but the audit results will be recorded elsewhere.

Security and Management of Information

All staff should ensure that they log out of CMS when not actively inputting or away from their desks. Any paper-based information must not be left open or easily accessible at any time.

There will be occasions when information about cases is requested by Statutory services or another Diocese. Such requests must be decided in the light of the requirements set out in the UK General Data Protection Regulation and the Data Protection Act 2018 and may be referred to our DPO for advice. If an information sharing agreement is supplied, this must be recorded and saved onto the CMS. All decision-making regarding information sharing, must be recorded within the CMS.

What is required within a referral case record?

Rigorous analysis

Making sense of complex cases requires detailed analysis. It involves paying careful attention to what is going on in any situation in order to understand that situation and make recommendations. Analysis is an ongoing process that the safeguarding team are engaged in all of the time.

Analysis is also a written record which captures key aspects of all the different parts of the analytic process – the thinking, listening and observations of the team. The written record of analysis involves selecting the most important details from all these aspects and writing in a way that makes these understandable to many different kinds of readers.



Structure

- Clear history running through - it is sequential and measured
- Analysis provides the history of what's happened and what's been discussed
- Clear reasoning, decision making and planning, all this is clearly connected to/ by the information previously given

Content

- Summarises and weighs up risks and risk factors, and shows protective factors, uses relevant risk tools
- Contains the right amount of detail
- Captures different perspectives in a non-judgemental way
- Brings in evidence, practice wisdom, information from other professionals, family, carers or those subjected to concerns
- Explains what's recorded and why
- Weighs up the likelihood or probability of change/ impacts

How it 'reads'

- Writer has a good understanding of the issues
- Being able to get a sense of the "subject" and what they see as a priority
- It is clear and concise
- When required, analysis should be tailored to the requirement of the report/assessment and distil the key information to inform the plan for the child/family/subject/community.

Focus

- Outcomes focused – short-, mid- and long-term outcomes
- States clearly what the outcomes or impacts will be and if these are positive or negative

The ethical principles underpinning written analysis

Respect for persons
Respect for human rights, dignity and worth is captured by good analysis. Respect for persons involves writing with sensitivity and is about being able to see the world from the viewpoints of others. Good analysis demonstrates thoughtful use of language that avoids labelling, stereotyping and cultural or other bias.
Professional integrity
Good analysis writing takes account of organisational requirements and legal obligations. It also means being mindful of professional boundaries and responsibilities. This integrity then leads good analysis to offer clearly articulated and justified decisions, while considering the broader social context. Accuracy in recording leads to a fair representation of a supported person's point of view, allowing records to be shared in an open and direct way.
Accuracy, judiciousness and credibility
Good analysis provides full and accurate information about people's circumstances and accurately records the information to give a clear understanding of their needs to other professionals working with them. It includes only essential and relevant details, and does not use emotive or derogatory language.
Reflexivity

Reflexivity is essential to safeguarding practice and writing reflexively is part of good analysis. Writing explores not only what an experience was, but considers the meaning the writer attached to it, both at the time and subsequently, and how this meaning may influence practice in the future. Good analysis gives the reader a sense that the writer has a sense of 'self' and has made connections between ideas, feelings and memories of experience.

Social justice

Strong analysis in safeguarding is one of the tools that can be used to challenge injustice, particularly as it relates to policies and practices. Good analysis openly values people's lived experiences, is critically reflective, connects with the audience, and draws attention to social injustices to advocate for social change. It can challenge negative discrimination and recognise diversity by using language that is inclusive and does not further stigmatise already marginalised people.

A framework for thinking about writing analysis

Writing analysis encompasses much of safeguarding practice. Here is a framework that may help when writing analysis.

There are many ways of talking about written analysis. 'Analysis' is sometimes thought of as one particular aspect or part of written records and there is often a section marked 'Analysis' in templated documents. But rather than think of analysis as one particular part of a written text, we think it is useful to think of analysis as being made up of four key elements.

1. Description
2. Explanation
3. Evaluation
4. Recommendation

Description

- Does the detail provided give a clear account of that situation?
- What details have been included and why?
- What have you decided not to include and why not?
- Is there any language you have used that you think is evaluative or judgmental, rather than 'neutral'?
- If you have decided to use an evaluative word or phrase, have you included sufficient detail to justify this use?

Explanation

- Have you made clear whose view is being reported and on what basis?
- Have you highlighted any possible contrasting explanations and perspectives?
- Have you indicated possible links between different sources and explanations?

Evaluation

- Is your professional position clearly stated?
- Will the reader be able to identify your summary evaluation and the basis on which it is made?
- Are there any revisions you think you could make to sharpen the evaluation in any way?

Recommendation

- Is the recommendation clearly stated?
- Is there any room for a reader misunderstanding your recommendation?
- Have you provided sufficient evidence to justify any recommendations you have made?

The person's view

- If you are reporting about a person's account and perspective, have used direct speech, e.g. 'I am worried' or indirect speech 'she said she was worried' and consider how the language you have used changes the meaning or tone in any way.
- Focus on whether you utilise the third person (she, he, they) to write about them or used the second person (you) to write to them and the possible effect of choosing one over the other.
- Notice if the record includes expression of care and love about the person. On the basis of your reflections, are there any changes you would make to the record? Why/why not?

Contingency Recording

What is contingency planning?

A contingency plan is a plan that is agreed (where appropriate with a child, family, subject or partner agencies). Should any agreed plan or action fail a plan, enables all parties to understand the actions that we and others will take if required.

A robust contingency plan is a way of increasing the safety of our community and that all involved know what action may be taken if agreed action or plan is not followed and where individuals can go for help if required.

Why do we need a contingency plan?

Professionals, those subject to concerns and families involved in enquiries, need to be aware when certain situations occur it could impact the safety of individuals or our community. For example: A individual under investigation highlighting mental health issues snd reported that this is deteriorating rapidly and become a risk to themselves and others.

A Contingency Plan should be recorded on the individual case file and should be kept up to date to consider the changing needs and circumstances. The subject/child, family and all relevant professionals need to be involved in the process and in some cases (particularly SG plans) agreeing the contingency plan. The plan should be specific to each individual/child and their circumstances, the plan should be reviewed and updated if risks escalate/deescalate or if new risks are identified. It is important that the plan is written in a way so that all involved understand its purpose.

The Contingency plan should focus on the needs of the Individual/child and what actions need to be taken to keep them or the community around them safe from significant harm **– naming a process is not sufficient.**

Where appropriate, Contingency Plans need to be shared and agreed with the Subject/Child, their family and partner agencies.

What should a Contingency plan include?

- Consider how any vulnerability involved in the matter could affect the safety of the community i.e does the vulnerability affect the motivation, ability to care for self

and/or child? What strategies can be put in place to support an individual? Is there a professional in their network who could provide support? Can they gain access to professional help? Have we identified safe alternative options/actions?

- Professionals should always consider how changes in circumstances for an individual (including parent/carer and their child) will be managed. The plan should clearly record any concerns raised and considerations made.
- For individuals with additional needs we should consider what additional support/services maybe required if their health deteriorates and who are their support network.
- For any individual who cannot be traced we should consider and agree how long before they are formally reported missing, what actions will be taken by whom before calling the police? How to proceed in their absence?

Contingency planning is a vital part of the **dynamic risk assessment process**. It ensures we have a clear understanding of the level of risk to any individual and community and a clear plan in place to reduce the risks and ultimately protect from significant harm.

We will predominately utilise contingency planning for our safeguarding plans and for our more complex casework. We should record this within the normal recording, but mark it as "Contingency plan".

For safeguarding plans this may include aspects such as;

- Action taken if does not comply
- Action taken if fails to attend Specified Mass
- Action taken when PP leaves Parish (meet with new Priest and subject)
- Action taken if requests to attend another Parish/Activity
- Action taken if in breach of Plan/Order
- Action taken if removed from RSO etc

For case work, it may include;

- Action taken if statutory authorities take NFA
- Action taken if does not meet statutory/criminal threshold
- Action taken to protect a community during any enq
- Action taken to return someone to Ministry/role
- Action taken if someone fails to comply
- Action taken if SG advice is not agreed by Senior Clergy
- Action taken if health both mental/Physical declines
- Action taken if support network is not functioning.

These are not exhaustive lists, but just some examples of what to consider on any contingency plan.

Assessing Risk

When assessing risk, all decisions should be clearly recorded as set out above. In complex cases, it is important that all decision making is recording chronologically, including decision not to take any action as well as what action was decided on.
Below is a chart to assist in the decision-making process.

Level of risk	Lower level of harm	Significant/ Very Significant Harm	Critical Harm
Category of abuse/ incidents	Concerns may be notified to the Local Authority, but they are likely to be managed at Initial Enquiry stage only . Low level concerns should be recorded however, and professional judgement applied so that cases of repeat low level harm will progress to further stages in the safeguarding adult process.	Concerns of a significant or critical nature should be referred to the Local Authority (with the consent of the alleged victim where this is relevant and appropriate to do so). They will receive additional scrutiny and progress further under safeguarding adult procedures. Where a criminal offence is alleged to have been committed, the Police will be contacted. Other emergency services should be contacted as required.	
Physical	▸ Error by staff causing no/little harm, e.g. skin friction mark due to ill-fitting hoist / sling. ▸ Isolated incident by other resident causing no/little harm, e.g. one resident strikes another but it leaves no mark and does not cause emotional distress lasting hours. ▸ Unexplained very light marking/bruising found on one occasion.	▸ Unexplained marking or lesions, minor cuts or grip marks on a number of occasions or a number of service users cared for by a specific team/carer. ▸ Inappropriate restraint that causes marks to be left but no external medical treatment/ consultation required.	▸ Serious bodily harm/assault with weapon leading to irreversible damage or death. ▸ Intended harm towards a service user. ▸ Deliberate withholding of food, drinks or aids to independence. ▸ Unexplained fractures/serious injuries / significant bruising. ▸ Assault by another resident requiring medical treatment.
Psychological Abuse	▸ Isolated incident where adult is spoken to in a rude or inappropriate way – respect is undermined but no or little distress caused. ▸ Occasional taunts or verbal outbursts which cause distress.	▸ Treatment that undermines dignity and damages esteem. ▸ Repeated incidents of denying or failing to recognize an adult's choices or of failing to value their opinion, particularly in relation to a service or care they are receiving. ▸ Occasional taunts or verbal outbursts which do cause distress between service users.	▸ Denial of basic human rights/ civil liberties, over-riding advance directive, forced marriage. ▸ Prolonged intimidation. ▸ Vicious/personalised verbal attacks. ▸ Humiliation of service user. ▸ Emotional blackmail e.g. threats of abandonment/harm. ▸ The withholding of information to dis-empower. ▸ Allegations or concerns relating to 'cuckooing'.

Level of risk	Lower level of harm	Significant/ Very Significant Harm	Critical Harm
Sexual Abuse	Not committed by a person in a position of trust, and: ▸ Isolated incident of teasing or unwanted attention, either verbal or physical (but excluding genitalia), where the effect on the adult is low. ▸ Isolated incident of teasing or low-level unwanted sexualised attention (verbal or by gestures) directed at one adult by another whether or not capacity exists -little or no harm or distress caused.	▸ Non-contact sexualised behaviour causes distress to the person at risk. ▸ Verbalised sexualized teasing or harassment. ▸ Being subject to indecent exposure where the service user is not distressed.	▸ Any allegation of sexualised behaviour, to include sexual acts in front of an adult or relating to a person in a position of trust against a person in their care. ▸ Sex in a relationship characterised by authority, inequality or exploitation, e.g. staff and service user. ▸ Sex without valid consent (rape). ▸ Voyeurism. ▸ Sexualised touch or masturbation without valid consent. ▸ Being made to look at pornographic material against will/where valid consent cannot be given. ▸ Attempted penetration by any means (whether or not it occurs within a relationship) without valid consent.
Domestic Abuse	Service user has no current fears and there are adequate protective factors, and it is: ▸ One off incident with little or no injury or harm experienced. ▸ Occasional taunts or verbal outbursts where the service user has capacity to decide whether to have the case is referred on.	▸ Unexplained marking, lesions or grip marks on a number of occasions. ▸ Controlling or coercive behaviour. ▸ Frequent verbal outbursts that cause some distress or some level of harm. ▸ Sexual assault or humiliation where the service user has capacity and does not want to be referred. ▸ Experiences occasional episodes of fear of the alleged perpetrator.	▸ Subject to regular violent behaviour. ▸ Threats to kill/choke/suffocate, etc. ▸ In constant fear of being harmed. ▸ Sex without valid consent (rape). ▸ Female Genital Mutilation (FGM). ▸ Honour based violence &/or forced marriage. ▸ Service user denied access to medical treatment/care/ vital equipment to maintain independence by alleged abuser. ▸ Frequent physical outburst that cause distress or some level of harm ▸ Subject to severe controlling behavior e.g. economic/medical.

Level of risk	Lower level of harm	Significant/ Very Significant Harm	Critical Harm
Neglect & Acts of Omission	▸ Isolated missed home care visit - no harm occurs, and no other service users/ clients is missed that day. ▸ Adult is not assisted with a meal/drink on one occasion and little or no harm occurs. ▸ Inadequacies in care provision leading to discomfort, but no significant harm e.g. the adult is left wet or soiled for a period of time. ▸ An unwitnessed fall that requires no external medical treatment/consultation, i.e. no call to 111 or admissions to hospital. ▸ Unwitnessed fall where 111 are called but do not recommend getting external assistance.	▸ Recurrent missed home care visits where risk of harm escalates, or one miss where harm occurs. ▸ Discharge from hospital where harm occurs that does not require re-admission. ▸ Recurrent lack of care to extent that health and well-being deteriorate e.g. pressure wounds, dehydration, malnutrition (assessed to the capability of the person reporting). ▸ Unwitnessed fall where 111 are called and recommend getting external medical treatment e.g. an ambulance.	▸ Failure to arrange access to life saving services or medical care. ▸ Willful neglect or failure to intervene in dangerous situations where the adult lacks the capacity to assess risk. ▸ Discharge from hospital where harm occurs that does require re- admission.
Medication Errors	▸ Isolated incident where the person is accidentally given the wrong medication, given too much or too little medication or given it at the wrong time. Health professional, e.g. GP 111 (out of hours) is consulted and little or no harm occurs or is identified. ▸ Isolated incident causing little or no harm that is not reported by staff member. ▸ Isolated prescribing or dispensing error by GP, pharmacist or other medical professional resulting in little or no harm.	▸ Recurring missed medication or errors that affect more than one adult and result in actual or potential harm to one or more adults. ▸ Recurring prescribing or dispensing errors by GP, pharmacist or other medical professional that affect more than one adult and/or result in harm to one or more adults. ▸ Covert administration without the person's consent or having a best interest decision recorded in the care plan. ▸ Misuse of/over-reliance on sedatives to control challenging behaviour.	▸ Deliberate maladministration of medications or failure to follow proper procedures, e.g. controlled medication. ▸ Pattern of recurring errors or an incident of deliberate maladministration that results in ill- health or death. ▸ Deliberate falsification of records or coercive/ intimidating behaviour to prevent reporting.

Level of risk	Lower level of harm	Significant/ Very Significant Harm	Critical Harm
Economic or Material Abuse	▸ Money is not kept safely or recorded properly. ▸ Misuse of buy one get one free product offers. ▸ Single incident of missing money and/ or belongings where the quality of the service user's life has not been affected, little or no distress is caused, and no other service user cared for by that worker/team has been affected. ▸ Adult not involved in decision about how their money is spent or kept safe - capacity in this respect is not properly considered.	▸ Adult's monies kept in a joint bank account – unclear arrangements for equitable sharing of interest. ▸ High levels of anti-social behavior reported. ▸ High levels of visitors to the property - tenant/ service user does not appear to be able to say 'no'. ▸ Tenant/service user is socially isolated. ▸ Service user is falling behind on rent payments. ▸ Service user deemed to be 'failing to engage' with professionals. ▸ General deterioration in service user's health and wellbeing. ▸ Property falling into disrepair.	▸ Suspected fraud/exploitation relating to benefits, income, property or will, including 'cuckooing'. ▸ Lasting Power of Attorney claimed to exist and/or unregistered. ▸ Adult denied access to his/her own funds or possessions. ▸ Misuse/misappropriation of property, possessions or benefit in kind by a person in a position of trust or control, including by Attorney. To include misusing loyalty cards. ▸ Personal finances removed from adult's control. ▸ Adult coerced or misled into giving over money, property or welfare benefits.
Organisational Abuse	▸ Lack of stimulation/ opportunities to engage in social and leisure activities. ▸ Service user not enabled to have a say in how the service is run. ▸ Denial of individuality and opportunities to make informed choices and take responsible risks. ▸ Care-planning documentation not person-centered/does not involve the service user to capture their views. ▸ Single incident of insufficient staffing to meet all client needs in a timely fashion but causing no harm. ▸ Organisation unaware or non-compliant of national, regional and local current best practice guidance and training.	▸ Rigid/inflexible routines that are not always in the service users' best interests. ▸ Service users' dignity is occasionally undermined.e.g. lack of privacy during support with intimate care needs. ▸ Recurrent bad practice lacks management oversight and is not being reported to commissioners/the safeguarding service. ▸ Unsafe and unhygienic living environments that could cause harm to the service users or have caused minor injury requiring no external medical intervention/consultation.	▸ Staff misusing position of power over service users. ▸ Over-medication and/or inappropriate restraint managing behaviour. ▸ Recurrent or consistent ill treatment by care provider to more than one service user over a period of time. ▸ Recurrent or consistent incidents of insufficient staffing resulting in harm requiring external medical intervention or hospitalization of service users. ▸ Recurrent incidents of insufficient staffing resulting in some harm.

Level of risk	Lower level of harm	Significant/ Very Significant Harm	Critical Harm
Modern Slavery	All concerns about modern slavery are deemed to be of a level requiring consultation.	No direct disclosure of slavery but: ▸ Appears under control of another. ▸ Spends long hours at work. ▸ Has poor living conditions/low wages. ▸ Lives in workplace. ▸ There is no health and safety in workplace. ▸ Is at risk of physical/psychological harm. ▸ Service user is being encouraged to participate in unsafe or criminal activity.	▸ Any direct disclosure of slavery. ▸ Regularly moved to avoid detection. ▸ Lives in sheds/lockup/containers. ▸ Risk of fatality or serious injury. ▸ No freedom/unable to leave. ▸ Wages used for debt. ▸ Not in possession of ID or passport. ▸ Subject to forced marriage. ▸ Unable to access medical treatment/ care/equipment required to maintain independence. ▸ Under control of others e.g. gang master, dealers, pimp for prostitution. ▸ Subject to violence/threats/fearful. ▸ Actual physical/psychological harm.
Discriminatory Hate Crime	▸ Isolated incident of teasing motivated by prejudicial attitudes towards an adult's individual differences. ▸ Isolated incident of care planning that fails to address an adult's specific diversity associated needs for a short period.	▸ Recurring failure to meet specific care/ support needs associated with diversity that cause little distress. ▸ Denial of civil liberties e.g. voting, making a complaint.	▸ Hate crime resulting in injury/ emergency medical treatment/fear for life. ▸ Hate crime resulting in serious injury/ attempted murder/ honour- based violence. ▸ Inequitable access to service provision as a result of diversity issue. ▸ Being refused access to essential services. ▸ Humiliation, threats or taunts on a regular basis. ▸ Recurring failure to meet specific care/ support needs associated with diversity that cause distress.

Level of risk	Lower level of harm	Significant/ Very Significant Harm	Critical Harm
Self-Neglect	▸ Self-care causing some concern – no signs of harm or distress. ▸ Property neglected but all main services work. ▸ Some evidence of hoarding – no major impact on health/safety. ▸ First signs of failing to engage with professionals. ▸ Property shows some signs of neglect. ▸ Evidence of low-level hoarding. ▸ No access to support.	▸ Refusing medical treatment/care/ equipment required to maintain independence. ▸ High level of clutter/hoarding. ▸ Insanitary conditions in property. ▸ Unwilling to engage with professionals. ▸ Problematic substance misuse. ▸ Potential fire risk/gas leaks. ▸ Lack of essential amenities. ▸ Property/environment shows signs of neglect that are potentially damaging to health. ▸ Chaotic substance misuse.	▸ Life in danger without intervention. ▸ Chaotic substance misuse. ▸ Environment injurious to health. ▸ Imminent fire risk/gas leaks. ▸ Access obstructed within property. ▸ Multiple reports from other agencies. ▸ Behaviour poses risk to self/others. ▸ Self-neglect is life threatening. ▸ Tenancy at risk because of hoarding/ property condition, i.e. notice served. ▸ Lack of self –care results in significant deterioration in health/ wellbeing.
Falls	▸ Isolated incident where no significant harm occurs. ▸ Multiple incidents where no significant harm occurs. **and:** ▸ A care plan is in place. ▸ Action is being taken to minimise further risk. ▸ Other relevant professionals have been notified. ▸ There has been full discussion with the patient, their family or representative. ▸ There are no other indicators of abuse or neglect. ▸ Isolated incident requiring attendance at hospital and no other form of abuse or neglect is suspected.	▸ More than one incident during a 6-month period requiring attendance at hospital. ▸ Multiple incidents where: - the care plan has **NOT** been fully implemented. - it is **NOT** clear that professional advice or support has been sought at the appropriate time. ▸ There have been other similar incidents or areas of concern. ▸ Any fall where there is suspected abuse or neglect by a staff member or other person or a failure to follow relevant care plans, policies or procedures.	▸ Any fall resulting in significant injury or death where there is suspected abuse or neglect by a staff member or other person or a failure to follow relevant care plans, policies or procedures.

Six Key principles of Adult Safeguarding work is enshrined in the Care Act 2014.

Empowerment	Accountability	Prevention
I'm asked what I want from the safeguarding process and this informs what happens.	I understand the roles of the people involved in my case.	I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to help.

Proportionality	Protection	Partnership
I am sure professionals will work in my interests as I see them and get involved as much as I need them to. I feel I'm supported to manage the risks I want to take.	I get help and support to report abuse and neglect. I get help so that I'm able to take part in the safeguarding process in a way that I want to.	I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together with me to get the best results for me.

Supervision

There is now a specific area for supervision on the CMS. Supervision will be reflective and detail both the informal discussions as well as the managers recommendations and overview. Supervision will include the following;

- What are the best interests for the safeguarding function or safety of the individual, case or environment
- A shared responsibility
- Regular over-view without being overbearing or disrupting case or case-worker
- Management, development, mediation & support

Where the Head of Safeguarding leads a case, supervision will take place in group reflective sessions, which will be recorded on the CMS and for more complex cases will be taken to the subcommittee panel meeting. Any recommendations or comments will be recorded on the CMS.

Closing a Case

The closing of a case must ensure the following;

- All details of persons involved are recorded (including contact details, DOB, Address etc
- All documents are attached (with password protection removed)
- All information has been recorded appropriately
- All actions have been completed
- Discussion regarding the case has taken place with HofS or other where appropriate
- All learnings from case (either the individual case/subject/or management of case) have been recorded on both CMS and Spreadsheet
- Closing summary is recorded accurately and concisely

Monitoring the effectiveness of your safeguarding procedures

How do we know that are safeguarding service is working? How do we test compliance?

All cases reported on the CMS will be subject to a random dip sampling once or twice a year to ensure that all staff understand what is expected of them and are recording the cases effectively. If any failings are found, a review of whether this is a team-wide issue or an issue affecting individual staff will take place. Mechanisms will be in place to ensure the Head of Safeguarding is fulfilling thier role effectively and conducting regular and effective supervision of staff.

Learning lessons from safeguarding shortcomings

There can sometimes be barriers that prevent organisations from learning important lessons following failures within the safeguarding processes. The Archdiocese of Southwark will work to ensure that there are proper mechanisms in place to record and review any shortcomings or failings in their safeguarding service, both historically and currently.

"If you have been the subject of an independent safeguarding review, it is good practice to set up a scrutiny panel to examine the review's findings. It would also help to develop a risk

register, to ensure you have identified the key risks you face and put plans in place to manage them."

Monitoring and Review

This practice guide will be monitored annually by the Safeguarding Sub-committee

Mary-Jane Crowley
Head of Safeguarding