



**GRADUATE CERTIFICATE in Consolidation
of Social Work Practice
LEVEL 6 - 60 Credits
BMPF6044**

**LEARNER PORTFOLIO
(PORTH AGORED and UNIVERSITY OF WALES
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Task 3

Safeguarding and working in complex situations – Case Study

Guidance;

Please ensure that you meet the National Occupational Standards and assigned Learning Outcomes for this task (see appendix 5 and 6 of the handbook).

Question:

Complete a critically reflective case study based on an assessment that you have undertaken with others, in your own area of work, concerning the safeguarding of either an adult or a child. You must demonstrate how the case relates to or could relate to safeguarding legislation, policies, strategies and procedures (including demonstrating an understanding of the interface between social services provision in Wales with the United Kingdom, the European Union (EU) and outside the EU). You must demonstrate your understanding of the integration of analysis in assessment, collaborative working and professional judgements in increasingly complex situations and the use of social work theories. You must refer to the specific dimensions of working in Wales.

4000 words (+/- 10%: include your actual word count at the end of each section).

11, 74, was a physically active, professionally adept woman with a sizable UK-wide social network and lived with her husband of almost 30 years (**22**) in a Welsh rural village; the Active Offer ascertained her first language was English. She was active in several local groups and clubs. She had noted a rapid decline in her cognition, reducing her ability to go out independently, and was diagnosed with dementia in Spring 2021. The diagnosing psychiatrist recommended that 22 apply for Power of Attorney; he did so for finances and took over all financial matters. Citing debt caused by 11's recent over-spending (a narrative shared widely but later found to have no factual basis) he removed her bank card and unsupervised access to her phone. (**124**)

Social Services intervention was requested due to primary carer acopia. An assessment of need was undertaken for 11 and carer's assessment for 22 under s14 of Social Services and Well-being (Wales) Act 2014. Service provision (s14a) centred around personal care for 11 using Direct Payments (s50 SSWB(W)A 2014).

11's Personal Assistant reported witnessing an altercation between the couple involving raised voices and an allegation by 11 that 22 had thrown her onto the bed. 11 disclosed that she has 'been on the receiving end of [22's] anger before'. A voicemail recording was also provided to Social Services and the police by the PA of 22 requesting help with 11, failing to replace the handset, and then of 22 shouting and swearing at 11, and 11 crying out. The incident was assessed as requiring safeguarding investigation under Part 7, s126 SSWB(W)A 2014. Police attended the property but did not speak to 11 after being told by 22 that she had dementia; they concluded that her disclosure was confabulated and her behaviour the cause of the incident. **(175)**

11 was assessed by me and her Community Psychiatric Nurse as having mental capacity; she chose to remain in the home with her husband. A history of similar decisions was reported by friends and family, who were concerned that previously, 11 had been able to remove herself from his 'controlling behaviour'. Now, she was less able to do so. This scenario reflects Walker's 'Cycle of abuse' (1979), wherein violent relationships often follow a common cycle.

- Tension building phase: Pleasing/ appeasing
- Acute violent incident: unpredictable and out of control
- The honeymoon phase: Apologies, promises to change, gifts, being pleasant
- Cycle continues repeatedly

Visiting professionals noted that 22 was charming and agreeable to others but often spoke over 11, directed any conversation (often onto himself/ his problems), and denigrated her cognition and abilities in front of her. He was provided with information, training materials and opportunities, but continued to report a lack of both understanding about dementia and support to manage. Despite being trained in moving techniques by multiple professionals, he continued to push and pull 11 when transferring or mobilising. I liaised closely with the CPN and mental health OT; we formed a multi-disciplinary approach to managing 22's apparent disguised compliance and addressing inconsistencies through inter-disciplinary cooperation and close working to ascertain the actual situation and understand the ecology

as it was changing. We favoured a person-centred approach (Rogers,1951), which has been vital in working with both parties, especially 11, as 22 does not appear to consider 11's needs outside of how they affect him. As 22 had been controlling the narrative it has been especially important in ensuring that 11 is empowered to convey her own narrative in her own time and is able to speak without fear of reprisal by 22, in confidence, knowing information will be used judiciously. Some documentation has been withheld from 22, to protect 11. We were also cognisant of the potential for secondary abuse through the power differentials between professionals and 11, which we had already seen in practice during police attendances. **(338)**

A paternalistic model would have denied 11 a voice and pushed a more risk averse option of care home placement, despite continued capacious decision-making to the contrary. 11's support team has encountered this from some professionals, and I have found that I have needed to strenuously promote 11's legal rights in these situations and escalate contraventions to our legal team and senior management. These occurrences have made me grateful for the effective working relationship built with 11's CPN, OT, Independent Domestic Violence Advocate and Domestic Abuse Officer, and for support from management, the safeguarding and legal teams, and my mentor. The complexities of this case have represented a learning curve for all of us, which has oddly helped me feel more confident in my role and as part of a support team when I was feeling overwhelmed. **(137)**

A few weeks after the first report,11 telephoned police late evening to report that 22 had pushed her down the stairs. On their arrival at the property, 22 reported that "she has dementia, she's crazy, you can't believe a word she says". 11 was lying at the top of the stairs on the landing; no phone was on her person or nearby. She was later found to have a fractured hip. Attending officers tried to get her to stand, then called an ambulance when she was unable to. They asked 11 how she had called them and got back up the stairs if 22 had pushed her down, as she had reported. She told them that 22 was behind her on the stairs and pushed her. She fell up the stairs and onto the landing. She repeated this many

times in subsequent weeks and months but because 11 had 'changed her story' no charges were pressed. Our safeguarding team escalated the matter and senior managers raised an official complaint. In response, a note was placed on the couple's record that attending officers to the property must ensure that 11 was supported by an independent person to share her account of events. This had limited effect. **(205)**

11 underwent an arthroplasty in hospital. 22 telephoned daily, sending her chocolates. He also contacted me regularly, saying he was so lonely without her, and insisting that I arrange her discharge as soon as possible, which remained medically contraindicated. Against medical advice, he brought her home. By the evening, he was telephoning her PAs and out of hours services in crisis. Increased support hours were hastily agreed and put in place. However, this action permanently reduced 11's mobility and curtailed her options to leave the home. **(86)**

During discussions the MDT became increasingly concerned about strong indicators of domestic abuse within the relationship, in particular coercive control. The Duluth Power & Control Wheel (A Theoretical model of domestic abuse) (2017 example used) lists indicators of abuse as:

- Intimidation
- Emotional abuse
- Isolation
- Male privilege
- Coercion
- Economic abuse
- Minimising, belittling

The term coercive control was coined by Susan Schechter (1982) and expanded on by Evan Stark (2007) to explore domestic abuse centering around the control of women by men, primarily, although others have argued that methods employed may also be by women against men or other women. It shares signs with the Duluth Wheel above, but adds

indications like close monitoring of activities (for instance controlling where you go or who you speak to); denying freedom (e.g. what you can watch on T.V., doing the things you love); 'gas lighting', (a term that comes from a 1944 film 'Gaslight' in which Ingrid Bergman's character's husband tries to drive her insane by denying her lived experiences) designed to make the victim doubt themselves; constant criticism; living by their rules (what is eaten, how the home is run, to suit the abuser); Jealous accusations. The MDT noted almost all of these indicators in 22's treatment of 11, and understood that her dementia and reducing abilities served to exacerbate the abuse, as she relied on him more and more to support her in all areas of her life. We also noted attempts by 22 to gaslight professionals, for instance stating certain things as fact when he knew we knew otherwise. **(258)**

I shared details of s76 of the Serious Crime Act 2015 in UK law, around controlling or coercive behaviour, with the MDT and explored this at safeguarding strategy meetings. April 2016 DoH guidance in relation to s7 of SSWB(W)A (2014) states:

"This means that a local authority's duty to make (or ask others to make) safeguarding enquires and determine what action is needed to protect "an adult at risk" are triggered by "reasonable cause to suspect" that an adult with health and social care needs is experiencing coercive control (where their needs prevent them from protecting themselves)."

We believed that we had recorded enough evidence of 22's coercive behaviour to use this legislation to safeguard 11 more effectively. Again we came up against her dementia as a cause of resistance from the police, as they knew that the CPS would not take the matter to court due to 11's supposed 'unreliability' as a witness, even if professionals had also witnessed those behaviours. We felt this to be discriminatory against anyone with a mental health issue and were increasingly frustrated by the lack of options available to us, as the primary responsible agency, to actively safeguard such an individual without further limiting their freedoms by monitoring them 24/7 or removing them from their home entirely, in effect punishing the victim. **(219)**

I had been exploring other options for 11 as she was adamant that she did not want to leave her home (“I paid for it, why should I?!”) and particularly to go into a residential care home. That was “a threat [22] uses all the time”, which she found extremely upsetting. I had begun by researching women’s refuges in case of emergency, but found that the few that were still running post-pandemic were aimed primarily at younger women with children. They would be unsuitable for 11 as there would be no form of care available. **(95)**

I attended an online workshop by Dewis Choice, a Welsh initiative, about a recent piece of research by Sarah Wydall, undertaken in partnership with Aberystwyth University, ‘Dementia, Domestic Violence and Abuse’, and further work aimed at ‘transforming the response to domestic abuse across the UK’, drawing on Dewis Choice research into DV and older people. I contacted Dewis Choice, asking if there had been any practical applications of this conclusion and had a long discussion with a senior manager of a Welsh helpline, outlining issues that we had found with this safeguarding case and the apparent lack of resources for older people in general, and people with dementia in particular. She was unaware of some of what I told her and later shared our experiences with the Wales Older People’s Commissioner. I am not aware of any practicable outcome, however. **(140)**

After escalating issues and two separate police attendances within 3 weeks, 11 agreed to go to a place of safety, a residential care home some 30 miles away. It was not ideal. She did not have access to her support network or social opportunities there. Public transport services between her village and the home was poor. 11’s cognitive function declines with change quite markedly and her first night there was traumatic for her, and challenging for staff.

Whilst there, staff reported repeated, verbally aggressive phone calls from 22. He did not accept 11’s wish for no contact. 11 agreed to speak to him on the 3rd evening. The staff member listening in cut the call short, describing the content of the call to be “extremely emotionally and psychologically manipulative” on 22’s part, greatly upsetting 11. After the call, overnight 11 was crying, shouting and smearing faeces. The manager contacted the

Community Mental Health Team the next morning, 11 was assessed and removed under s5 Mental Health Act 2005 to hospital. She was diagnosed with “a raging UTI” the following day. Within two days, despite this, the ward manager was pressing for discharge. It was inappropriate for 11 to return home in that condition and the care home would not take her back. I advised the ward manager of the safeguarding concerns and that records could be accessed by many of their staff, including strategy meeting minutes. 11 saw the ward psychiatrist and he decided to wait until the UTI was resolved and then treat her. **(255)**

Three weeks later, after spending two hours with her discussing her overall situation, I assessed 11 as having capacity to decide to return home with support. Her CPN concurred. A psychiatrist (who had not met her before) disagreed; she remained on the ward under s2 MHA for three further weeks despite our objections. My manager contacted the local Regional Safeguarding Board, one of six across Wales, for advice. No Deprivation of Liberty Safeguard was sought at the change of status between s5 to s2. I raised this with our safeguarding unit and escalated this for challenge by the council's legal department, given that 11 was then being held illegally. DoLS is an amendment to the Mental Capacity Act (2005) applicable to care homes and hospital settings in England and Wales only. 11 was in a Welsh hospital. Article 5 of the Human Rights Act (1998) states that 'everyone has the right to liberty and security of person. No one shall be deprived of his or her liberty [unless] in accordance with a procedure prescribed in law'. This article is based on Article 5 of the European Convention on Human Rights (1950). **(191)**

During the three-week delay in 11's discharge from hospital several multi-disciplinary meetings took place, some of which were attended by a representative from the Regional Safeguarding Board due to the issues and complexity. We hoped that their remit of improvement and quality assurance under P7 SSWB(W)A 2014 would promote improved cooperation from partner agencies also under their aegis. I undertook another mental capacity assessment and again found 11 to have capacity around a decision to return home. The sticking point with the ward was the nature of the safeguarding concerns. While the MDT agreed that 11 was at serious risk from 22 while remaining in the home with him, we also recognised her long-held capacious conviction to remain there, which she continued to

hold. At a final meeting, in a room full of medical staff, accompanied thankfully by my manager, the head psychiatrist expressed concern about 'it coming back on [them] if something bad happens if she goes back to him'. This led me to suspect that the insistence on 11's 'lack of capacity' was less about capacity and possibly more about risk aversion and self-protection. It was a daunting experience to sit in a hostile environment, faced with almost universal opposition, and advocate for the rights of an individual already extremely disempowered by a combination of factors. Ward staff opined that the only way 11 could go home was with 24/7 support, which 11 did not want and had refused multiple times. Following the broken hip incident, Social Services support was already at its upper limit, with many hours of extra care in place to give 22 more time to himself and 11 increased opportunities for enjoyable activities. This was part of a safety plan that aimed to reduce the stresses on 22 of a caring role and ensure that 11 could spend time away from him each day. Due to the rurality of the property and general crisis in care situation, we had been unable to source the length of evening calls we wanted to put in place. We anticipated continuing issues sourcing 24/7 supervision, which in any case appeared to be an inappropriate imposition on 11 (and 22). I had recorded my conversations with 11 in detail when assessing capacity and asked both psychiatrists to explain why they felt that this evidence did not meet their criteria for capacity. Both refused to read the documents I provided and continued to state that the risks were too high to allow 11 to go home. I asked for a capacity assessment by a mental health professional who knew her, preferably a female. This was refused. Eventually it was agreed that, while we all recognised the risks and had doubts about the wisdom of 11's decision (ref. principle 3 of MCA 2005), it was her legal right to return home with support. **(472)**

In one sense, this was a positive outcome. 11's capacious wishes were respected - eventually, and after a great deal of persuasion and quoting of legislation. In another, her community support team girded itself for further incidents and attempted to plan for contingencies. Despite 22's promises to seek support before escalation occurred, we were aware that he probably would not do so. He habitually went from relatively calm to uncontrolled very quickly and would not walk away instead of engaging. I used Motivational Interviewing (MI) extensively during a degree placement and continue to attend monthly

webinars with one of the creators Dr Steve Rollnick (Miller & Rollnick (2002), Emlyn-Jones, R & Bremble (2012)). After 11's first return home from hospital and the required crisis intervention this engendered, I had arranged with 22 to spend one afternoon a week with them, especially working with him around how he coped with the changes in his life. MI is based around Prochaska and di Clemente's 1993 Cycle of Change model and I thought it could be useful to go through the intensive, time-limited process that the Integrated Family Support Service uses. IFSS is an approach described in Children and Family (Wales) Measure (2010) and subsequently in SSWB(W)A (2014), working with families in Wales where safeguarding measures are in place, specifically around changes in behaviour that reduce risk. We scheduled our sessions for a specific afternoon each week but I found that 22 tended to cancel sessions, and those that occurred did not result in any change in attitude or behaviour. I used our lone working protocol for my own safety during the sessions that did take place, in addition to informing my manager of sessions, in case 22 became agitated by the focus on his behaviour, but he largely ignored the work whilst paying it lip service, and remained outwardly charming. While 11 was in hospital, 22 declined our meetings altogether, stating he was spending all his time at the hospital with her. The MDT felt that this indicated his need to control his environment to his liking, his attitude of entitlement and a level of misogyny that various professionals had identified. We did not anticipate that concerns around domestic abuse would reduce, despite increasing support and monitoring visits.

Withing weeks of returning home, 11 made a disclosure to her CPN, and to a PA, **55**. 11 reported that 22 shouted at her and was 'very nasty', held her lips closed and ejaculated on her despite her telling him not to touch her. 22 acknowledged to CPN that he had held 11's mouth closed and that he had continued to give her sedatives after they were discontinued by her psychiatrist. CPN submitted a report to the safeguarding unit which went to Multi Agency Risk Conference (MARAC) the next morning. Abuses listed were Physical, Sexual, Emotional/Psychological, Neglect. **(472)**

55 told 22 the details of the disclosure "because [11] has dementia" and no corroborating evidence was found by police when they attended the property after MARAC. Police

arrested 22, and officers visited 11 at home to take a statement. When the DAO and I arrived, having requested a joint visit with them, uniformed officers had already questioned 11 and she was quite distressed. She was offered the opportunity to leave the property and go to a place of safety, namely a local care home, which was the only suitable option available. 11 capaciously agreed as she stated that she was concerned about retribution from 22. He was released on bail later that day, conditional upon his having no contact with 11 for 28 days.

Shortly afterwards I visited 11 at the care home. Although she was upset and shaken, she told me that she felt safe for the first time in months. She wished to stay for a while so that she could have some time to consider her options.

Staff reported that they had already received calls from 22 demanding to speak to 11, although he was not supposed to know where she was. It was concluded that, because he knew about the allegation, he had set up some kind of recording device in the living room before police arrived. In the weeks that followed, 22 impersonated a GP and his own son to staff, trying to speak to 11, which he was repeatedly advised would break his bail conditions. He visited the home in person with chocolates but was refused admittance. He sent a card to her professing his love but containing manipulative statements and untruths, again breaking conditions, but not followed up by police. At the same time, he left verbally abusive, threatening voicemails on professionals' numbers, demanding the return of 11's mobility equipment claiming it belonged to him. He disposed of all of 11's belongings, despite advice to the contrary. He would not provide her with any of her own money from their joint account unless she agreed to talk to him. She had no independent access as he had removed this when she was first diagnosed. I raised a concern with the Office of the Public Guardian about 11's financial vulnerability given 22's behaviour and actions to date but it took several weeks for practical action to be taken. **(395)**

Joint bank accounts were frozen a few weeks later following banks' concerns of possible fraud by 22. At subsequent professional strategy meetings concern was shared about 22's behaviour since being bailed, however as 11 was now in a safe place the MDT felt that risks

were mitigated as long as she chose to stay away from him. No charges were brought against 22.

A few weeks after moving to the care home, 11 decided to stay there permanently and divorce 22. LPA has been rescinded. 11 has worked with one bank's Coercive Control team to open her own accounts and recoup some of her funds. She is supported by a Domestic Violence Advocate and has retained a solicitor. Following a further review, the safeguarding case will likely close. **(128)**

The learning curve in this case has been huge; the complexities have taxed even the most experienced amongst our safeguarding team. I feel like I was consulting the Wales Safeguarding Procedures (2019, SCW online) weekly on how to put p7 SSWB(W)A 2014 duties into practice effectively. I have undertaken research in DV amongst older people and with dementia in effort to understand presenting issues and identify potential solutions and support. I find myself both heartbroken and enraged by findings. NICE (2014) guidelines talk about the social model of disability removing barriers to promote the choices and quality of life of people with disabilities, whose disadvantages come less from impairment or differences and more from how societies are structured. The case has highlighted to me the barriers created by intersectionality, how two or more types of discrimination interconnect. Thiara says in his 2016 study, "It is about how, racism, sexism, class, ableism etc. create layers of inequalities, vulnerabilities and disadvantages". In 11's case, barriers to effective support have included being female, being elderly, having a mental health issue (dementia) with fluctuating capacity, and physical disability. Services themselves have created inequalities: police favouring 22's narrative over 11's due to dementia (and possibly misogyny), refuge support being refused on the basis of age and disability, staff on a mental health hospital ward making paternalistic (and unlawful) decisions, even our own lack of timely decisive action at times due to the complexities of the situation. Thiara's study reported that in 2015-16, 15.7% of disabled women experienced domestic violence. That figure is undoubtedly higher for the lockdown periods of 2020-2021 when supporting agencies were less able than usual to intervene. **(274)**

Within the remit of social support, there were institutional barriers of insufficient resources to meet assessed need, delays caused by procedures, ineffective communication between agencies, limited access to assistive technology appropriate for someone with memory issues; even the allocation of the case to a Social Worker inexperienced in safeguarding work possibly caused delays while advice and information was sought. Two of the MDT had personal experience of DV and coercive control; there was discussion around whether this was useful in identifying red flags quickly or detrimental to 22's support due to confirmation bias, or both. I found it difficult to work with him at times, difficult to adhere to Codes of Professional Practice (SCW) around respect and the promotion of his rights when 11's were being eroded by him, and when he was blatantly disrespectful towards women in general. I found his gaslighting attempts particularly vile and had to remove myself from him on one occasion, until I regained my equilibrium enough to engage further with him. The MDT did a lot of peer reflecting during this case; none of us felt confident that we or our respective services could offer a level of support that would meaningfully mitigate the loss both 11 and 22 were undergoing, in many different forms. We felt such frustration at times when our efforts did not have the positive effects we hoped for, when services failed them, when we ourselves were less effective than we would have wished. **(244)**

11 is now safer and happier, her support has resulted in a reasonably positive resolution of living with DV. Because the care home is close to her former home she has been able to retain much of her local support network and in some cases re-engage with friends she had lost touch with due to 22's control over who she could speak to in person and on the telephone. 22 is less happy. He has told others of his loneliness, reduced circumstances, stress-induced illness. I am mindful that I was unable to support him with my skill set and experience to make the changes that could have engendered a very different outcome for them both. I am saddened by this, although I know that these were decisions and changes he had to choose for himself. I am a different person and a different practitioner from the one I was a year ago because of this case, these experiences, these people. In terms of safeguarding experience, this has been a baptism of fire, but it has taught me so much and improved my practice markedly. **(184)**

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