



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

**LEARNER PORTFOLIO
(PORTH AGORED and UNIVERSITY OF WALES
TRINITY SAINT DAVID)**

Learner's name: Karen Lander

Email address: karen.lander@swansea.gov.uk

Learner's University Registration Number: 2320475

Cohort: 21 onwards

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).

The purpose of this case study is to demonstrate how the case relates to safeguarding legislation, policies, strategies, and procedures. It will also critically reflect on my role as a social worker, including my actions and the resolution of the case.

As the Care Quality Commission (2015) states, "Safeguarding means protecting people's health, well-being, and human rights, and enabling them to live free from harm, abuse, and neglect."

This case study examines a safeguarding assessment initiated for an elderly man, referred to as 1, following a referral from the hospital ward due to concerns of possible domestic abuse at home by his wife (2) and daughter-in-law (3). The safeguarding issue involve an adult and his adult family members. Safeguarding refers to the actions taken to protect vulnerable individuals from abuse, neglect, and harm, ensuring their health, well-being, and human rights are upheld.

The referral was made in accordance with the Social Services and Well-being (Wales) Act 2014 (SSWBA), which requires intervention when there is a reasonable suspicion that an adult is at risk of harm (Welsh Government, 2014). The Wales Safeguarding Procedures (2019) are operational guidelines that support the implementation of the SSWBA. These procedures provide a clear framework for professionals managing safeguarding concerns. The procedures stipulate that multi-agency collaboration is essential for ensuring an individual's safety. Similarly, the SSWBA, places a statutory duty on professionals to safeguard the well-being of adults at risk of abuse or neglect (Welsh Government, 2014).

The Act also requires that Local Authorities work collaboratively with other agencies, such as specific safeguarding teams, healthcare and housing, to provide support. Taking direction from the SSWBA, I arranged a consultation with the Local Authority Safeguarding Adults Team to ensure that 1's situation was thoroughly assessed. This included determining whether alternative accommodation was needed due to the risk of harm upon returning to the family home.

Following the consultation, the local safeguarding team and I coordinated with health professionals and other relevant services to address 1's needs and protect him from further harm. The procedures also advise on how to involve third-party support services, such as domestic abuse agencies, which were offered to him. Referring back to the GDPR, I ensured only relevant information was shared among professionals to balancing privacy with protection from harm. (European Union, 2016).

1 had been referred to social services after a conversation with a nurse during his hospital stay. 1 was been admitted to hospital with ulcerated and infected legs, initially appearing to be a result of self-neglect. However, 1 disclosed that 2 and 3 had prevented him from performing self-care. He revealed that 2 had told him not to return home and that both 2 and 3 regularly mocked and ridiculed him. They also restricted or timed his access to the bathroom, making self-care difficult. 1 disclosed a history of verbal, physical, and financial abuse from 2 and 3, which had significantly impacted his well-being.

1 also explained that the family had relocated from England and that he felt 'forced' to move with them to Wales when his home was sold. Despite these disclosures, 1 remained adamant about returning home, demonstrating confusion about what he had done 'wrong.' This pattern is common in domestic abuse cases, where victims often feel emotionally attached to their abusers and may not fully acknowledge the extent of the abuse they have suffered.

Stark (2007) explains that in cases of domestic abuse, *"it is common for victims to deny or minimize the extent of abuse due to emotional attachment, fear, or feelings of entrapment."* This was reflected in 1's account, as he consistently downplayed the severity of the abuse and expressed a desire to return to his home environment, despite the risks involved. Safeguarding concerns escalated when it was revealed that 1 did not have a bedroom in the home and had been forced to sleep on a chair in the kitchen, contradictory to previous medical advice to keep his legs elevated and rested. Furthermore, 1 and his family, all of whom were members of a specific religious community, hadn't reached out to their local Kingdon Hall community and so 1's lack of connection with local religious groups left 1 isolated, further contributing to his vulnerability.

When I engaged with 1, he initially appeared in denial about the abuse and did not recognize his situation as harmful. I explained that his treatment constituted abuse and infringed on his human rights, as outlined in relevant safeguarding legislation. Initially, he expressed a willingness to explore alternative accommodation and consider third-party support from domestic abuse services. However, during a follow-up visit, he reiterated his desire to return home, hoping to repair the relationship with 2 and refused to acknowledge that abuse was taking place.

SSWBA also emphasizes empowering individuals to make informed decisions about their care, with a focus on preventing harm and offering support to those at risk. Although 1 was initially reluctant to acknowledge the abuse, the safeguarding team's duty was to inform him of his rights and the protection available under this legislation. 1's legal rights were explained, and the risks of returning home were assessed in the context of the ongoing abuse.

In England, safeguarding is primarily governed by the Care Act 2014, which shares many similarities with the Welsh legislation. Both the Care Act and the Social Services and Well-being (Wales) Act 2014 impose a statutory duty on Local Authorities to intervene when an adult is at risk of abuse (UK Government, 2014). In both countries, safeguarding is driven by the principle of multi-agency working, ensuring that social services, healthcare, housing, and other relevant agencies collaborate to protect vulnerable adults.

However, a key difference lies in the structure of service delivery. In Wales, the SWBA integrates health and social care more comprehensively than in England, where these sectors remain more divided. If this case had occurred in England, the safeguarding response would have followed similar principles under the Care Act, but the referral might have been handled differently, with a greater focus on Local Authority intervention rather than integrated health and social care systems. The local safeguarding team in England would have assessed 1's risk and potentially involved other local services, much like in Wales.

While the UK is no longer part of the European Union, EU Member States maintain safeguarding systems influenced by human rights legislation, particularly the European Convention on Human Rights (Council of Europe, 1950). The UK has adopted this under Human Rights Act (1998). Article 3 of the Act prohibits inhumane or degrading treatment, forming the legal basis for safeguarding practices across the UK and EU. Had this case occurred in an EU country, the protection of 1 would likely have been framed around the concept of safeguarding as a human right.

In the EU, the EU Charter of Fundamental Rights provides additional legal safeguards, emphasizing the importance of protecting vulnerable individuals from abuse (European Union, 2000). While individual EU Member States may have varying safeguarding policies, like the UK, the overarching human rights principles ensure that individuals like 1 would have access to protection and support services. However, compared to the Social Services and Well-being (Wales) Act 2014, many EU countries' legislation is less specific in detailing the processes for multi-agency collaboration and statutory referrals. In Wales, safeguarding is highly procedural, with clear steps laid out for professionals to follow when an adult discloses abuse, as seen in the Wales Safeguarding Procedures (2019).

Across both the UK and EU, GDPR plays a crucial role in safeguarding by governing how much personal information is shared between agencies (European Union, 2016). In Wales, GDPR compliance ensures that any information shared about 1 between the hospital, Local Authority, and safeguarding team must be done with his privacy in mind and only relevant information to that agency must be shared. However, GDPR also allows for exceptions in safeguarding cases, where the individual's safety is prioritized over confidentiality concerns.

In this case, the safeguarding team followed GDPR guidelines to ensure that information about 1's situation was only shared, when necessary, particularly when 3 was calling the hospital for medical information on 1. Similarly, had this case occurred in the European Union, GDPR would still allow for exceptions where safeguarding concerns arise, as it includes provisions for protecting individuals from harm while balancing data protection.

During the course of my involvement with 1, I made multiple visits to the hospital ward to carry out a comprehensive assessment of his situation. Throughout these visits, it became clear that he had the mental capacity to make his own decisions. According to the Mental Capacity Act 2005, (MCA) adults are presumed to have capacity to make decisions unless proven otherwise (UK Government, 2005). My assessment found no indication that he lacked this capacity. However, there were multiple references from health staff who stated otherwise. MCA also acknowledges that individuals have the right to make decisions that others may consider unwise, as long as they understand the consequences and risks associated with those decisions.

This aspect of the MCA presented an ethical dilemma in the case of 1. Although he was aware of the risks involved in returning home, including the ongoing abuse from 2 and 3, he was within his legal rights to choose to return to the home. As a social worker, I had to balance his autonomy and rights with the need to protect him from harm. Risk versus autonomy is a central ethical dilemma in social work. Banks (2012) notes that social workers often grapple with the tension between respecting a person's autonomy and the professional duty to prevent harm. This requires navigating the delicate balance between ensuring an individual's rights are upheld and mitigating the risks to their well-being.

From a theoretical perspective, person-centred theory informed my approach to this case. This theory emphasizes the importance of respecting an individual's autonomy and empowering them to make decisions about their own lives (Rogers, 1951). It focuses on the client's perspective and their right to be in control of their decisions, which aligns with the ethical principles of social work. In this case, my role was to ensure that 1 fully understood the risks associated with returning home and that he had access to all available support options, including domestic abuse services.

Additionally, systems theory played a role in shaping my understanding of the complexity of his situation. Systems theory views individuals as being part of broader systems—such as family, social networks, and communities—that influence their behaviour and choices (Bronfenbrenner, 1979). In this case, 1 was part of a complex family dynamic, with multiple individuals influencing his decisions and well-being. The relationship with 2 and 3, and the isolation caused by his relocation and lack of connection with local religious or community groups, were significant factors in his desire to return home despite the abuse. Systems theory helped me recognize that addressing the risks to his safety involved not only looking at his immediate circumstances but also understanding the family structure and the emotional ties that made him feel compelled to return.

One of the key challenges in this case was ensuring that all risks were being considered, despite his reluctance to acknowledge the severity of the abuse. Although he was aware of the risks, he appeared to trivialise the potential harm, which is not uncommon in cases of domestic abuse. Stark (2007) explains that victims of domestic abuse often struggle to

recognize the extent of the harm they are experiencing, either due to emotional attachment or a belief that the situation can improve. This posed a challenge in terms of balancing respect for his decision-making capacity with the need to safeguard his well-being.

As part of the assessment, I also visited his home to engage with 2 and 3 directly. During this visit, I explained the situation to them, including the severity of their actions on him, and discussed the relevant legislation that applied to their treatment of him, such as the Human Rights Act 1998 and SSWBA. I made it clear that he had the legal right to return to his home and that their actions were potentially infringing on his human rights. In line with the Codes of Professional Practice, I was open and transparent, ensuring that both 2 and 3 understood the severity of the situation. I urged them to consider the impact of their decisions and actions moving forward, particularly in relation to his right to return home in a safe and supportive environment.

Furthermore, I outlined that he would require his own bedroom and that this arrangement would need to be made before he could return home. I also informed them that carers would be involved as part of the discharge process, and the carers would provide ongoing support to meet his needs, offloading some of the responsibility of 1's care from them, but they would have a duty to report any concerns they have about the home environment. The involvement of professional carers was aimed at not only assisting with his self-care needs but also as a deterrent for the family's treatment of 1, to provide an additional safeguard against further abuse.

Reflecting on this stage of the assessment, it was clear that the MCA played a pivotal role in guiding my decisions and I was able to refer professionals who questioned 1's decisions to the MCA. While it was difficult to accept that 1 was making a choice that could potentially lead to further harm, it was imperative to respect his autonomy. This experience highlighted the ethical complexities of working with individuals who are at risk of abuse but are capable of making decisions that may place them in danger. Banks (2012) notes that social workers must balance individual autonomy with safeguarding responsibilities, often requiring difficult professional judgment calls in cases where the individual's choices may lead to harm.

During this case, effective multi-agency working played an important part in ensuring 1's safety and well-being. Collaboration was key throughout the process, involving various professionals from different agencies. I worked closely with the Adult Safeguarding Team, sharing information and insights to ensure that all risks were identified and managed, including private details disclosed by 1. The team guided the whole safeguarding process, particularly in advice on assessing his capacity and understanding his decision to return home. Stevenson (2016) highlights that effective safeguarding relies heavily on multi-agency collaboration, as different professionals can provide a more comprehensive view of the risks and protective factors involved in safeguarding vulnerable adults.

In addition to the safeguarding team, I maintained open communication with the nurses on the ward, ensuring that all relevant information about his health, mental state, and decisions were passed between us. Laming (2003) emphasizes that communication and information sharing are critical components of safeguarding practice, as they enable professionals to intervene early and avoid harm.

A considerable part of the discharge process was working with the occupational therapists and physiotherapists to assess 1s physical needs. Once he made the decision to return home, we had to arrange for a home visit to assess the property and identify any necessary equipment or modifications that would need to be in place before he could be safely discharged. This collaboration ensured that his return to his home was supported with appropriate adaptations to minimize risks, promote independence and prevent 2 and 3 using a lack of equipment as a reason for any harm to 1. Carpenter et al. (2012) highlights the value of multidisciplinary teams in safeguarding adults, as such teams enable the integration of health and social care assessments to ensure all needs are met.

In addition to the health and social care teams, I also engaged with external support services, including a representative from a male victim domestic abuse charity. This agency provided vital resources and advice on how he could be supported in the community as a male victim of abuse. Additionally, I sought guidance from my peers and supervisor, who helped me identify other potential services in the area that could provide ongoing support once he returned home.

Given that 1 and his family were Jehovah's Witnesses, I made inquiries with the local Jehovah's Witness group to see if they could offer community-based support to help him feel less isolated. Thoburn (2010) argues that understanding and incorporating the cultural and religious context of individuals in social work practice is essential for ensuring that interventions are respectful, appropriate, and effective.

My professional judgment in this case was based on positive risk taking - respecting 1s wishes to return home, despite the risks identified. Central to my decision was ensuring that 2 and 3 understood the implications of his returning home and the changes that would need to be made to create a safe environment. They were also both offered support under the SSWBA Section 24, meeting the needs of carers. I had multiple discussions with them, emphasizing the need for 1 to have his own bedroom and personal space, which would reduce the risk of further harm. This included a detailed conversation about the involvement of carers and the long-term complex team, who would be managing his care moving forward. I facilitated a home visit with the manager of the long-term complex team, and we jointly discussed with 2 and 3 what their role would be and what the care would look like.

One of the challenges I faced during this collaborative process was resistance from the hospital staff, who felt that he should not return home due to the potential risks posed by 2 and 3. Some staff members believed that he should be supported to retrieve his finances from joint bank accounts and suggested that 2 and 3 be removed from the home. They expressed concern that his decision was unsafe and did not agree with my support of his right to return home. While their concerns were valid, I had to advocate for 1s right to make his own decisions. To address these concerns, I had multiple discussions with hospital staff and provided evidence from my MCA assessments, demonstrating that he had the capacity to make informed decisions, even if these decisions were not what the staff deemed best or were seen as 'unwise' (MCA, 2005)

which was supported by the outcome of the capacity assessments I had conducted. This experience reinforced the importance of multi-agency collaboration, but also highlighted the

complexities that arise when professionals from different disciplines have contrasting views on the best course of action. Laming (2003) suggests that disagreements in multi-agency working are common, but communication and clear assessments are essential to ensure that decisions are grounded in safeguarding principles and respect for the individual's rights.

SSWBA emphasizes a person-centred approach and multi-agency collaboration, which were integral to managing his case. This Act requires professionals to engage in early intervention and to work together to ensure the well-being of vulnerable adults. The focus on empowering individuals to make their own decisions, while still ensuring their safety, aligns with his situation, where his desire to return home had to be balanced with safeguarding concerns.

A significant aspect of working in Wales is the emphasis on preventative services, which are designed to promote independence and well-being, avoiding unnecessary interventions. This principle was central to my approach, as I worked with various professionals to ensure that he had the necessary support to return home safely, while also respecting his autonomy.

In contrast, safeguarding practices in other parts of the UK, such as England, are governed by the Care Act 2014. While the Care Act also prioritizes safeguarding and multi-agency collaboration, SSWBA places a greater emphasis on well-being and preventative care, which shaped my approach in this case. Additionally, the legislative framework in Wales integrates health and social care services more comprehensively, which was evident in the ease with which I was able to collaborate with health professionals, occupational therapists, and physiotherapists.

The inclusion of cultural and community support is also an important dimension of social work in Wales. By engaging with the local Jehovah's Witness group, I was able to provide culturally sensitive support, which may not be as commonly integrated into practice in other regions. This approach acknowledges the Welsh Government's focus on community-based interventions, particularly in cases where religious or cultural identities are important to the individual's sense of well-being.

While collaboration was largely effective, there were challenges, particularly in resolving the differing opinions of the various professionals involved. The hospital staff were resistant to 1s decision to return home and expressed concerns about the potential risks. Their focus was on removing 2 and 3 from the home, rather than supporting his autonomy. This difference in opinion created tension, as I had to advocate for his right to make decisions about his own life, while also ensuring that all relevant professionals understood the reasoning behind my support for his decision. This highlights the ongoing challenge in multi-agency work where professionals from different fields may have different perspectives on risk and autonomy.

Upon reflection, I recognize that balancing 1s right to self-determination with the duty to safeguard him from potential harm was a significant challenge. The Mental Capacity Act 2005 emphasizes that individuals have the right to make unwise decisions and 1 was determined to return home despite the clear risks posed by 2 and 3, and while I respected his autonomy, this created an ethical dilemma regarding how far I should intervene to

ensure his safety. Banks (2012) argues that social workers must often navigate conflicting duties, where the principle of respecting autonomy may clash with the duty to protect individuals from harm.

Looking back, this case taught me a great deal about the importance of reflection and supervision in managing complex situations. Discussing the case with my supervisor helped me process the ethical dilemmas I faced, and it provided me with different perspectives on how to manage the risks while still respecting his autonomy. Schön (1983) emphasizes the importance of reflective practice, particularly in situations where there are no clear solutions, and this case exemplified that. Reflecting on my practice, I could have taken a firmer stand towards the pressures from health professionals regarding how quickly to discharge 1. I could have used this time to research additional support options and spend more time with him, offering him and signposting him to various other areas of support.

Furthermore, this case highlighted the importance of understanding the cultural and religious context of the individuals I work with. 1s religious background as a Jehovah's Witness played a significant role in his sense of isolation and decision-making. This is something I didn't think was of importance in the beginning, until I spoke with 1 and he explained that his whole life had been supported by his Jehovah's Witness 'family'. By engaging with the local Jehovah's Witness community, I was able to offer culturally sensitive support that helped him feel more connected and supported. This experience reaffirmed the value of acknowledging and integrating cultural considerations into practice. Thoburn (2010) argues that cultural and religious factors are often under-recognized but are crucial to effective social work interventions.

Ultimately, this case reinforced my understanding of the complexity of safeguarding decisions, particularly when balancing risk with respect for autonomy. It also underscored the importance of working collaboratively with other agencies and professionals, even when there is a difference of opinion on what's best. Moving forward, I will carry these lessons into my future practice, particularly the importance of reflective supervision, multi-agency collaboration, and the need for a culturally sensitive approach to social work. I have also gained a deeper appreciation for the legal and ethical frameworks that guide safeguarding decisions, particularly in cases involving vulnerable adults.

Throughout the case, the application of key social work theories such as person-centred theory, systems theory, and strengths-based theory played an essential role in guiding my practice. By prioritizing his autonomy, I was able to respect his right to self-determination while also ensuring that appropriate safeguarding measures were in place.

The effectiveness of multi-agency working was central to the case's outcomes. Collaborative efforts between the Adult Safeguarding Team, healthcare professionals, and external support services ensured that all aspects of 1s needs were considered. Although there were challenges, such as differing opinions among professionals regarding the safety of returning home, clear communication and the use of structured assessments and supporting legislation, helped facilitate informed decision-making. This case stresses the importance of multi-agency collaboration in safeguarding, as highlighted by Laming (2003), who highlights the importance for clear communication in achieving the best outcomes for service users.

SSWBA, rightly so, was at the centre of the case throughout. Its emphasis on a person-centred approach and empowering individuals to make their own decisions, while still providing the necessary support, aligned well with the actions taken. This legislative framework enabled me to respect 1s wishes to return home, even when concerns arose from others around him. Additionally, the Act's focus on preventative services was reflected in the efforts to engage him with external domestic abuse services and community-based support, which lead to positive outcomes such as contact with the local Jehovah's Witness group, ensuring that he had access to a broader support network beyond the immediate family.

Reflecting on the case, it is clear that safeguarding measures were effective in mitigating the risks associated with 1s return home. The involvement of carers and long-term support teams provided an additional layer of protection, and continuous monitoring with 1s consent, allowed for positive future plan to keep 1 safe for further abuse. However, this case also highlighted the ethical dilemmas inherent in safeguarding practice, particularly when there is tension between a person's right to autonomy and concerns for their well-being.

In conclusion, this case provided valuable insights into the application of social work theories in practice, the importance of multi-agency collaboration, and the need for a strong legislative framework to guide safeguarding decisions. Moving forward, cases like this reinforce the importance of reflective practice, as well as the need to remain flexible and open to new approaches when balancing autonomy with safeguarding. Ensuring that individuals are supported not only by formal services but also through, knowledge, understanding and community and cultural connections is crucial to providing holistic care.

Word Count 4357