



**GRADUATE CERTIFICATE in Consolidation
of Social Work Practice
LEVEL 6 - 60 Credits
BMPPF6044**

**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 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).

I will be using Jasper's Model of Reflection (Jasper, M 2003), as it will support me on focusing on, what happened, my own feelings, what factors influenced the situation and will support me on looking at my own experience, of safeguarding and the processes which fall within this area. It will support me on my reflection on what I have learned how laws and legislation support the safeguarding procedures, and further learning on my own development. It will also support me in meeting the learning objectives of collaborative working and professional judgement in complex situations when it comes to safeguarding. The safeguarding concern involved a couple I will refer to as service user 3 (3) and carer 4 (4), in line with Section 2 of the Code of Professional Practice for Social Care (Wales) 2017, (COPP,2017) which requires confidentiality and the protection of identity.

For context, 3 is an older adult living with COPD and dementia, both of which significantly reduce her ability to manage daily living tasks. She is highly dependent on her husband, 4, for support, and the couple have been known to social services for some time. Despite this, they have consistently declined formal care services, preferring to maintain their own routines. Their reluctance may reflect not only personal preference but also deeply held cultural beliefs and generational values, particularly around privacy, self-reliance, and a strong sense of marital duty. Within the Welsh social care context, it is essential to recognise how these cultural values influence engagement with support. The Code of Professional Practice for Social Care (Wales) requires practitioners to respect the individual's culture, identity, and beliefs, while ensuring these do not prevent the person from receiving the care and protection they need. I feel I have upheld this expectation throughout my involvement with the couple. And with my understanding of these values, beliefs have been critical to me, for building trust,

and offering meaningful support (Thompson,2018). This way of working, also aligns with Welsh Government commitments to culturally sensitive practice, including the Active Offer, which ensures that individuals are offered services in Welsh without needing to ask, and the More Than Just Words framework, which emphasises the importance of language, culture, and identity in person-centred care. For 3, who is living with dementia, being supported in her preferred language is particularly important, as cognitive impairment can make it more difficult to process information in a non-first language. Understanding and respecting the couple's cultural values was therefore essential, but this must be balanced with professional responsibilities to promote wellbeing, safeguard adults at risk, and ensure that cultural beliefs do not unintentionally contribute to unmet care needs or increased vulnerability of 3.

At the same time, I also had to consider the wider context of practice, particularly the current pressures on care services. In Wales, limited resources, recruitment issues, and increased demand mean that formal care services often involve long waiting times (Carers Wales, 2022; Social Care Wales, 2025). Reflecting on this helped me understand that even if 3 and 4 agreed to services, delays could impact the immediacy of safeguarding measures. This made me more aware of the need for safety planning, proactive monitoring, and clear communication about limitations, as safeguarding does not occur in isolation from system pressures (Welsh Government, 2016; 2018).

4's role as an informal carer places significant emotional, physical, and psychological demands on him, particularly as 3's dementia and COPD have increased her dependency over time. Informal carers often experience high levels of stress, fatigue, and social isolation, especially when they feel solely responsible for meeting complex care needs. In 4's case, the couple's long-standing cultural values around privacy, independence, and family responsibility appear to reinforce his belief that caring should remain within the home, which prevent him from accepting external support even when he is struggling. This aligns with research showing that carers frequently minimise their own needs and delay seeking help until a point of crisis. (carers UK 2022). The repeated pattern of the daughter making referrals when 4 becomes overwhelmed suggests that his coping capacity fluctuates and that he may be experiencing carer strain. The Social Services and Well-being (Wales) Act 2014 (SSWB(W)A 2014) part 5 recognises carers as people with their own rights and entitlements, including the right to have their needs assessed under part 3 SSWB(W)A 2014. However, 4's reluctance to engage with services has meant that his needs have remain unmet, increasing the risk of burnout, relationship tension, and reduced ability to provide safe and sustainable care for 3. Understanding the pressures on 4 as an informal carer therefore needs to be considered and what has been disclosed by 3 and if they are a contributing factor of his behaviour. When caring responsibilities become overwhelming for 4, their daughter tends to make a referral at points of crisis which is a protective response which can be understood through attachment theory, which suggests that early relational patterns can influence how individuals respond to stress and vulnerability within family systems. (Bowlby, 1969) ; however, services are repeatedly declined once the immediate crisis has passed. This behaviour pattern aligns with crisis theory, which suggests that individuals often only engage with support when their usual coping mechanisms break down, leading to temporary disequilibrium (Caplan, 1964). Once the acute stress reduces, people may revert to long-standing cultural norms of self-reliance and family responsibility. Although 3 initially agreed to respite to allow 4 a break from his caring role, 4 later contacted services to say it was no longer required, stating that 3 had changed her mind. This withdrawal of support after the crisis passed reflects both crisis theory

and the couple's cultural values around independence and maintaining control within the family unit. As a result, respite remained on 3's care and support plan as a contingency measure to prevent future crises and reduce the risk of carer breakdown or relationship strain. This cycle also reflects the preventative focus of the Well-being of Future Generations (Wales) Act 2015, which emphasises early intervention, long-term thinking, and supporting individuals to maintain well-being before crises escalate. Applying this lens highlights the importance of developing sustainable, proactive support for both 3 and 4, rather than responding only at points of breakdown. Ensuring that services work collaboratively and preventatively is essential to reducing the likelihood of repeated crises and promoting their long-term safety and stability.

During a routine visit by another professional, concerns were raised regarding possible emotional and physical abuse within the relationship between 3 and 4, based on disclosures made by 3. The professional contacted me to discuss the information, as I had previous involvement with both individuals. Given the nature of the concerns, I advised that a Multi-Agency Referral Form (MARF) should be submitted in accordance with Part 7 of SSWB(W)A 2014, which places a statutory duty on relevant partners under section 128 Part 7, SSWB(W)A 2014 to report an adult at risk, and section 126 of the SSWB(W)A 2014 sets out the definition of an adult at risk and sets out the duties of the local authority to make enquires where there is reason to believe a person is at risk of abuse/neglect.

In my view, there should have been no uncertainty about the need to report, given the information disclosed. It appeared the professional sought reassurance that no previous safeguarding concerns had been raised during my earlier involvement. While I was aware of the long-standing dynamics of 3 and 4's relationship—including the length of their marriage, the gradual decline in 3's health, and the increased dependency this created—I did not allow this contextual familiarity to influence my professional judgement even though I had not seen any indicators of abuse, this did not mean it hadn't occurred. Research highlights that long-term caring relationships can reinforce dependency and power imbalances, which may act as barriers to recognising or reporting domestic abuse (Stark, 2007; Dutton & Painter, 1993). Although no prior safeguarding concerns had been recorded, the new information clearly met the threshold for action.

Under Part 7, Section 126 of the SSWB(W)A 2014, 3 met the definition of an "adult at risk" due to her care and support needs, which placed her at risk of abuse or neglect. In the Local Authority I work with when a MARF is placed to the safeguarding team, an allocated safeguarding office if assigned to make initial enquires into the report, by contacting other professionals, refer, and agency to gather the required information needed at this stage, as per part 7 of the Code of Practice and Statutory guidelines linked to SSWB(W)A 2014, states that enquires should be undertaken within 7 days of the referral being received by the team, and what action needs to be taken should be determined within this time frame. (Welsh Government 2016).

However, the disclosure made in relation to 3 did not meet threshold for Section 126 enquiries under the Wales Safeguarding Procedures 2019. The Adult Safeguarding Team undertook the enquiry in line with the Wales Safeguarding Procedures (Adult at Risk Process 1a). The outcome concluded that no abuse or neglect had occurred and that no further safeguarding action was required at that time. However, it was identified that 3 had significant care and support needs, and therefore a full assessment was required urgently due to her deterioration. It was also noted that any further safeguarding concerns should result in a new MARF being

submitted, in accordance with the Wales Safeguarding Procedures (2019). And this was triggered over to care management for further support and assessment.

Despite this, I did not fully agree with the outcome. A genuinely person-centred approach was not taken, as 3's views were neither sought nor meaningfully considered. This is inconsistent with the principles set out in the Code of Professional Practice for Social Care (Social Care Wales, 2017), which requires practitioners to actively involve individuals in decisions that affect their lives and ensure their voice, wishes, and feelings guide the direction of intervention. Reflecting on this, I strongly believe that 3's perspective should have been central to the enquiry, rather than the concerns being attributed solely to carer stress experienced by 4. In my professional judgement, 3 meets the criteria for an adult at risk under Part 7 of the Social Services and Well-being (Wales) Act 2014, as her significant care and support needs place her at risk of abuse or neglect if these needs are not adequately met (SSWB(W)A, 2014). This reflection highlighted for me the importance of ensuring individuals are not overshadowed by the needs or narratives of those around them, particularly when cognitive impairment or communication barriers increase their vulnerability.

This also engages wider rights frameworks: the UN Principles for Older Persons emphasise independence, participation, care, self-fulfilment, and dignity, reinforcing the need to centre 3's will and preferences and to avoid paternalism (UN, 1991). In domestic law, the MCA requires presuming capacity, supporting decision-making, accepting unwise decisions, and, where capacity is lacking, acting in the person's best interests in the least restrictive way (MCA, 2005). Alongside this, the HRA protects 3's rights to respect for private and family life (Article 8) and freedom from inhuman or degrading treatment (Article 3), which are directly relevant to both autonomy and protection (HRA, 1998). In practice, ethical dilemmas arise where autonomy honouring 3's wishes appear to conflict with protection/safeguarding addressing neglect risk, or where carers' views influence decisions that risk marginalising 3's voice. Balancing these frameworks requires transparent capacity assessments, proportionality, and careful justification of any restriction on rights—ensuring that rights-based, person-centred reasoning is evidenced throughout MCA, 2005; HRA, 1998; UN, 1991.

Throughout this case, supervision played a crucial role in supporting my professional judgement, emotional processing, and decision-making. Given the complexity of balancing 3's cognitive impairment, her fluctuating disclosure, possible coercive control, carer stress, and cultural values around privacy and independence, supervision provided a safe reflective space to explore my reasoning, challenge assumptions, and ensure that my actions remained lawful and proportionate (Hawkins & Shohet, 2012). Supervision also enabled emotional containment and resilience, helping me to process the moral ambiguity of working with couples where dependence, love and possible harm co-exist, and to maintain clear focus on 3's rights, safety and voice; this mirrors the reflective 4×4×4 approach in safeguarding, which emphasises critical reflection, support and learning to sustain safe practice (Morrison, 2005) and promoted strength based, person centred approaches when working with 3 and 4.

During my subsequent home visit with both 3 and 4 to discuss their current situation and what can be done to support both as I have a duty not only to 3 under section 3 SSWBAW 2014 but 4 as an informal carer, as he provides a substantial level of support to 3 on a daily, basis. Ruch, G (2005) suggests that rapport building in social work, is not just about communication, but is an important part, in forming meaningful, trusting relationships that enable effective assessment and intervention, which I felt I have managed to do with 3 and 4 owing to my previous involvement as I have always listen to what they wanted, in relation to not accepting

formal care and support even though I could see that this was needed, I respected their choice and beliefs in relation to wanting to continue as they are in their lives, and showed the co-dependency between 3 and 4, within their long-term marital relationship and this has reinforced patterns of dependency, power imbalance, and emotional enmeshment, particularly due to 3's chronic illness and cognitive decline. Research highlights that such dynamics can act as barriers to recognising or reporting abuse, as the dependent partner may normalise the behaviour or fear losing the relationship (Stark, 2007; Dutton & Painter, 1993). Owing to the rapport I had established, I felt that I was able to be open and honest with them on the current situation and the impact that declining services is having on them both and the risk of not accepting services by taking a holistic approach as this involves considering the whole person, including their physical health, mental wellbeing, relationships, environment, strengths, and risks, rather than focusing solely on the presenting issue. This approach aligns with the Social Services and Well-being (Wales) Act 2014, which requires practitioners to explore all aspects of an individual's wellbeing and the wider context of their life. Holistic assessment supports more accurate decision-making, enables person-centred practice, and ensures that safeguarding concerns are understood within the complexity of the individual's circumstances (Milner & O'Byrne, 2009; Trevithick, 2012).

Empowerment was a central consideration throughout this safeguarding intervention, particularly as the Social Services and Well-being (Wales) Act 2014 places a clear duty on practitioners to promote voice, choice, and control in all aspects of assessment and decision-making (Welsh Government, 2014). During my involvement with 3, it became evident that her ability to express her wishes and act independently was significantly reduced, partly due to the long-term dynamics of her relationship with 4 and the mannerisms she displayed, such as hesitancy, avoidance of eye contact, and seeking reassurance before responding. These behaviours suggested a lack of empowerment and potential coercive control, which are recognised risk factors in domestic abuse (Home Office, 2015; Kelly & Westmarland, 2016). The Wales Safeguarding Procedures (2019) emphasise the importance of supporting adults to participate fully in safeguarding decisions, and reflecting on this through Jasper's model helped me recognise how disempowerment can limit a person's capacity to disclose concerns or seek help. This experience reinforced the need to adopt a strengths-based, person-led approach that actively supports individuals to regain autonomy and participate meaningfully in decisions affecting their safety and wellbeing (Adams, 2008).

Once on her own 3's recollection of the disclosure she made to professionals appeared inconsistent at times, which is understandable given her diagnosis of dementia. Cognitive impairment can affect a person's ability to accurately remember events, sequence information, or distinguish between past experiences and present concerns. Case law such as *A Local Authority v JB* [2021] reinforces that capacity is decision-specific and that difficulties with memory, retention, and the ability to use or weigh information can significantly impact a person's ability to make decisions about their own safety, particularly in the context of dementia. Overall, this case law reinforces the principles in the Mental Capacity Act 2005, (MCA2005) by clarifying how memory difficulties, fluctuating cognition, and impaired reasoning should be considered when determining whether someone can make decisions about their own safety and wellbeing. While it is important to consider how dementia may impact her memory and the reliability of her account, it is equally important not to dismiss her disclosures as confusion or fabrication, particularly when they relate to fear, distress, or potential harm as per the Mental Capacity Act Code of Practice: (Department of Constitutional

affairs, 2007). The Wales Safeguarding Procedures (2019) emphasise that adults with cognitive impairment remain at heightened risk of abuse and that practitioners must take all disclosures seriously, even when memory difficulties are present. Therefore, 3's statements was re-submitted to Safeguarding, even though it the same concerns were closed by safeguarding, for care management intervention, I still had a duty to report what had been said and with 3 stating that she would be unable to call for help if needed highlighted further that she was an adult at risk under section 7 SSWB(W)A 2014 and that this needed further investigation by Safeguarding to look further into the concern in relation to potential emotional abuse, controlling behaviours and possible domestic abuse. From a social work side and to support in safeguarding 3, we discussed a lifeline alarm pendant which she would use if she felt she was in danger or needed support, she consented to this under section 15 of SSWB(W)A 2014 under technology enabled care provision, but more importantly support in safeguarding 3.

Given the nature of the disclosure, I also considered the Domestic Abuse Act 2021, which provides a statutory definition of domestic abuse, including coercive and controlling behaviour, emotional harm, and behaviour that causes fear or distress. These elements were potentially relevant to 3's situation, particularly as she had expressed fear of 4 and described behaviours that may indicate intimidation or control. As an older woman with dementia and significant care needs, 3 is at increased risk of harm, and her experiences must also be understood within the wider context of violence against women, which recognises that women are disproportionately affected by domestic abuse and may face additional barriers to seeking help. This aligns with the Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015, which places duties on professionals to prevent abuse, protect victims, and support those at risk.

However, though I consider the above, in relation to possible domestic abuse, I felt that the most appropriate and proportionate action at the time was to submit a Multi-Agency Referral Form (MARF) to safeguarding. This ensured that her disclosure was taken seriously, that her safety was prioritised, and that a multi-agency response could be coordinated to assess the risks and provide appropriate protection. Given her vulnerability, cognitive impairment, and the gendered nature of the concerns raised, escalating the matter through safeguarding was essential to ensure that 3 received the support and Throughout the process, I had to consider confidentiality in line with the Code of Professional Practice for Social Care (Wales) 2017, which requires practitioners to respect people's privacy and handle information responsibly. However, confidentiality can be overridden when safeguarding concerns arise. Under the Data Protection Act 2018 and UK GDPR, information may be shared without consent when an individual is at risk of harm and sharing is necessary to protect their vital interests.

Reflecting on my involvement with 3 and 4, I became increasingly aware of the ethical dilemmas that arise when trying to balance their rights under the Human Rights Act 1998 while also fulfilling safeguarding duties. Article 8 grants both individuals the right to respect for private and family life, which includes autonomy, choice, and the ability to make decisions about how they live. For 3 and 4, these rights are deeply tied to their cultural beliefs around privacy, independence, and maintaining their usual routines. However, as 3's needs increased, safeguarding concerns also grew, raising the possibility that her Article 8 rights might need to be limited in order to protect her from harm.

This is where the ethical tension emerged for me. On the one hand, supporting 3's autonomy by respecting her and 4's wish to decline services upholds Article 8. On the other hand, Article

8 is a qualified right, meaning it can be lawfully restricted if necessary for the protection of health, wellbeing, or the prevention of neglect. This created a dilemma: how to respect 3's autonomy while still ensuring her safety, particularly as dementia reduced her ability to communicate her wishes directly. I found myself questioning whether declining services was genuinely an expression of 3's will, or whether 4's preferences were unintentionally overshadowing her voice. Balancing the rights of both individuals—each with their own autonomy and identity—became a complex ethical challenge.

Article 3 introduces an additional layer of complexity. It protects individuals from inhuman or degrading treatment, including neglect arising from unmet care needs. Article 3 is an absolute right, which means it cannot be restricted under any circumstances. This heightens the ethical responsibility when safeguarding concerns suggest that a person may be at risk of harm if their care needs are not met. For 3, whose health conditions significantly limit her independence, the risk of unintentional neglect is real, especially as 4's caring role becomes more demanding. Ethically, I had to reflect on whether respecting their preference to manage independently could inadvertently allow a situation to develop that conflicts with Article 3.

These dilemmas made it clear that safeguarding decisions are not only legal processes but also involve navigating competing rights and values. Upholding 3's Article 8 rights without addressing the risk of Article 3 breaches could compromise her safety; yet acting too defensively risks paternalism and undermines her autonomy. At the same time, 4 also has Article 8 rights to family life and to continue providing care in the way he feels is best. Balancing these rights—ensuring neither person's autonomy overrides the other's wellbeing—required careful reflection, proportionality, and a focus on whether decisions were necessary, least restrictive, and in 3's best interests, in line with both the MCA 2005 and the SSWBA 2014.

Reflecting on this helped me recognise the need for transparent decision-making, sensitive discussion with the couple about risk, and ensuring that any intervention was proportionate and rights-based. It also highlighted the importance of exploring whether 3's true wishes were being captured, and ensuring her voice was not lost due to cultural norms, cognitive impairment, or the caregiver's understandable stress. Ultimately, these dilemmas reinforced the importance of ethical reasoning in safeguarding practice, where neither autonomy nor protection can be viewed in isolation, and both Human Rights Act duties must be balanced carefully and respectfully.

In conclusion, this safeguarding case involving 3 and 4 highlights the complexity of supporting older adults whose care needs, cultural values, and family dynamics intersect in ways that increase vulnerability. 3's dementia and COPD significantly impact her ability to manage daily living tasks, placing her in a position of high dependency on 4. Her disclosure of fear and distress could not be dismissed, even though her cognitive impairment affects the consistency of her account. The principles of the Mental Capacity Act 2005 emphasise that capacity is decision-specific and that individuals with dementia may still express valid concerns about their safety. This required a sensitive, person-centred approach that ensured 3's voice was heard and her rights upheld.

The case also highlighted the pressures faced by 4 as an informal carer. His fluctuating ability to cope, combined with the couple's long-standing cultural beliefs around privacy, independence, and marital duty, contributed to their repeated refusal of formal support. This pattern aligns with crisis theory, which suggests that people often seek help only when their usual coping strategies fail, leading to temporary disequilibrium. The daughter's repeated

crisis-driven referrals further demonstrated the fragility of the situation and the risk of carer strain if support was not sustained.

Working within the Welsh context required culturally sensitive practice. The Code of Professional Practice for Social Care (Wales), the Active Offer, and the More Than Just Words framework emphasise the importance of respecting language, culture, and identity. For 3, who is living with dementia, ensuring communication in her preferred language was essential to supporting understanding and reducing distress. Balancing cultural values with safeguarding responsibilities was therefore a key part of the intervention.

Given the nature of 3's disclosure, it was necessary to consider the Domestic Abuse Act 2021, which includes coercive control, emotional harm, and behaviour causing fear within its statutory definition. As an older woman with cognitive impairment, 3 faced additional barriers to seeking help, aligning her experience with the wider context of violence against women. The VAWDASV (Wales) Act 2015 reinforced the duty to protect her from potential harm.

Balancing confidentiality with the duty to safeguard required careful consideration of the Data Protection Act 2018, UK GDPR, and the Human Rights Act 1998. Submitting a MARF was a lawful, necessary, and proportionate step to ensure a coordinated multi-agency response. Ultimately, this case reinforced the importance of professional curiosity, culturally informed practice, and a rights-based approach to safeguarding adults at risk.

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