



**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: Jacquelyn Zoe Price

Email address: zoe.price@powys.gov.uk

**Learner's University Registration Number:
2127369**

Cohort: 18 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).

Child 3 is 17 years old and is on the Child Protection register under the categories of neglect and sexual harm. She had been living with her mum and two younger siblings, there were multiple concerns which largely centred on how mum's poor mental health impacted on her ability to care for the children and tend to their basic needs, the arguments mum and 3 have, the impact of this on 3s mental health and mum's inability to work with agencies to protect 3 from risk of exploitation. **(88)**

Things reached crisis point and mum was arrested and charged with child neglect. Bail conditions were put in place which meant mum could have no contact with anyone under the age of 18. 3s siblings went to live with their biological father and have remained there ever since. 3 also went to live with her own biological father, this was short lived and problematic because she had only reunited with him 3 months prior to mum's arrest (after a 15 year absence). As soon as bail conditions were dropped, 3 chose to return to live with mum.

Biological father lived hundreds of miles away and was not able to be an active part in 3s life and a few months later he was imprisoned for a number of years due to a drug-related crime. **(134)**

The mental health of mum and 3 was poor, mum repeatedly expressed her frustrations of 3 and repeatedly said she could not have her living with her because of the impact on her mental health. Things came to a climax when, over the space of a few days, both mum and 3 made attempts of suicide. When 3 was discharged from hospital she was given homelessness status under s73 of the Housing (Wales) Act 2014 and the Local Authority's Housing Team fulfilled their duty to her by allocating her a room in a Bed & Breakfast for a few days until a more suitable flat became available. **(107)**

Maslow (1943) argues that people have a hierarchy of needs (physiological, safety, love/belonging, esteem, self-actualization) and that the needs lower down in this hierarchy have to be met before a person can meet their needs further up. With this knowledge in mind I was aware that until 3 has the opportunity to have her physiological needs met (food, accommodation, clothing) and her safety needs met, she will struggle to reach her potential (self-actualization). I was instructed to undertake an assessment of 3s care and support needs, under s21 of the Social Services and Well-being (Wales) Act 2014 (SSWBA); the focus of this assessment was to consider 3s housing needs and options. In line with my employer's policy, this assessment was undertaken jointly with the Housing department. **(126)**

This type of joint assessment was a first for me and others in my team were inexperienced with it too. I made use of my agency's Policies and Procedures forum and followed the guidance set out. I also made contact with an experienced colleague in a different area of the service. Due to my length of service with the agency I work for I felt I was fortunate to have these additional connections and knew who else I could readily approach from other teams

for support. Talking to someone who had completed such an assessment helped my learning style and I was better able to put into practice what the policy laid out. **(113)**

When completing the assessment I was aware of case law judgement G v London Borough of Southwark 2009 UKHL 26. As part of the assessment I applied the five-point test outlined within the Southwark Judgement: -

1. Are they a child?
2. Are they a child in need?
3. Do they normally live in the local authority?
4. Do they require accommodation as a result of section 76 (1, a – c) or section 76 (3) (SSWBA)
5. Do they wish to become looked after?

It was my professional opinion that 3 satisfied all of the points above, that her mum was not able to provide her with suitable accommodation or care (s76, 1c) and that 3s wellbeing would be seriously prejudiced if she was not provided with accommodation (s76, 3). As a result, it was my recommendation that 3 became a Child Looked After so that she could be offered appropriate housing and guidance so that she can begin to have stability, begin to feel safe and engage in ongoing support around her to build her life skills. **(178)**

Despite the assessment recommending she becomes CLA, and despite her saying this is what she wanted, she then declined the offers of accommodation made to her. To make matters worse, her tenancy was terminated after her flat was vandalised by friends and the Housing team stated they no longer had a duty to accommodate her. 3 returned home to live with mum in a 1 bedroom flat. **(67)**

Bowlby's attachment theory (1969) (where a secure bond between a baby and the primary caregiver is fundamental to the baby's development) is renowned and has been developed by other writers and is now proved beyond reasonable doubt (Maclean & Harrison, 2015, p. 103). Sadly for 3, her mum's mental health difficulties have contributed to an insecure bond between the two. Although Bowlby referred to babies, attachment security is also important to adolescents like 3; Moretti and Peled (2004) highlight how securely attached adolescents are less likely to engage in excessive drinking, drug use risky sexual behaviours and have fewer mental health problems. 3 is frequently let down by her mum, she engages in risky activities, mum continuously rejects her by prioritising visiting the younger siblings and 3 continues to hope that her mum will change and will be the loving, nurturing caregiver she longs for. **(145)**

During the assessment process Mum was admitted to a mental health hospital. Immediately prior to this there had been concerns because she was threatening violence to neighbours; she had armed herself with a weapon and stated she had purchased a firearm. Whilst in hospital she had been messaging 3, laying blame at her door for her own current situation (a repeated pattern). In order to risk assess and consider the ongoing safety of 3 I made contact with the hospital. They were reluctant to share information and made reference to mum's privacy. Wales Safeguarding Procedures (Social Care Wales, 2023) stipulate that data protection legislation allows for the sharing of such information in situations like these and information sharing is good. The Welsh Government Code of Safeguarding Practice stipulates that when information is not shared in a timely way, decisions about how to respond may miss vital information leading to poor safeguarding consequences (Welsh Government, 2022). **(155)**

At the hospital's request, an email was sent where I gave them background information (i.e. 3 is on the CP register, is open to CSE protocols, is living with mum, is being blamed by mum) and outlined the lawful basis upon which I was making this request for information (as referred to above). I asked for an update on mum's mental health and to be included in their discharge planning meeting. The following day I made an unannounced visit to 3 and was shocked (and

angered) when she told me that her mum had just arrived home. Although I recognised that mum was in an English hospital (and so staff will not follow the same procedures as workers in Wales), the need to share information is also reflected in the Data Protection Act 2018 and General Data Protection Regulation (GDPR) which apply to the whole of the United Kingdom. These pieces of legislation state information can be shared legally without consent if a practitioner is unable to gain consent (which applied to me when mum was in the hospital and with her attitude towards me) and if it is to keep a child or individual at risk safe from harm (which applied to 3) (HM Government, 2018). I fed this practice back to my manager and senior manager so that further conversations and considerations could be held; in my opinion their lack of information sharing potentially put people at risk. **(240)**

As well as the issues of housing, repeated concerns for 3 were being shared by agencies because of the peers she associated with, her vulnerability around them and her association with risky adults. 3 was drinking alcohol excessively at times, she was experimenting with drugs, she had several sexual partners, she gave little respect to a safety plan developed in conjunction with her mum. Within weeks of completing the assessment to consider 3s housing needs, I was also required to undertake a s47 investigation to consider 3s risk of harm in relation to her peer groups. This request was made via my agency's Child Sexual Exploitation arena which was running alongside the Child Protection registration and planning. This has been a difficult process to navigate. I was unfamiliar with this arena until my involvement with 3 and there have been so many additional requirements and tasks for me to complete to satisfy the criteria of the CSE protocol. Point 39 of the Code of Practice Part 7 (Safeguarding Children from Child Sexual Exploitation) states that different types of abuse and exploitation are interrelated and so practitioners' responses should be "child focused rather than issue based" (Welsh Government, 2021). By singling out "exploitation" and discussing this within a Child Exploitation Strategy Meeting I feel that this practice does then become "issue" based. If Child Sexual Exploitation is a form of child abuse, and 3 is on the Child Protection Register under the category of risk of neglect and sexual harm, then why is the Child Protection plan and process not sufficient to deal with the issues holistically and in a "child focused" way? **(272)**

Setting aside my inexperience within the CSE protocols and my attitude towards the process (as described above) I set about to the task in hand of completing the assessment. The definition of Child Sexual Exploitation is when an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a young person under the age of 18 into sexual activity in exchange for something the victim needs or wants and/or for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual (Department for Education, 2017, p. 5). **(106)**

The Mental Capacity Act 2005 (MCA) applies to children aged 16-17. I think the MCA is an empowering piece of legislation because at the outset, the first principle is to assume a person has capacity to make decisions (s1 (2)). The MCA is further empowering in the principle that a person should not be deemed to lack capacity just because someone else thinks they have made an unwise decision (s1 (4)). Despite the worries I shared with colleagues, there was no reason for me to consider an assessment under the MCA. The analysis of my assessment was that 3 is a vulnerable young adult who is at times making unwise decisions and is participating in risky behaviour. I felt there was no evidence to suggest she is at risk of child sexual exploitation because throughout the period of engagement with 3 she has not disclosed to any professional, nor has there been evidence to suggest, that there has been an exchange between herself, her sexual partners or another. **(168)**

My understanding of child development made me aware that changes in teenagers' brains make it hard for them to think about consequences or what might happen in the future. 3 is engaging in typical teenage risky behaviour (e.g., using drugs, drinking alcohol, being sexually active, getting into unsafe situations) but unfortunately, linking back to attachment theory, 3 does not have strong, consistent relationships with adults in her life who have been able to guide her, protect her and support her during her teenage development. She has also not had

a stable, safe home environment and these factors lead her to continue to take risks, to try and gain peer approval and she has come to harm. **(116)**

My colleagues within the CSE arena did not agree with my professional judgement and at the subsequent CSE strategy meeting the majority felt she was at risk of exploitation and so she remains open to this arena. I was accepting of this difference of opinion. Earlier on in my social work career, if someone has disagreed with my analysis and recommendation, I have worried that I have “got it wrong”. I have utilized discussions in supervision to work on these feelings and am now comfortable in owning my own assessment and opinion and understanding that not everybody will agree. In this scenario I could completely accept that the complexities of the case, as well as the complexities of recognizing CSE, compounded people’s worries and led to the decision to remain within CSE protocols. **(133)**

Mum’s mental health has added layers of difficulty to this case. Sharing information, opinions and plans of action with her have often been met with resistance and hostility from her. She has made several threats to my personal safety and has sent me multiple, vicious text messages – for example, I was called “a vile excuse of a human”, was told that she would “rip my throat out” if I visited, was told I discriminate her because of her mental health and was blamed for her suicide attempt. I experienced various emotions when I received these types of messages; I was upset she would think this way, I was worried for my safety, I questioned if I could have approached things differently and I wondered if I was to blame, as she suggested. In addition, there were almost daily concerns being shared by various agencies. The SSWBA lays down the duty to partner agencies that if there is reasonable cause to suspect a child is at risk, they must inform the local authority of this (s130). These concerns are shared by way of a Multi-Agency Referral Form (MARF) which are submitted to my agency’s initial point of contact team. The decision making and case management was tiring. **(206)**

Goleman (1996) has described Emotional Intelligence as “Being able to motivate oneself and persist in the face of frustrations; to control impulse and delay gratification; to regulate one’s moods and keep distress from swamping the ability to think; to empathize and to hope”. Using Emotional Intelligence to manage my personal feelings alongside managing the case proved difficult at times and tested my resilience and made me question my abilities. I was often conscious that mum’s own needs and behaviour could distract me from the needs and safety of 3. To manage my own thoughts and feelings I would regularly discuss the case with the Support Worker from within my agency who was working alongside me. We would use reflective models in our discussions following visits to the home when mum was present. We would consider what had happened/what we saw/what was said and share our thoughts and how we felt. We would consider if we had acted appropriately, had we relayed our message, had we considered the risk, had we seen 3 and given her a chance to share her thoughts.

(181)

This helped me to ensure I remained mindful and sensitive to the difficulties mum faces (and the allegations she made) whilst continuing to ensure I did not let this cloud my thinking and continue to practice in a child-centred manner by putting 3s safety and welfare first. My professionalism and practice was validated by a colleague from Child and Adolescent Mental Health Service (CAMHS) who sent me the following email after a core group meeting – “Just wanted to email to say what a great job you’re doing Zoe. Your practice its beautifully empowering and supportive. The family are extremely hard to engage and have complex needs. You keep all professionals up to date with what is happening even when you’re dealing with crisis, which supports with the multiagency working”. Sadly, this praise was completely ignored by my line manager (who had been copied in to the email by the CAMHS worker and her own manager) and this frustrated me. Supervision is described as “an accountable, two-way process, which supports, motivates and enables the development of good practice for individual social care workers” (Care Council for Wales, 2012). Sadly this was not my experience of supervision; it felt more like a tick box exercise to check which tasks I had completed and yet always focussed on things I had not managed to compete. During this

period of involvement I felt very unsupported by management (an issue felt across the team), it made a difficult job more difficult and left me feeling very vulnerable at the time. **(255)**

As 3 is on the Child Protection register, I have a number of responsibilities to fulfil as her Social Worker. These responsibilities are laid out in Wales Safeguarding Procedures and including visiting 3 every 10 working days, visiting her at home at least every 4 weeks, having core group meetings every 4-6 weeks. Trying to engage 3 and her mum with the child protection plan has been very difficult. Mum's hostility towards me, her lack of understanding of the concerns for 3 and her mental health difficulties meant she was often resistant to my communication and obstructive to my home visits. **(101)**

As a registered Social Worker in Wales, I am bound by the rules, responsibilities and values set out in the Code of Professional Practice for Social Care (Social Care Wales, 2017). These codes include respecting the views and wishes and promoting the rights of individuals (code 1); striving to establish and maintain the trust and confidence of individuals (code 2), promoting the well-being, voice and control of individuals while supporting them to stay safe (code 3) and respecting the rights of individuals while seeking to ensure their behaviour did not harm themselves or other people (code 4). In addition, my training has taught me that The Equality Act 2010 lists nine protected characteristics (sec 4) on which people are not allowed to discriminate. Section 6 of this Act stipulates that a person has a disability if they have a physical or mental impairment which has substantial and long-term adverse effect on their ability to carry out normal day-to-day activities. 3s mum has struggled with mental health difficulties throughout her adult life and from my assessments, and those of other colleagues, it has a detrimental impact on her parenting capacity (i.e. normal day-to-day activities). **(193)**

The European Convention on Human Rights 1950 (ECHR) stipulates that everyone has the right to respect for their private and family life (Article 8), and s17 of the Children Act 1989 puts mum at the centre of raising 3. Although I gave consideration to these rights, I also

needed to balance them against 3s rights. Article 19 of the United Nations Convention on the Rights of the Child 1950 (UNCRC) stipulates that 3 has the right to be protected from “physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parents” while Article 39 states she has the right to receive special support to help her recover her health, dignity, self-respect and social life as a result of the neglect, abuse and exploitation she has experienced. In Wales, social work is underpinned by the Social Services and Well-being (Wales) Act 2014 which aims to improve the well-being of people who need care and support and this Act pays close attention to the UNCRC by stating that a person exercising functions under the Act must have due regard to the UNCRC (SSWBA, s7). **(194)**

In order to be sensitive to mum’s mental health disability and in attempts to engage her with the care and support protection plan, I made an “active offer” of advocacy to her. One of the fundamental principles of the SSWBA is “voice and control” and despite the barriers I faced, it was my duty to try and help mum have a voice so that core group members and I could have due regard to her views, wishes and feelings (s6, 2). Advocacy is a central tenet of the SSWBA, it allows people to have a clearer voice and a stronger understanding of the care and support process they are in. As such Part 10 Code of Practice (Advocacy) has been published to guide practitioners like me. Mum is estranged from her family and has often stated she has no friends locally, as a result she did not have an “appropriate individual” (Welsh Government, 2018, point 47) who could support her during the child protection process and so a referral to an independent professional advocate was made in line with section 47, Part 10 Code of Practice (Advocacy). Mum declined this offer. An “active offer” of advocacy was also offered, and declined, by 3. These offers were repeated through the course of involvement, each time declined by mum and 3. **(219)**

I worked closely with mum’s Community Psychiatric Nurse and Domestic Abuse Support Worker, arranging joint visits to the home. My purpose was twofold, one to give mum the opportunity to engage and to feel supported and understood by her own workers and two, to

give them insight into the concerns I had and to create greater understanding. I would often receive telephone calls or emails from mum's workers, detailing to me mum's difficulties, relaying information she has shared with them and questioning my actions. I often felt that they did not have professional curiosity and were taking what mum told them as fact. During this assessment period I worked alongside many agencies supporting this family (e.g. Adult Mental Health Service, Child and Adolescent Mental Health Services, Housing, Child Exploitation services, Police, Domestic Abuse Support Services). All have their own focus and agenda and their understanding of child protection responsibilities, duties and threshold are, understandably, not as detailed as mine. Balancing the feelings of oppression mum would share with her workers, against the worries and anxieties colleagues had for 3 and explaining the limitations and expectations of my role was difficult at times. Good communication and collaborative working was key. I consider myself to have been the "boundary spanner" across these agencies; Oliver (2013) defined boundary spanners as those whose role is to "work between systems whose goals, though superficially complementary, may carry inherent conflicts requiring mediation, negotiation and strategy' (p. 777). As 3s Social Worker, I feel my approach has been more holistic, considering all of these agendas and trying to work together to ensure the safety and wellbeing of 3 as well as her mum. **(276)**

I am still involved with 3 and her mum. 3 remains on the CP register and is still open to CSE protocols. She is now pregnant and I have been allocated as her baby's social worker. 3 will soon turn 18 and so planning is now focussing on the transfer of her care and support needs to Adult Services whilst also focussing on the baby's safety and needs. I have had many conversations in supervision with my line manager where we have discussed my fatigue with the case (I have been working with 3 and her mum for 18 months, from Care and support status, through to child Protection and now further, with pre-birth involvement). We agreed for the unborn baby to be allocated to me because of the background information I have for the family and the relationship I have. At times I feel disappointed that I have not been able to engage mum throughout this process, but I feel confident that I have worked hard, I have been sensitive and I have collaborated with colleagues to continue to try and engage her in this process and to give her voice and control in her daughter's care planning. I recognise that

mum is likely to find it difficult to work alongside whichever Social Worker is allocated to support her child (and now grandchild). **(224)**

This case has been testing because of the issues of adult mental health, adolescent mental health, child sexual exploitation and homelessness. I often had feelings of anxiety when MARFS were being frequently submitted, 3 was at risk of harm, she had no stable home and yet my assessment had recommended she should become a Child Looked After. I needed to make good use of supervision and thankfully a change in management meant I was able to do this and has helped me to manage my personal emotions which has helped me to continue to be professional towards 3, her mum and partner agencies. **(103)**

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