



**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).

I will be using the What? So what? Now what? model of reflection developed by Terry Borton (Maclean, 2016), to critically reflect on my safeguarding case study. What? Can be defined as reflecting in action. So what? as reflecting on action, and Now what? as reflecting for action.

What?: Individual 2 was referred for a social work assessment by her community psychiatric nurse [CPN], due to concerns about this lady's ability to care for herself, and the potentially neglectful behaviour of her son. Individual 2 lived with her pet dog, but had ongoing professional oversight from CPNs due to a diagnosis of dementia. Her son lived nearby and claimed to provide a meal every day, and undertook grocery shopping for her. Her CPN was concerned that individual 2 had lost the mental capacity to manage some activities of daily living, and this posed a risk to her wellbeing. The CPN was also concerned that her son was not providing sufficient or nutritious food, and was placing individual 2 at risk but neglecting to remove out of date food, which individual 2 was eating due to her impaired cognition; the CPN had previously raised the issue with the son, but he had neglected to act; hence her referral to social services. The referral was allocated to me for a rapid response assessment of need, and to establish whether there were any safeguarding concerns.

I visited individual 2 with the CPN and undertook an assessment of her needs for care and support under the Social Service and Wellbeing Act (Wales) 2014 [SSWBA], and identified that she did have needs for care and support. I assessed her mental capacity under the Mental Capacity Act 2005, to make decisions about how her care and support needs, and found that she did not have capacity to make these decisions. I found that there were legitimate

safeguarding concerns, I also assessed her mental capacity to consent to a safeguarding referral. I found that she did not have capacity to consent to this. As her only relative was the alleged perpetrator and there were ongoing concerns, myself and the CPN decided it was in her best interest to make a safeguarding referral.

There was an immediate concern that individual 2 was continuing to eat very out of date tinned and dry packed food; some of the food was several years out of date. It seemed that sometime earlier when she was less severely affected by her dementia, and still able to go out into the community independently, she had gone through a period of overbuying long-life food. I contacted the son and explained my concerns, and that the tinned food needed to be urgently removed from the property. I gave him a timescale to have completed this, and informed him that the situation would be monitored to ensure he has completed the task. At that point I did not know whether there would be a lead coordinator from the safeguarding team, but I knew that I would be organising some form of longer-term social work involvement because of her broader care and support needs

I made a referral to the local authority's safeguarding team, but it was felt that a lead coordination role was not needed immediately, as the actions I had taken had safeguarded the lady for the time-being, but this should be reviewed as her son had failed to act previously. The nature of my social work role is to undertake urgent assessment, and my role is very short-term. It was agreed that on-going social work involvement was needed to ensure that the son took action to safeguard his mother, and for formal safeguarding involvement to be actioned if he neglected to act. It was also agreed that the long-term social worker would be best placed to complete a best interest meeting to decide how individual 2's care and support needs should be met in the longer-term. I transferred my involvement to the community social work team for them to urgently complete this work, making it clear what action I had taken, what was agreed with the safeguarding team, and what social work actions were still outstanding.

So what?: The main thoughts I had in relation to this lady and her circumstance was that my practice, and any recommendations I made needed to be firmly strengths based, and anti-oppressive. Her dementia had resulted in her becoming consistently disorientated to time, and to lack insight into her needs. However, what struck me during the assessment was that she had a lot of strengths and capabilities, and that with some minor effort from her son, and a small amount of support she would be very safe at home, and able to go about her days with little intrusion and continue to make decisions about what she does with her time.

I remember feeling pleased that I had been able to develop a rapport with individual 2, because the CPN had warned me that she is often 'stand-off-ish' and reluctant to engage with professionals. However, during the assessment we shared moments of warmth and good humour, and this led to her being quite open with me, though in the context of having a lack of insight. This included showing me around the first floor of her home, which she had not previously allowed the CPN to see.

I felt annoyed that her son had not taken action when previously advised by the CPN. There was a very large volume of tinned and packaged food in the house, all of which as far as I

could tell was out of date, and some severely out of date; yet she was continuing to consume it due to her disorientation to time i.e. she had no concept of the current date, so could not judge if something was safe to eat. I was conscious of this and careful not to adversely affect how I communicated with him. There were potential legal and ethical dilemmas in this situation, which I was careful to identify and address. My personal attitude to food hygiene, and her and her son's attitude could be very different to my own. I wanted to avoid being paternalistic, oppressive, or judgemental, so I was careful to identify her thought and feelings in relation to eating out of date food; in doing I had certainty that in advocating for the food to be removed and her having support to ensure she only had access to safe food, I was facilitating her personal outcomes. Legally I was also careful to ensure that she was not a capacitated adult making unwise choices, and therefore would have no legal basis on which to proceed, and would have to work carefully with her consent to find a way to keep her safe whilst respecting her wishes.

I felt my application of safeguarding legislation, policies and procedures was good and proportionate. In Wales the duties and powers in relation to safeguarding adults are contained within section seven of the SSWBA. Section 126 of the SSWBA defines an adult at risk as someone who "is experiencing or is at risk of abuse or neglect, has needs for care and support (whether or not the authority is meeting any of those needs), and as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it (The National Archives, 2023a). Individual 2 clearly met that criteria, because her dementia prevented her from understanding whether food was out of date, and she has continued to consume that food which is a risk to her health and wellbeing. Her dementia was also preventing her from taking action to clear the out of date food from the property and replacing it with safe food. She needs support to ensure that she has access to food that is safe, and to prevent her from consuming food that is unsafe. Her son had been tasked with clearing the out of date food, but had not taken action.

Section 126 of the SSWBA goes on to state that "if a local authority has reasonable cause to suspect that a person within its area (whether or not ordinarily resident there) is an adult at risk, it must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken (whether under this Act or otherwise) and, if so, what and by whom, and decide whether any such action should be taken" (The National Archives, 2023a).

Section 128 of the SSWBA places a statutory duty on relevant partners of a local authority to report adults who may be at risk of abuse and neglect. In this case that hadn't been done by the CPN, she had made a referral for an assessment of care and support, I subsequently identified individual 2 as an adult at risk. Within my employing local authority there is a dedicated safeguarding team, and it the policy and procedure to report safeguarding concerns to that team, they decide whether safeguarding investigations are needed, and act as lead coordinators.

In Wales the national procedures for safeguarding are set out within the Wales Safeguarding Procedures. In taking a citizen centred approach, and to comply with the guidance on consent

with the Wales Safeguarding Procedures I did seek consent for a safeguarding referral from individual 2. I consider seeking consent the default procedure in these circumstances, and for all of my social work functions. Within the Wales Safeguarding Procedures practitioners are instructed to seek consent, unless there are specific reasons not to e.g. doing so would increase the risk to the individual. Based on my collaboration with the CPN, who knew individual 2 and her son well, I felt it was reasonable to proceed based on her consent if possible, because there was no evidence that seeking consent would increase the risk to her or complicate any safeguarding investigations. In this instance, and based on my discussions with her, I considered it necessary and appropriate to assess her mental capacity to consent to a safeguarding referral, and as outlined above found that she lacked capacity to make that decision, and it was agreed it was in her best interest to make the referral.

Whilst decision specific, the issue of mental capacity in this case was broader than the issue of consent. This is because in assessing her mental capacity, and finding she lacked capacity to make a specific decision, and undertaking a best interest decision I then had to formally record this information in the social services computer system, which will provide valuable reference and context for future social work involvement, helping other practitioners to work with this lady in an appropriate and legal way. It is also because in making her mental capacity a formal part of the safeguarding process, it will mean safeguarding practitioners will consider the extent to which individual A can be a decision maker and give direction in any safeguarding process. This is not an invitation for safeguarding practitioners that might become involved in this case to be oppressive, but I was seeking to recognise that the Wales Safeguarding Procedures states “it is crucial that the adult at risk, dependent on mental capacity to make best interest decisions at a particular time, is in control of decisions as to how the risks they face in relation to abuse and neglect are managed” (Wales Safeguarding Procedures, 2023a). Therefore, her mental capacity must be considered in order for safeguarding processes to proceed appropriately and safely.

Based on my understanding of the Wales Safeguarding Procedures guidance on managing immediate concerns about the safety of an adult at risk (Wales Safeguarding Procedures, 2023b) I felt it was appropriate to take action to safeguard individual 2 prior to the formal safeguarding referral, because if I didn't she would continue to eat severely out of date food, and therefore continue to be at risk of harm. However, the volume of food in the property was very large and there was no way that I would have been able to remove that food immediately. Although her son was the alleged perpetrator, and neglected to remove the food from the house at the CPN's previous request I made the judgement that he was still the person best placed to remove the food from the property; this was based on information given by the CPN about her previous interactions with the son, which had not raised any concerns about broader abuse or the possibility of abuse/neglect escalating.

In liaising with the son it seemed that he had not fully understood the way his mother's dementia was impairing her ability to care for herself, or the extent to which he needed to assume a caring role. He also reported difficulties attending regularly because of work commitments, a lack of skills in supporting someone with domestic tasks. He also stated that that his mother was very house proud and did not like people interfering in her home, and that she was always the one to take on the caring and supportive role within the family. I tried to

understand this in the context of social role theory, which states that people's behaviour and styles of interaction are influenced by the social roles that they adopt; and that these roles are often gendered roles in stereotyped ways (Eagly, 1997). Individual 2 was born, raised and continues to live in one of the many rural communities in Wales, where traditional social roles are still practiced, and many of these role are strongly split along gender lines. Knowing and understanding this, and being able to work respectfully within these contexts is part of working as a social worker in Wales, and is something I fully expect to encounter in the future as there are several rural communities within the area of my employing local authority. Individual 2 and her son have adopted identities that are stereotypically gender based, and unfortunately her son's inflexibility with his role, and individual A's determination to maintain a role which is now unsustainable have resulted in a lack of action from her son, and a certain amount of neglect. Part of my role in this context is to impress upon him the immediate need to change his role and take action to safeguard his mother, but in the medium and longer term to consider what he is willing and able to do as a carer, whilst maintaining the social role and identity he wishes to. Therefore, I tasked him with removing the out of date food immediately, which he agreed to do, and explained that a social worker would be following this up to ensure that he had removed the food. I also explained that his mother had broader needs for care and support, which I had assessed, and this issue would also be followed-up by the longer-term social worker.

Because the nature of my social work role is to undertake only urgent assessments I do not take on a caseload of long term work, and where there will be a need for ongoing social work input I would organise allocation to a long-term community social worker to undertake the ongoing work. In this instance my transfer summary to the receiving social worker included instructions to urgently review whether the son had taken action, and if not to take responsibility for clearing old food from the property, as per the recommendations of the safeguarding team. But in that instance I also instructed them to re-refer to the safeguarding team, as they would need to have formal involvement to coordinate the safeguarding response. These decisions were made in liaison with the local safeguarding team and the involved CPN. During my discussions with her son he claimed to have lasting power of attorney for health and welfare and property and finances. In my transfer summary I also instructed the receiving social worker to consider contacting the Court of Protection if he continued to neglect his mother, as this would indicate that he may not be a suitable attorney that could act in her best interests. I also instructed the receiving social worker to continue to develop and then action the care and support plan in my assessment, but requested that his should be done with all involved parties, including her son as long as he continued to be regarded as someone that could act in her best interests.

I think I succeeded in acknowledging how interrelated her needs for safeguarding and care and support were, but I also succeeded in advocating for a strength based approach and measures that were proportionate and anti-oppressive. In respect of the need for safeguarding the immediate risk was centred around access to safe food, she was otherwise safe and happy in her own home, though there were other activities of daily living where she had eligible needs for care and support, they were less immediate. She was still independently able to prepare food for herself, so the limit of the support she required for this need was for someone to ensure she only had access to food that was safe. Therefore both my actions to safeguard

her and the recommendations I made for meeting her care and support needs focused on the immediate risks and on meeting her needs without infringing on what she was still independently capable of doing. Any attempt to do more would have mischaracterised her needs, been oppressive, and could not have been justified as a 'least restrictive option' as defined by the Mental Capacity Act 2005 (Department for Constitutional Affairs, 2007), for example placing her in residential care.

I think my intervention also showed a good understanding of principles from other legislation that interfaces with the SSWBA and Wales Safeguarding Procedures. For example in acting to safeguard her from eating severely out of date food, I am also acting to protect her article 2 right to life under the Human Rights Act 1998 [HRA], and the same right under article three of the United Nations Universal Declaration of Human Rights [UNUDHR]. In advocating for an approach that respects and maintains her strengths and capabilities, and ensured that her care and support is provided in her own home, where she is happiest and wants to be, I am promoting her article 5 right to liberty under the HRA, and under article 3 of the UNUDHR. In taking that strengths based approach, following the Wales safeguarding procedures, the Mental Capacity Act code of practice, and the SSWBA code of practice on assessing needs, I am also seeking to promote her article 12 right under the UNUDHR by ensuring as much as possible that my interference in her private life is not arbitrary.

At all times I am trying to ensure that my practice as a social worker is demonstrably good, in Wales standards of good practice are set out in Social Care Wales' Code of Professional Practice for Social Care Workers. I do feel that my work with individual 2 shows good congruence with the principles in the code of practice, this is not just in the actions I took to safeguard her, or the recommendations I made for her ongoing care and support, but also in the way I approached the assessment and worked in partnership with her as much as possible. I did "strive to establish and maintain the trust and confidence of individuals and carers" (Social Care Wales, 2017) by treating individual 2 with respect at all times, and despite her obvious difficulties with retaining information I was always transparent and explained everything I was doing and why. As mentioned above the way I safeguarded her, and limited my intrusion in her life as much as possible were based on a respect for her rights, but also an attempt to protect her from harm, as set out in section four of the code of practice. In acting to safeguard her and in following safeguarding processes, and seeking to meet her needs I am also seeking to act with integrity and uphold public trust in social work as set out in section 5 of the code. I felt one of the best outcomes from my practice was that I was able to maintain a very person centred representation of her personal outcomes and the support she would want. Although she lacked insight into the extent to which her dementia was effecting her, I was able to gain an understanding of how she would feel if she did have insight. For example she was not able to accept that she was eating out of date food, but would give detailed responses when asked hypothetical questions, such as 'how would you feel if you were eating out of date food, but didn't realise?' and 'if your memory declined and you started eating out of date food, what help would you want?'. By being able to establish her views and wishes it means I can then respect them in the way I advocate for services that are proportionate and person centred, as set out in section 1 of the code of practice.

Overall, I felt happy with my intervention, particularly within the context of my role, which is very short-term. I felt conflicted about the response of the safeguarding team. On one hand it was positive that they felt the actions I had taken to safeguard her were appropriate, and that their input wasn't needed for the time-being. On the other hand I felt slightly vulnerable that there was not any specialist oversight to coordinate the safeguarding. Being professionally accountable whilst working autonomously are part of becoming an experienced practitioner. However, I had clearly defined both the short and longer-term plans for the receiving social worker, which should prevent any further harm.

Now what: One of the dimensions of integration of analysis in assessment which was a learning point in the case was negotiating separate legislation, policies and procedures simultaneously. I was assessing her need for care and support under the SSWBA, gathering information to determine whether she could be defined as an adult at risk, and what this meant in terms of my duty to report and act under the SSWBA and Wales Safeguarding Procedures. Consent also had to be considered, and so I needed to interface my assessment with the Mental Capacity Act. One of the elements of practice I am developing is a more integrated style of assessment, so that where appropriate there is less distinction between my assessment for care and support and my assessment of mental capacity. In my interaction with individual 2 it was more compartmentalised, and there were times when questions in relation to mental capacity may have had a better response if they were asked earlier, when I was focusing on care and support needs. This is a matter of professional judgement, as there will be times when a more compartmentalised approach is more appropriate. It also depends on developing an expert knowledge of legislation, policies and procedures, so that in practice I can negotiate the way they interface with as little effort and as much confidence as possible, so that they do not interfere with my interactions with individuals.

Since qualifying this was the first safeguarding related case where the individual lacked mental capacity to consent to a referral or safeguarding involvement. This increased the level analysis needed because I had to make a judgement about if consent was needed, whether I shouldn't seek consent because there may be a negative impact on the individual, or whether it wasn't needed due to a lack of mental capacity. I gained a lot of knowledge and confidence from this, which I will continue to explore and develop.

Although it is related to my practice more broadly, rather than just in relation to safeguarding, this case was an opportunity for me to develop skills in working in partnership with people who lack insight into their needs and circumstances. Because she lacked insight into the way her dementia was affecting her, and could not accept that she was inadvertently putting herself at risk, or take action to protect herself, I couldn't engage her in actively planning to stay safe. But because she was still intelligent and articulate, and because we had developed a good enough rapport, she was open to answering hypothetical questions, which helped to understand what her views and wishes would be if she did have insight. This meant I had confidence that both the personal outcomes identified in her assessment and the safeguarding plan were person centred. The effectiveness of specific types of questioning and styles of interaction will vary from individual to individual, and between scenarios, but again being able to judge how to engage with an individual is a vital social work skill, and something I will continue to focus my development on.

It is often said that the nature of social work is to deal with uncertainty and complexity. As the level of uncertainty and complexity grows so does the level of professional accountability required. Personally, I often find the level of professional accountability quite anxiety inducing. However, one of the lessons I have learned from this case is that as I improve my knowledge of legislation, policies and procedures, and improve my ability to apply them, my anxieties about professional accountability are lessened. This is because I feel more confident that I can justify and defend my interventions.

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