



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

**LEARNER PORTFOLIO
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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).

Working with children and families can be one of the most challenging yet rewarding aspects of social work. 'Essential' to this area of practice is the undertaking of assessments (Taylor et al, 2024), which can be both formal and informal. This requires social workers to apply analysis and professional judgement to situations to determine the best way to support a family and safeguard children. Since qualifying as a social worker, I have had a role in the assessment team in a local authority in rural Wales. Within this team, it is my responsibility to complete assessments under the Social Services Wellbeing Act 2014, wherein I gather multi-agency information, identify safeguarding concerns and wellbeing needs, and generate recommendations for ongoing support or action. In this assignment, I will critically reflect on a case where I had to exercise my own professional judgement in a complex situation, and where my assessment of needs informed the intervention which was taken. This case caused me to reflect on the tensions and conflicts which can arise in relation to collaborative working, particularly when the wishes of the child contrast with what will keep them safe. In this assignment, I will identify the underpinning legislation, procedures, strategies and policies which I used to inform and guide my decision making, and reference the theories and approaches which have underpinned my own values and ethics as a children's social worker. I will utilise Korthagen's Reflective Model (2010) to assist in identifying areas of professional development.

The case which I will focus on in this assignment involves a 16 year-old female who will be referred to as 1 throughout this assessment for the purposes of confidentiality. When 1 was

allocated to me, she had been living with distant relatives who she referred to as her grandparents for some years due to difficulties in her relationship with her parents. In 1's family home lived her mother and father, and her two brothers aged 15 and 18 respectively. The family are of White British heritage, are first-language English, and had lived in Local Authority X, a rural county in Wales, for their entire lives. Wales has a rich cultural and linguistic background, with many of the nationals wishing to converse in Welsh. To honour the Active Offer (2015), it was important for me to confirm whether the family would prefer all communication in English or Welsh at the beginning of my involvement, to foster anti-oppressive practice. The family confirmed that they would like to converse in English.

1 had been known to Local Authority X since she was very young, primarily due to parents raising concerns about managing her behaviour which they described as challenging. My involvement with 1 began in October 2023, following the receipt of 5 referrals within the space of 2 weeks which raised concerns about her increasingly risky behaviour, missing episodes, self-harm and suicidal ideation. Additionally, there were concerns about her vulnerability as she had been accepting alcohol from older males in the community. Under Section 3 part 1 of the Wales Safeguarding Procedures, a strategy meeting was convened where professionals from social services, health, education and police came together to discuss the concerns, and it was a unanimous decision that 1 should be placed on a Risky Behaviour Plan. The purpose of the plan was to outline expectations and guidelines for professionals, family, and 1 herself, with the aim to keep her safe and promote her wellbeing. Due to the seriousness of the concerns, this was decided prior to me having had my initial meeting with 1. Whilst 1 had no say in her being placed on the Risky Behaviour Plan and was not present in the meeting, I felt that it would be important for me to take the time to sit with her and explain what the plan meant in a way that she understood. Symonds, 2018, notes the importance of initial meetings and conversations as the basis for a working relationship between professionals and service users. I reflected about how to approach our initial meeting, and I decided to take some time to speak one to one with 1, to get to know her and to help her feel comfortable around me prior to sharing the Risky Behaviour Plan. I made an effort to ensure that I spoke plainly and clearly, and gave 1 the opportunity to ask any questions. 1 agreed to sign the Plan after I had discussed it with her, to indicate that she understood what the Plan meant for her and why we were worried.

In the following weeks, due to regular concerns about her self-harm and suicidal ideation, 1 had several voluntary hospital admissions under Section 136 of the Mental Health Act, and on one occasion she was involuntarily admitted under Section 2 of the Mental Health Act (1983), as professionals believed that this would be in the interests of her own health and safety, and the protection of others. When 1 was assessed during these periods, mental health professionals told social services that they could not meet her needs as her issues were behavioural, and 1 was discharged following each admission. I found this period of time frustrating and disheartening, as it was my view that 1 would be far safer in the care of mental health staff than out in the community, as was evidenced by almost daily occurrences where she was making attempts to harm herself or end her life. The decision for 1 to be discharged after each admission placed a significant strain upon social services, as we had a responsibility to keep her safe in the community, when 1 was determined to find ways to cause harm to herself. In Wales and the rest of the U.K, there is a strong focus on the integration of

health and social services. This can be more fragmented in other countries such as the United States, where there are a range of private and public services available. First Minister for Wales Mark Drakeford has said that collaboration should be 'entrenched between local government and the health service' (Drakeford, in Livingstone et al, 2023). Pertinently, the case reviews following the tragedies of Baby P (2007) and Victoria Climbié (2000) also highlighted the importance of regular and collaborative information sharing between professionals. Despite this, I felt as if social and health services were working against, rather than with, each other at this time. On reflection, I feel that the limitations of time, funding and resources for both social and health services was a disservice to 1 and meant she was not always the centre of decision making. If I was holding the case now, I would have made more of an effort to understand the policies and procedures that guide decision making in the health sector, to understand how we could better work together rather than against each other.

This time period felt chaotic, with crises happening on a regular, sometimes daily, basis, and with professionals at odds with each other. In the midst of this, despite regular attempts to engage 1 in conversations about what had been happening and safety planning, this seemed to make little difference at this time. Prochaska's Cycle of Change (1983) posits that there are 6 stages to changing behaviour, and effective change will only come about if the work completed with the individual reflects the stage they are in. The theory states that there are three stages- pre-contemplation, contemplation, and preparation- prior to any change actually taking place. I had assessed 1 to be in the pre-contemplation stage, meaning she did not have a desire to stop making attempts to harm herself or end her life, and was not reflective about recognising the negative impact this was having on her. Additionally, 1 would not discuss why she felt the way she did with either myself or her mental health worker. My role felt reactive rather than proactive, and I found myself struggling to find the time to reflect about the best way to move forwards. In hindsight, I can recognise that I was overwhelmed during this time period, and I feel that this may also have impacted on my ability to make decisions and keep 1 as my focus. Maddock (2024) notes that experiencing stressful and traumatic situations as a social worker can have an impact upon being able to effectively carry out our roles. During this time, I utilised supervision to receive both practical and emotional support. Regular supervision and oversight enabled me to manage both own emotions, and the case itself, and provided a safe space for me to consider what actions needed to be taken to safeguard 1.

It ultimately became clear that an alternative solution should be sought, as the cycle of 1 attempting to harm herself or end her life, being admitted to hospital, then discharged, then harming herself again was unsustainable. In consultation with my managers and service manager, it was agreed that for her safety, 1 should be accommodated by the Local Authority. It was decided that 1 would be placed under Section 76 of the Social Services and Wellbeing Act (2014), a voluntary agreement meaning that her parents had consented to her being accommodated by the Local Authority. Despite 1's statements that she did not wish to leave Local Authority X, or her grandparents' home, a residential placement was ultimately found approximately 5 hours away, and 1 allowed us to place her there. I made efforts to explain to 1 why it was felt that this would be the safest option for her at this time, however 1 was very upset at being placed so far from her family. The Fostering Network states that from 2018 to 2023, the number of children in care in Wales has risen by 5.4%. Around 70% of these children are cared for by Local Authority foster carers, meaning the remaining children are placed with

private or independent foster carers, or in residential placements (Foster Wales, 2024). Due to the high level of care that 1 required, it was agreed by service manager that a residential placement would be the best option for her, as based on the evidence it was determined that a foster placement would not be able to manage her level of risk. However, residential placements which were equipped to meet 1's needs were scarce. Within the next month, 1 spent time in three different residential placements, with the first two placements stating that they could no longer manage her level of risk, as she was making active attempts every day to harm herself or end her life. Safety planning was undertaken, but it became clear that this would not be sufficient. 1 moved into a new placement which was more suitable for her needs, as it was a long-term placement with staff trained to deal with her presenting behaviours. She was also given 3:1 staffing and waking staff. However, concerns around 1's self-harming behaviours and suicidal ideation persisted. Whilst staff were being vigilant about sharp objects being kept out of her reach, 1 was finding alternative ways to harm herself, including using anything she could as a ligature. The staff raised concerns that they could not keep her safe without depriving her liberty by locking doors, searching her person, or removing her personal items.

I discussed my concerns with my supervisor and managers, and it was decided that I should make a referral for a Legal Planning Meeting with my manager, Service Manager, and legal representative to discuss the next steps. At this meeting, it was ultimately agreed that 1 could not be kept safe without additional safeguarding measures implemented. With advice from our legal team, it was decided that the Public Law Outline would be initiated, as we intended to make an application to court both for an Interim Care Order (ICO) and a Deprivation of Liberty Order (DoLS). A Pre-Proceedings Meeting was held so that the plan could be shared and discussed with 1's parents, who were in agreement that the applications should be made. Whilst 1 and her safety were the focus of each meeting, I was conscious that she was not present in the meetings to speak for herself. The British Association of Social Workers' Code of Ethics (2021) places a responsibility on social workers to empower the people they work with, to ensure that they are able to understand their rights and share their views. I explained to 1 that because we were worried about her, we were having to get some legal advice about how to keep her safe. I encouraged 1 to accept an advocate who would be able to help her understand the process, and represent her views where needed. 1 accepted this referral, and I made the application promptly.

The Deprivation of Liberty Safeguards are an important amendment to the Mental Capacity Act 2005. They are additional safeguarding measures ordered by the Court of Protection, and are required if restrictions and restraints used will deprive a person of their liberty. Article 5 of the Human Rights Act asserts that 'everyone has the right to liberty and security of person. No one shall be deprived of his or her liberty [unless] in accordance with a procedure prescribed in law' (Human Rights Act, 1998). However, the right to liberty is a qualified right, rather than an absolute right; meaning that it can be interfered with if it is deemed that the individual poses a risk to themselves or others. Interfering with an individual's liberty is extreme, and therefore must be appropriate and proportionate. I was conscious that a DoLS Order would only be agreed if the measures used met the following criteria: 1) the least restrictive of her rights and freedoms, 2) proportionate to the anticipated harm, 3) the least required to ensure her safety and that of others, and 4) respectful of her dignity. Making the

applications for a DoLS Order was not something that I took lightly. Whilst I believed that applying for the Order was necessary to keep 1 alive, I had conflicted feelings about making the application. I used supervision to explore this internal conflict. On the one hand, restricting 1's liberty in any way felt oppressive and at odds with the values I wanted to emulate as a social worker. Welsh social policy places an emphasis upon collaborative working and 'partnership' (Drakeford, in Livingstone et al, 2023), and encourages practitioners to 'work with rather than unto others' (Livingstone et al, 2023). I was conscious that depriving 1's liberty would be contrary to her wishes, and it felt contradictory to my personal values. I was concerned that depriving her liberty would lead to a further deterioration in her mental health and emotional wellbeing.

On the other hand, I understood that 1 would continue to be a risk to her own life if such extreme measures were not taken. Article 2 of the Human Rights Act 1998 states that everyone has the right to life. This places a duty upon the government to take appropriate measures to safeguard life by making laws to protect individuals, and in some cases taking steps to protect individuals if their life is at risk. It is noted that a right to life does not include a right to death. In order to protect 1's right to life, I reasoned that depriving her liberty would be a reasonable and proportionate measure. I also acknowledged that the staff at 1's placement were not able to keep her safe without additional measures in place. In Learning for the Future: final analysis of serious case reviews, 2017 to 2019 (Department for Education, 2022), it is highlighted that professionals often face difficulties in recognising 'the point at which the threshold for action had been reached'. Delay in responding to risk or inaction altogether can lead to increased risk for children. I knew that in this instance, a result of inaction on my part could mean that 1 might seriously harm herself, or even end her own life. Reflecting on the above and through discussion with my supervisor, I was able to understand that making the applications for an ICO and DoLS was a necessary and proportionate measure, to safeguard 1 from harm. Fenger (2018) remarks upon the 'growing imperative for person-centred practice', in the hopes that this will lead to more positive outcomes for service users. Upon initial consideration, I had not thought applying for a DoLS to be 'person-centred' as it was the opposite of what 1 wanted for herself. However, through reflecting and utilising supervision, I was able to understand that it was possible to be person-centred even without collaborating with 1. By acting against 1's wishes, we were taking the necessary action to ensure that, as far as possible, we were doing our best to safeguard her from any harm, which was ultimately in her best interests even if this is not something she wanted for herself.

I was required to write a Social Work Evidence Template (SWET) when making the application to Court. I was advised by my supervisor to be very clear about why I believed the DoLS to be a necessary and proportionate, and why less restrictive measures could not be taken. I was also advised to be clear about what measures I was recommending should be put in place. Kemshall and Pritchard (1997) note that balancing an individual's right to protection and right to take risks 'will produce dilemmas for practitioners' due to the conflicting agendas. I utilised the Signs of Safety approach (Turnell and Edwards, 1999) in my analysis, to unpick the complexities in this case. By identifying what was already working well, what harm had taken place and what were we worried would take place, I was able to outline what measures I felt were needed to keep 1 safe. Writing the SWET also helped me to prepare for explaining to 1 why we felt an application to court was needed. Unfortunately, due to the distance of 1's

placement, it was not logistically feasible for me to have these discussions with her in person. Additionally, 1 told me that she did not like video calling, and said that she would prefer to audio call. This again proved to be a barrier, as I was not able to fully gauge her response to the information. In hindsight, I would have made more of an effort to visit 1 in person to deliver this news, to provide the opportunity for us to spend time together and to have a more in depth discussion where she may have felt more comfortable to ask questions.

The Court agreed with the recommendations I had made in the SWET, and an Interim Care Order and Deprivation of Liberty Order were made in respect of 1. Some of the restrictions included in the DoLS were locks on the doors and windows, staff being able to carry out searches on 1 if they had reason to believe she was concealing a dangerous item from them, and removal on 1's bed sheets and pillow cases, as she had previously used these as ligatures. 1 was not happy that the restrictions had to be put in place, however I made efforts to explain to her that it was for her safety. Despite having restrictions in place over her liberty, I sought ways to ensure 1 felt listened to. 1 had expressed that she was feeling lonely in her new placement and was struggling to settle in. Her placement at the time was in a sizeable urban town (Local Authority Y), close to a city, which was a great contrast from the small rural town that 1 had lived in her entire life. Furthermore, Local Authority X had a primarily White population. According to the 2021 census, whilst Local Authority Y was predominantly White, 46.5% of the population belonged to Black and Minority Ethnic groups. 1 had raised that some of the staff at her placement spoke to each other in their own language, which made her feel paranoid as she did not know what was being discussed. I addressed this with the manager of the home promptly, asking that staff could ensure they spoke in English when 1 was present, to decrease her anxiety over what conversations were being had. Additionally, I asked 1 what would help her to feel more comfortable in the placement. She told me that she missed having her pet rabbit with her, who had been a source of comfort to her whilst she was living with her grandparents. Following discussions with management and grandparents around logistics, it was agreed that 1's rabbit would be transported to her on the next statutory visit. This subsequently had a positive impact on 1's mood and general wellbeing.

The culmination of my involvement with 1 was the creation of her Care and Support Pathway Plan (Children Act 1989). This plan was created in conjunction with 1, and was written from her perspective, in order to keep her voice and views as central. I found writing the plan from 1's viewpoint an impactful and thought-provoking process, particularly given everything that had happened in recent months. It required me to put myself in 1's shoes, which gave me greater insight into what she may have been feeling during this time. The plan was modelled on a Signs of Safety approach, to identify what was working well, what the ongoing worries were and what we would like to see happen for 1, in relation to her ongoing health, developmental, educational and wellbeing needs. On reflection, I feel that writing 1's Pathway Plan earlier would have been beneficial as it would have given me a greater understanding and awareness of what 1's lived experience was like, and how this might be influencing her actions. Shortly after the Court Hearing, 1 transferred to one of the long-term childcare teams for continued support and monitoring under her Pathway Plan.

In summary, this case provided me with a great deal of learning and experience. It highlighted the tensions and conflicts around collaborative working, particularly when capacity is a factor,

and when the wishes of the child are contrary to what will keep them safe. It also required me to work collaboratively on a regular basis with all professionals involved in 1's care, including health services, education, staff at her placement and her independent reviewing officer. The demands of trying to keep 1 safe and find ways to engage with her required me to regularly utilise formal and informal supervision to critically analyse and reflect upon what would be in her best interests, whilst managing my own anxieties, preconceptions and frustrations. Ultimately, I feel that working with 1 for this period of time enabled me to grow in confidence around exercising my own professional judgment in complex situations, and in my own practice as a social worker.

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