



**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).

This case study presents a critical reflection on an assessment I undertook as a social worker in an Adult's services team. The case study will demonstrate legislation such as Social Services and Well-being (Wales) Act 2014, Mental Capacity Act 2005, Human Rights Act 1998, Equality Act 2010, Well-being of Future Generations (Wales) Act 2015, United Nations Convention on the Rights of Persons with Disabilities 2006, United Nations Convention on the Rights of Older People 1991 and Data Protection 2018. As well as key policy and procedural frameworks such as Wales Safeguarding Procedures 2019, Working Together to Safeguard People 2019, Discharge to Recover and Assess model 2021, Social Care Wales Code of Practice 2017 and National Action Plan to Prevent Abuse of Older People 2022.

The case will also demonstrate how I applied analysis during the assessment process to inform interventions, worked collaboratively with individuals and professionals, and applied my professional judgement to navigate a complex situation. It will also demonstrate the interface between health and social care in Wales particularly the financial and structural pressures will be critically explored throughout. It will critically examine the tensions and conflicts including autonomy v protection, resource constraints v quality of care, among others. The case will also draw upon the use of systems theory, trauma-informed practice and the person-centred approach.

The focus of the intervention was an adult (referred to here as 1) who had spent a period in hospital and had now been assessed by the hospital as medically fit for discharge. As 1 was receiving support via a care package prior to their admission to hospital, the hospital referred 1 to the Social Work team for an assessment for care and support needs under Pathway 1 of The Discharge to Recover and Assess model (Wales) (Welsh Government, 2021). To apply analysis in my assessment and inform my interventions, I approached the assessment using a strengths-based and person-centred framework, underpinned by the Social Services and Well-being (Wales) Act 2014. This required me to consider all aspects of 1's well-being, and their environment. This allowed to gain an understanding of 1's strengths, needs and what matters to them under Social Services and Well-being (Wales) Act 2014 part 3, to agree a plan which meets their personal outcomes (Welsh

Government, 2014a). I drew upon system's theory to consider how psychological trauma, resources, and individual agency could work together to reduce risk (Payne, 2014).

Upon my assessment, while it was deemed that 1 met the threshold for care and support under Part 4 of the Social Service and Well-being (Wales) Act 2014 in order to meet his personal outcomes, it became clear that discharge was not straight forward. 1 disclosed that they were fearful of sleeping in the bed at home, and had previously been sleeping in their wheelchair, and they were planning to continue this upon discharge home. Despite being physically ready to be discharged, 1's psychological and physical needs, and how they were going to meet them, raised concerns. 1 was diabetic and had been experiencing leg ulcers and pressure sores prior to admission. While the leg ulcers had healed, 1 was still experiencing pressure sores, and this behaviour presented ongoing health concerns. These behaviours were indicators of self-neglect and highlighted the need for a complex and collaborative discharge planning process.

Self-neglect is a particularly complex area of adult safeguarding, involving an adult's inability or unwillingness to care for their own basic needs – including hygiene, nutrition and housing. The challenge with self-neglect lies in the tension between respecting an individual's autonomy and the duty of care from professionals. Unlike other forms of abuse, such as physical, emotional, sexual, financial and psychological abuse, there is no harmful action caused by another individual, and decisions around intervention need to carefully balance the adult's capacity to make informed choices with concerns for their safety and well-being (Braye, Orr and Shoot, 2011). This makes self-neglect a uniquely nuanced and ethically challenging issue within adult safeguarding.

The situation with 1 required my full understanding of and compliance with several interrelated legislative duties. Central to my intervention was the Social Services and Well-being (Wales) Act 2014, particularly Part 7, which governs adult protection and safeguarding, and defines the local authority's duty to make enquiries where an adult is at risk (Welsh Government, 2014b). Under Section 126, I had a duty to ensure that 1 was not placed back into an environment that could reasonably be considered to cause harm or neglect.

It was highlighted by hospital staff that 1 had been sleeping in the bed while in hospital. However, during assessment 1 was able to engage with questions and explain that as they were unable to transfer independently, at home, they felt confined to the bed. 1 expressed frustration of long wait times between care package calls and a sense of loss of independence and control. 1 felt that there was nothing that could improve the situation for them as this had become an internalised fear. Reflecting on my assessment, I realised that although my main concern was 1's physical well-being and the risk of deterioration of the pressure sores, their main concern was the psychological fear, and this needed to be addressed in order for 1 to feel in control.

During my assessment, I considered the Mental Capacity Act 2005 and carried out an assessment of 1's decision-making ability in regard to their sleeping arrangements. 1 was able to understand the risks and concerns, could weigh them up and consistently communicate their reasoning. These are points stated in the Mental Capacity Act 2005 Code of Practice to consider when assessing an individual's ability to make a decision (Department of Health, 2007). 1 was assessed as having capacity. Legally, this meant they had the right to make the decision regarding their sleeping arrangements, even if professionals or others disagreed with this decision. However, guidance on self-neglect makes it clear that having capacity does not preclude safeguarding intervention if there is evidence of serious harm or potential deterioration (Welsh Government, 2024). This presented an ethical tension between respecting autonomy and acting to prevent further harm.

Although 1 was found to have capacity under the Mental Capacity Act 2005, this did not mean I could simply step back. The Social Care Wales Code of Professional Practice for Social Care Workers (2017) requires social workers to challenge unsafe practices, promote the well-being of individuals, and act in a way that upholds rights and safety. This includes a duty to act when someone, even with capacity, is at risk. If 1 had been assessed as lacking capacity to make the decision, the Mental Capacity Act would have guided my actions. I would have initiated a Best Interest Decision-Making process. I would have consulted with family and friends and involved an Independent Mental Capacity Advocate if needed, to ensure that 1's voice remained central throughout. The Local Authority also have a designated Adult's Safeguarding Team which I could have referred to at any point in my

involvement if I felt that the risk could not be managed by the individuals and professionals within the support network.

The Code of Practice for the Mental Capacity Act 2005 emphasises that best interest decisions must consider not just physical welfare, but also emotional, psychological, and cultural factors. In a reflective sense, the best interest process is not just procedural—it is deeply ethical and relational, reinforcing the importance of voice, even when it cannot be directly expressed (Department for Health, 2007). It may also have been required to consider a Deprivation of Liberty Safeguards Order and a referral to the Court of Protection.

Research from serious adult reviews (Braye et al., 2015) has consistently shown that professionals sometimes withdraw from intervening when capacity is present. However, I was determined to avoid this and allow 1 to become another adult not protected appropriately. I drew on trauma-informed practice principles (Sweeney et al., 2018) recognising that 1's fear of the bed may stem from past experiences.

During supervision with my line manager, we discussed the case in depth and considered whether an Adult at Risk referral, to instigate Section 126 enquiries under the Social Services and Well-being (Wales) Act 2014, was required. Again, as this case involves concerns around self-neglect, the safeguarding process is not clear, since self-neglect does not always meet the threshold of abuse or neglect as defined by the Act. Taking into account 1's personal outcomes and the fact they were assessed as having mental capacity, we concluded that a referral was not required at this time. We agreed that the risks could be appropriately managed through a robust care and support plan, with ongoing monitoring and review to prevent escalation. Had an Adult at Risk referral had been made, this would have instigated an Adult Protection Enquiry under section 126 of the Social Services and Well-being (Wales) Act 2014, to determine whether the individual was at risk and what actions would be necessary to prevent or reduce the harm. If the individual has been deemed to be at risk, a safeguarding plan would have been developed in partnership with the individual. If not, alternative support pathways or signposting to appropriate services could have been considered (Welsh Government, 2014b).

Working collaboratively, I arranged a care planning meeting with 1, myself as Social Worker, the Nurse and the Occupational Therapist. This meeting was a protective and empowering step to engage 1 in safer planning. The aim of the care planning meeting was to co-produce a care plan that addressed immediate risks while respecting 1's autonomy and preferences. The role here was not to force decisions but to build trust. The care planning meeting allowed 1 to make choices but also gave them the advice and guidance of professionals to reduce harm. It reflected the Making Safeguarding Personal approach promoted across Wales and the UK which centres the individual in decisions and ensured 1 remained an active participant in all discussions and decision-making (Local Government Association, 2020). The Wales Safeguarding Procedures 2019 provided a structured framework that guided my actions. It emphasised a multi-agency response to risk, and the case planning meeting was a direct application of this. I also applied the Working Together to Safeguard People 2019 guidance, particularly the emphasis on person-led and outcome-focused practice.

Person-centred practice, originating from Carl Rogers, underpinned my communication style—non-judgmental, empathetic, and empowering (Hall and Scragg, 2012). I reflected on how a strengths-based approach allowed 1's voice to guide the plan, reinforcing autonomy rather than focusing solely on deficits (Saleebey, 2006). During the care planning meeting, we jointly agreed that 1 would return home with a care package involving four calls a day, with the use of a pressure-relieving mattress and wheelchair pillow. The care and risk management plans were robust and included carers to encourage 1 to sleep in the bed and make a recording of the choice. A district nurse was also scheduled to monitor and treat the pressure sores. We also discussed various strategies to support this, such as changing the layout of the bedroom.

However, the care package was delayed due to provider availability, which is a common theme in this line of practice. Meanwhile, the hospital continued to urge discharge. This placed me in the challenging position of defending the plan while resisting the discharge that would place 1 at potential risk. To do this, I utilised the safeguarding rationale and my legal obligation under Social Service and Well-being (Wales) Act 2014, which

requires that no adult be placed knowingly in a harmful situation without appropriate mitigation (Welsh Government, 2014).

As hospital staff are under immense pressure to free beds and avoid delayed discharge costs, I encountered significant resistance when advocating for a delay in discharge until a care package was available. These institutional tensions prompted me to reflect on the moral positioning of social work within multi-disciplinary teams. I was reminded of Parton's (2014) argument that social work must maintain a counterbalance to managerial and medical logics, insisting on values of care, dignity and justice, even when they run contrary to systemic pressures.

Collaborative working with medical staff is often not without disagreement. Power imbalances are clear – hospital staff operate within a tight clinical framework and my role as a social worker can at times require a longer-term view. This requires persistence, effective communication and careful challenging. I reflected afterwards that collaboration does not mean holding the same views and agreeing. Sometimes, maintaining collaborative relationships means communicating clearly and advocating assertively for the best interest of the individual (Whittington, Leiba and Weinstein, 2003).

Critically reflecting on my own position, I acknowledged the discomfort of holding a dissenting voice within a pressured discharge team. However, I returned to the professional code of ethics which requires social workers to promote the well-being of individuals and challenge structures that threaten it (British Association of Social Workers, 2021). I documented my concerns robustly, and ensured any decisions made were ethically defensible, legally compliant and evidence by my research, legislation and policies.

It also required me to navigate the interface between social care policy in Wales and the broader UK/EU law and policy. Social Care in Wales is devolved to Welsh Government and adopts a distinct social model of disability and care. The Social Services and Well-being (Wales) Act 2014 is the overarching legislation in Wales and requires Local Authorities to consider and uphold the principles of the United Nations Convention of Older People 1991, placing emphasis on well-being, rights and participation (Welsh Government, 2022a). It places duties on practitioners to prevent the escalation of need and to involve individuals in decisions which affect their lives. The Well-being of Future Generations (Wales) Act 2015 also places long-term outcomes and citizen involvement at the centre. In contrast, the pressure from the hospital to free up beds reflected a medical model and a target-driven, managerial approach where efficiency and clinical outcomes were prioritised.

Additionally, I considered the UN Convention on the Rights of Persons with Disabilities 2006 and the UN Principles for Older Persons 1991, both of which promote autonomy, dignity, and participation. These values reflect a rights-based model which aligns with the Social Services and Well-being (Wales) Act 2014 and were instrumental in challenging the views of medical professionals.

The use of legislation in social work is a value-driven framework. The Social Services and Well-being (Wales) Act 2014 promotes voice, choice and control. Upholding these principles requires an understanding of ethics and the rights, laws and duties of individuals and practitioners. This shapes our thinking, practice and processes in which we follow, supports up to uphold professional standers and practice ethically. It also provides a shield of protection for practitioners who follow legislation and practice guidance and allows practitioners to work to protect individuals we work with (Madden, 2003).

During the assessment and care planning meeting, I was mindful of my duties under the Data Protection Act 2018 and UK General Data Protection Regulation when handling and sharing 1's personal information. These frameworks require that information is processed lawfully, fairly, and transparently, with particular emphasis on data minimisation and purpose limitation (UK Government, 2018). During multi-agency discussions—such as the care planning meeting—I ensured that only relevant information was shared, and that 1 was informed about how their data would be used, in line with the principle of transparency.

This case was representative of the kinds of complex, multi-layered situation that social workers increasingly face. It required continual application of professional judgement, particularly when navigating tension between autonomy and managing risk. 1's case was not unusual, many individuals with capacity choose unwise decisions. What made this case complex was the cumulative impact of risk, the potential for rapid deterioration, and the pressure of the clinical framework which were not conducive to a person-centred approach.

When applying my professional judgement, I used the Banks (2012) ethical decision-making model to work through the dilemma: Where were the ethical principles at play? What were the legal duties? Who might be harmed? What action respected the person's rights while preventing unnecessary suffering? Furthermore, I considered the broader implications of austerity and resource shortages. The Welsh Government (2022b) National Action Plan to Prevent Abuse of Older People highlights that self-neglect is now a dominant theme in adult safeguarding referrals. This wider policy context re-affirmed my decisions and helped me to conclude the least restrictive safeguarding-informed intervention was necessary. This allowed 1's wishes to be upheld and reduced harm.

I was also mindful of the Equality Act 2010, particularly in relation to 1's status as a disabled person. This places a duty on public services to not only avoid discrimination but also proactively remove barriers. 1's reduced mobility and diabetes constituted a disability under the Act, and therefore, any intervention had to ensure that reasonable adjustments were considered, including ensuring access to appropriate sleeping arrangements and care.

In navigating 1's case, I was continually aware of how structural inequalities can compound individual vulnerability. Anti-discriminatory and anti-oppressive practice are central to the British Association of Social Workers Code of Ethics (2021) and Social Care Wales Code of Professional Practice (2017) and were particularly relevant in understanding how 1's intersecting identities—older person, disabled, reliant on care—might affect their access to appropriate support. 1's reduced mobility and underlying health conditions meant that any failure to provide timely, person-centred support—such as adequate care packages or pressure-relieving equipment—could amount to indirect discrimination.

Additionally, I considered how the intersection of ageism and ableism might influence how 1's needs were interpreted by professionals. At times, there was a risk that staff framed 1's decisions as irrational or overly dependent. However, drawing on critical social work theory (Dominelli, 2002), I was able to reframe these perceptions to reflect trauma, systemic constraints, and valid expressions of autonomy. Embedding anti-discriminatory practice required me to continually challenge assumptions and ensure 1 was involved in all decisions. It also required me to act as an advocate—not just for an individual—but against broader systemic biases in care allocation and service delivery.

In supporting 1's right to make autonomous decisions while safeguarding against potential harm, I was guided by key human rights frameworks. The Human Rights Act 1998, particularly Article 8, protects the right to respect for private and family life. In 1's case, this included his right to decide how and where he sleeps, even if this decision appeared unwise. Equally, failing to plan a safe discharge with appropriate support could have risked breaching Article 3, which protects individuals from inhumane or degrading treatment. These rights were further reinforced by the United Nations Principles for Older Persons 1991, which emphasise the rights of older adults to autonomy, dignity, and participation—principles embedded in the Social Services and Well-being (Wales) Act 2014. Likewise, the UN Convention on the Rights of Persons with Disabilities 2006 upholds the right to make personal decisions and live independently (Article 19), as well as the right to privacy (Article 22). Together, these frameworks provided a strong ethical and legal foundation to advocate for a person-centred and rights-respecting intervention. They supported my decision to resist an unsafe discharge and to ensure that 1's wishes, well-being, and dignity were prioritised in line with social work values.

In applying a person-centred approach, I was also mindful of my duties under the Welsh Language (Wales) Measure 2011, which gives the Welsh language official status in Wales and upholds the principle that individuals should be able to access services in Welsh, if they so choose. As part of the assessment process with 1, I asked about their language preference, in line with the principle of "active offer" promoted by the Welsh Government and More Than Just Words framework (Welsh Government, 2012). While 1 chose to communicate in English, I recognised the importance of this enquiry as a key part of culturally sensitive, rights-based practice.

The Measure mandates that public bodies, including local authorities and health boards, ensure services are equally accessible in Welsh and English. Failing to consider this can lead to indirect discrimination and reduce service engagement, particularly among older Welsh speakers, who may feel more confident expressing complex thoughts and emotions in their first language. According to research by Williams (2013), individuals may experience reduced well-being and increased anxiety when forced to communicate about sensitive issues in a second language. Upholding language rights is not just a legal requirement but also an ethical component of dignity, identity, and accessibility. In line with the Social Services and Well-being (Wales) Act 2014, it supports the broader duty to promote well-being in all its forms—including cultural and linguistic identity.

This case has profoundly shaped my understanding of safeguarding in practice, especially in the context of complex decision-making, autonomy, and systemic pressures. One of the most significant lessons was the importance of balancing rights and risk in a nuanced, ethically informed way. Although legal frameworks like the Mental Capacity Act 2005 and Social Services and Well-being (Wales) Act 2014 provide procedural clarity, they do not remove the ethical complexity involved in real-world decisions. Going forward, I will pay greater attention to how power operates in assessment and intervention processes, ensuring I remain critically reflexive about both my own position and the wider systemic influences on practice (Turney and Ruch, 2018).

This case also highlighted how critical it is to listen deeply and compassionately to people's experiences, even when their decisions might seem unwise to professionals. It reinforced the value of trauma-informed practice and the importance of recognising behaviour as a form of communication (Sweeney et al., 2018). In future practice, I will continue to incorporate a person-centred and strengths-based lens in my assessments, focusing on co-production and working with people (Tew, 2011).

Moreover, the challenges I encountered working within a pressured multidisciplinary team helped me develop professional resilience and reinforced the need to be confident in challenging decisions that conflict with ethical or legal responsibilities. The experience validated Banks' (2012) idea that ethical social work requires moral courage and the willingness to dissent and advocate even when it's professionally uncomfortable. I will bring this assertiveness into future multi-agency settings, using evidence, values, and legislation to challenge unsafe decisions or systemic bias.

I also developed a deeper appreciation for the importance of supervision and reflective practice as a space to process emotions, manage ethical uncertainty, and enhance decision-making (Morrison, 2007; Wilkins, Whittaker and Grant, 2017). I now understand that safeguarding practice cannot be sustained without emotional processing and critical dialogue. Discussions with colleagues were a vital source of support while working on this case to offer mentorship and support to encourage personal and professional growth.

Another key learning area was around anti-discriminatory and anti-oppressive practice. The subtle ageist and ableist assumptions evident in this case made me more aware of how such biases can influence risk assessments and decision-making. Reflecting on Dominelli's (2009) and Dalrymple and Burke's (2019) work, I will now be more

intentional in challenging professional assumptions and ensuring my practice considers how intersecting identities and structural inequalities shape the lives of those I support.

Finally, engaging with Welsh legislation and policy has deepened my understanding of what it means to work within a devolved context that prioritises well-being, rights, and long-term outcomes (Welsh Government, 2015). I am now more confident in using Welsh-specific legislation—such as the Well-being of Future Generations (Wales) Act 2015—as a foundation for ethical and forward-thinking intervention. I will continue to use these frameworks to centre the person’s voice and resist medicalised or deficit-driven approaches

In conclusion, this case study has highlighted the dynamic and ethically challenging nature of safeguarding practice within adult social care in Wales. It critically reflects on how I navigated the interface between autonomy, protection, and systemic pressures while ensuring that the individual, 1, remained central to all decision-making. This was achieved through the application of person-centred, rights-based practice, grounded in robust legal and ethical frameworks such as the Social Services and Well-being (Wales) Act 2014, the Mental Capacity Act 2005, the Human Rights Act 1998, and the Equality Act 2010. What became clear is that social work in Wales operates within a rights-based framework, but still contends with the challenges of applying those principles in practice amid institutional constraints, such as resource scarcity and competing organisational priorities.

While much of my intervention centred on 1’s expressed fear and physical health needs, a deeper layer of complexity emerged around the emotional and psychological aspects of their experience. This reinforced the need for holistic safeguarding that considers not only the presence of risk but also the meaning behind behaviours that might be interpreted as “unwise”. Drawing on trauma-informed practice allowed me to reframe 1’s choices not as resistance or dependency but as an adaptive response to prior trauma, unmet needs, and powerlessness in care systems. This reflects the importance of seeing behaviour within context—something that legislation alone cannot achieve without the integration of theory and critical thinking.

My engagement with this case was also a reminder of the emotional labour inherent in safeguarding work. Advocating for a delayed discharge placed me in direct tension with medical colleagues who were driven by different imperatives. This called for emotional resilience and a firm grounding in the values and ethics of the profession. Holding a safeguarding position when others may be urging immediate action requires confidence, clarity, and often discomfort. But this is where social workers must uphold the profession’s values and ethics.

In relation to diversity and anti-discriminatory practice, I was able to reflect more critically on the assumptions held by some professionals regarding 1’s capacity, disability, and age. These moments prompted me to challenge ageist and ableist narratives and reaffirm the person’s right to participate meaningfully in planning—even when their decisions do not align with professional expectations. The Equality Act 2010 provided a legal foundation, but critical theory and reflective supervision were vital in helping me notice how implicit bias could influence decision-making in subtle ways.

Importantly, this case underscored the significance of Welsh policy frameworks that promote well-being, prevention, and participation. The Social Services and Well-being (Wales) Act 2014, alongside the Well-being of Future Generations (Wales) Act 2015, offered a framework for long-term, values-led intervention that felt distinctly different from the more medicalised approaches often found elsewhere in the UK. This distinction is one I became increasingly conscious of through this work—and proud to uphold.

Ultimately, safeguarding is a relational, ethical, and political process. This case reminded me that good social work is not just about ticking legal boxes—it's about standing with people in complex situations, negotiating power, and applying professional judgment with compassion and clarity. It is about walking the line between risk and autonomy and doing so in a way that is ethically robust, rights-focused, and led by the voices of the individuals in need of support.

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