



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

**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).*

This essay will be critically reflecting on a case study of an assessment that I conducted with an adult service user with safeguarding concerns. The essay will begin by discussing background information about the service user and their situation and the assessment that was done with the service user. It will then go on to discuss relevant safeguarding legislation, domestic and international legislation, strategies, policies and local safeguarding boards. The essay will discuss different theories and approaches that were used and are relevant to this case and what were the complexities and professional judgements in the case. The essay will conclude by reflecting on my practice and analysing what went well and how I can improve future practice.

For the purpose of this essay the service user discussed throughout this case study will be referred to as '2' and this is to make sure that their identity is kept confidential and protected in line with the Code of Professional Practice for Social Care Wales, (2017).

2 is a middle aged white male who has lived in a coastal town for a number of years after moving to Wales from England when he was a teenager and is English speaking only. 2 was diagnosed with learning difficulties when he was younger and is now hard of hearing so is advised to wear a hearing aid. In the past eighteen months 2 lost both his elderly parents, which was a big shock to him and would take him time to adjust to all the change. He was heavy reliant on his parents all his life as 2 has limited independent living skills. The home he had been living in for the past few decades had to be sold which left him without a home and his extended family had grave concerns of him being able to live independently. This was when 2 was referred into service for extra support and was open to myself. 2 moved

into 24 hour supported accommodation in the coastal town he had resided in most of his life. The town has very good transport links and all local amenities are within walking distance to him. The accommodation provided him with food, advice and guidance and a care and support plan supporting him with independent living skills.

2 received an inheritance after his parents passed away and he was unemployed due to having enough money to live off. Although 2 lives with other service users with differing needs and has friends and family living locally he still states that he is lonely and that he craves companionship. His nearest relative is his brother who work abroad and his brother is also his lasting power of attorney (2007) overlooking his finances and if needed any health decisions required on 2s behalf

The Social Services and Wellbeing (Wales) Act (2014) (SSWBA) is the legislation in Wales that all local authorities adhere and follow if there are any safeguarding concerns raised. The SSWBA (2014) defines what an 'adult at risk' under section 7 of the act and then goes on to define what abuse is under section 10 of SSWBA (2014). The use of 'at risk' of abuse means that it can be reported before abuse happens to ensure that practitioners adopts and early intervention form of working. The introduction of the Wales Safeguarding Procedure (2020) (WSP) supports practitioner to implement the SSWBA (2014) legislation and give clear guidance to practitioners and make them understand their roles and responsibilities (Safeguarding.wales 2020). The WSP (2020) identifies other safeguarding legislations and guidance and includes the statutory safeguarding guidance 'Working Together to Safeguard People' (2022). The 'Working Together to Safeguard People' (2022) is the code of safeguarding practice that the Welsh Government expects everyone to follow and what are the safeguarding arrangements.

Compared to the SSWBA 2014 definition of 'adult at risk' and other countries interpretations are different to Wales. For example in the United States of America (USA) in some states they define adult at risk as 'protections are available to any "disabled", "dependant", "incapacitated" or "vulnerable" adult, without regard to age' (Montgomery et. al, 2016) and this varies from state to state of how they implement it. This differs from SSWBA 2014 which states and adult which experiencing or is at risk of abuse of neglect and had needs for care and support which focuses on every adult not ones that fall into certain categories. In Australia they don't use any definition of an adult at risk and there is no national legal and policy basis (Montgomery et. al, 2016) and it differs from each state to the information that they provide.

After a period of settling in for 2 in his new supported accommodation it was decided mutually that he would be closed to our services as his needs were being met by the accommodation provider. A few months later the safeguarding team in the local authority received an adult at risk report about 2 and that he had been a victim of online fraud. It was decided in the multi-agency safeguarding hub (MASH) who screen the safeguarding reports that it did not meet the adult at risk threshold and was advised that 2 was reopened to the team and myself to complete some online safety work and monitoring. Article 8 of the Human Rights Act (1998) (HRA) states 'guarantees the right to private life, family life and a home life' which has to be considered in 2's case and the best course of action to safeguard

him. MASH were satisfied that all the risk reducing procedures had been followed by the supported accommodation reporting it to the police and making an adult at risk referral and myself completing some education work around online safety and online fraud.

When I restarted supporting 2 I completed an integrated assessment collaboratively with him, his supported accommodation support worker and speaking with his brother after gaining consent from 2. As I knew 2 could only speak English and could not converse or understand the Welsh language I still gave him the active offer which is the offer of a service in the Welsh language without the service user having to ask for it (gov.uk, 2017). The Welsh Active Offer is in line with the Welsh Language Measure (2011) which ensure that the Welsh language is not treated less favourably than any other language. To support with the active offer it is supported by the Welsh government 'More Than Just Words' strategic framework that promotes the Welsh language in health and social care (Gov.wales, 2012).

When I visited 2 for the first time since the referral I completed a 'What's matter conversation' with him in line with part 2 of the SSWBA (2014) to establish what support he felt he wanted and to gather his wishes and feelings. The assessment was done over three sessions with 2 to allow him time to share his story and information and for me to complete some online safety work with him. Parker (2013) discusses that assessment all follow a similar pattern which include; preparation and planning, data collection and creating perspective, preliminary analysis and interpretation of data, deeper analysis after testing data and then a construction of an action plan. I ensured that I took a person centred approach especially on the last point of creating an action plan or a care and support plan. This ensured that I was working alongside 2 and making decisions collaboratively and not on their behalf and that they had control of the care and support plan (beesly, et. Al., 2017). I was satisfied after the online safety work in my professional opinion that 2 was able to spot any red flags when he was on the dating websites and for him not to share any personal information.

Having a robust assessment with 2 was key in finding out what his care and support needs he had and how we move forward in supporting 2 and what interventions would be best placed for him. In the actual assessment I used the questioning model (Smale et.al., 1993) which allowed a conversation between the both of us with me asking open and closed questions and allowed me to use observation and active listening skills. By using this model it allowed 2 to have his say about the current situation and build a rapport between the both of us. I also adopted the aspire model by Sutton (1999) to fit the assessment into the social work process which looks at 4 different stages in a cycle which is assessment, planning, intervention and review. By using these two models when assessing 2 allowed me to collect the information and the use my professional judgement if 2 had care and support needs and as 2 did what would be the best intervention for him.

A few weeks after 2 being reopened to myself and engaging well the safeguarding team in the local authority received another adult at risk referral about 2 potentially being a victim of online fraud for the second time. There were concerns that he had shared personal details with a person on a dating website. The support workers had notified the Police and a Police Community Support Officer (PCSO) was going to visit 2 to do some more education work

with him. I was invited to the MASH meeting which included the police and the safeguarding officers to discuss 2's case and trying to manage the risks. By working collaboratively with the police and the safeguarding team we were able to share knowledge and gain more information about the situation and what were the next necessary step to support 2 (Whittington et al., 2003). It was decided that I would undertake a section 126 enquiry with 2 in line with the Local Authority policy and the SSWBA (2014). A recommendation was to set up a Multi-disciplinary meeting with all professionals involved to share their concerns and to share any potential risks (Koubel and Bungay, 2012).

I undertook the s126 enquiry with 2 within the legal time frame of 7 working days at his home with his support worker who he wanted present and of which 2 had decided on the location, this was to make sure he had control and a voice (Socialcare.wales, 2017). The enquiry brought up a few concerns when speaking with 2 and I questioned if 2 had capacity to identify people on the dating websites who were taking advantage of him due to their online profile picture and what they were saying and keeping himself safe online. I questioned his capacity around looking after his finances safely due to him disclosing he had sent money via gift cards to the perpetrators after receiving an obviously fake official letter wanting money. With this information I presented it to the safeguarding lead officer which was overseeing the case. The safeguarding lead is the single point of contact of which the information is shared with this is to ensure that there is no confusion with the investigation (xxx safeguarding board, 2020).

It was decided that adult at risk threshold was again not met as he was not in any immediate threat and safeguarding measure could be put in place to safeguard 2. The safeguarding lead felt as though the risks could be managed in an MDT arena with all the appropriate professionals involved in 2's case in the meeting (xxx safeguarding board, 2020).

The MDT was booked a couple of days after the determination of what the local authority had decided. Involved in the MDT was myself chairing the meeting, a local PCSO, a social worker from the MASH team, a local authority solicitor, 2's support worker and manager of the supported accommodation he was residing at. I visited 2 and explain the decision of the adult at risk referral and that I was arranging an MDT meeting. I asked if he wanted to be part of the MDT meeting but he declined because of how many professionals that were involved and he felt to overwhelmed with so many professionals attending the meeting. This made me reflect on the power-imbalance and the barrier that it created from him being involved and being able to share his voice. It is important that the victim is felt empowered and listening to their voice (Koubal, 2016) which intertwines with Article 2 of the HRA (1998). I offered an advocate and explained the role of an advocate and how they were independent but he declined as he felt that I and the support staff could advocate on his behalf and feedback to him after the meeting. There is a risk for 2 to feel oppressed by the whole process with so many professionals involved and everyone saying what should happen and not consider 2's feeling helpless (Koubal, 2016).

As I was chairing the MDT meetings I again contemplated the power imbalances that might occur between professionals in the meeting. In previous meetings I had attended I had witnessed some professionals taking over the meeting and not listening to any other points

that was given by other professionals. I was keen to lay rules in the meeting and that there was non-hierarchical structure in the meeting and that everyone knew the rules about ensuring confidentiality and sharing information. (Koubal, 2016). To ensure this was in place I read the MDT terms and conditions and gave every professional involved the opportunity to share any risks or updates that they had.

The MDT was also an opportunity for all professionals involved with 2 to discuss any information or updates about 2 and to agree as a collective on any actions and who were tasked with actions. Being part of the MDT was vital for professionals to share information and knowledge and if they had any concerns which enabled everyone to take collaborative approach to supporting 2 and try to mitigate the risk (Petch, et. al., 2002). Having the MDT recorded by a minute taker allowed a record to be done of all concerns and information shared which then could be shared with all agencies involved and so 2 could have a copy to read and for him to have a say on what was discussed.

In the framework 'Working together to safeguard people' Volume 3 it focuses on Adult Practice Reviews (APR) and the criteria for this is in the 'Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015 (Gov.wales 2017). The APR focuses on having a positive culture in multi-agency working by learning about different complex cases and any future learnings of mistakes or good practices that have happened in the past (xxx Safeguarding board). In the MDT meetings that were happening regularly for 2 a safeguarding social worker attends which they share any practice learning of historic APR and suggests what is best to try and reduce and prevent any future risks. By considering other similar cases to 2's case it allows everyone to learn what the best intervention to take to try and prevent 2 being exploited in the future.

I was tasked with creating a risk assessment collaboratively with 2 and his support staff in the accommodation. I contacted his bank with 2's consent to notify them of what had happened and they put a marker on his account to spot and suspicious activity. I also cancelled his passport as he had shared a picture of it with the perpetrator and the supported accommodation was going to block his internet use as this was not something that they had to share as part of their license agreement. These actions were all discussed with 2 and his brother of which the two was in full agreement. As I had concerns with his mental capacity I was tasked with undertaking a capacity assessment around being able to keep himself safe online and his financial capacity about keeping his money safe.

The reason I completed the risk assessment with 2 was for him to try and understand the risk and the risky situation that he was placing himself in. I tried to make the risk assessment visually such as presenting pictures and making it as easy to understand by drawing on examples to do with his interest such as trains and vehicles. The purpose of this was to apply a strength based approach so he could relate more to the topic (scie.org.uk, no date). The risk assessment being completed collaboratively supported 2 to identify the risks in online dating and who he speaks to but also identifying how to try and keep himself safe. This was done in the most person centre way possible so he could voice his opinion in a safe environment and not feel as though he was being told what to do (beesly, et. Al., 2017). The process of completing the risk assessment did conflict my personal and professional

values as I acknowledged that 2 was lonely and was desperate to find companionship and that he was just trying to please the people he was meeting but I knew professionally that he struggled to keep himself safe online and was always at risk because of his trusting nature and would be vulnerable to be exploited. I reflected on how hard it was for 2 being lonely and that he just wanted some affection but knowing also that he wasn't able to do so without putting himself at risk.

I completed the mental capacity assessment in line with the Mental Capacity Act (MCA) (2005) which is intertwined with the SSWBA (2014) for safeguarding adults. When completing the capacity assessment I had to follow the MCA 2005 procedure and was guided by the Mental Capacity code of practice (2007). To start with I had to assume that 2 had capacity to make decisions. I had to consider the 2 stage test which is if they have an impairment of the brain and if the impairment mean that they are unable to make specific decision. As 2 had a learning difficulty I was able to move on to the second stage and assess whether he was able to understand relevant information, retain information, weigh up the information and communicate their decision. To make sure 2 had every opportunity to demonstrate the above it was completed over two sessions and was done with different techniques such as visually by showing videos and pictures thus making it as person centred and strength based as possible (beesly, et. Al., 2017). I had to keep in mind my assessment was thorough as it could be challenged by 2, his family and other professionals, so I had to keep in mind the HRA 1998 and the Equality Act (2010) and that I was not discriminating against 2.

For this Mental Capacity Assessment I used case law to support in my preparation. I studied the case of 'Re A (Capacity: Social Media and Internet Use: Best interest) [2019] EWCOP 2. The above case had a similar concern to what 2 was doing of which Judge Cobb ruled that that they should have limited time online. His judgment gave me insight into what questions I should be asking.

I deemed 2 not to have capacity in being able to keep himself safe online or managing his own finances. It was tough as I had to balance the risks and if 2 was making an unwise decisions or did not have the capacity in the areas I assessed and also keeping in mind how to keep 2 safe and not compromising his autonomy. I reflected on my professional opinion and the social work values and keeping in mind the Code of Professional Practice in regards to 2's independence. But I believed my professional judgement was correct not to deem him to have capacity and that I would be accountable for my decision. It was difficult to assess the risk as there is always an element of risk in whatever anyone does (Smeeton, 2020). After speaking with 2 about the decision that I had made about the assessment I explained that we had to have a best interest meeting of which 2 was ok after I explained the process and who would be attending of which he agreed to attend with a support worker. The best interest meeting happened via video call so his brother could be part of it of which included another team manager chairing the meeting, a local PCSO, a social worker from the MASH team, a local authority solicitor, 2, 2s support worker and his brother advocating on his behalf. The purpose of a best Interest meeting is to consider all aspect to make sure a decision is made in their best interest and have to consider four aspects which is ascertainable past and present wishes, beliefs and values, other factors and individual

would likely consider and views of others in line with MCA (2005). By considering the 4 it should support the process of making a decision and make sure it's in the most least restrictive way (Bramer, 2024). Everyone in the meeting was in agreement with the decision of 2 lacking capacity and agreed with the rational and my professional judgement. It was agreed for his brother to have access to his internet banking and also to sort out a pre-paid card for 2.

Systems theory takes into account that an individual network can be but under pressure when there is a change of circumstance, the change can put a lot of pressure on the system not working and a professional should be able to identify what is not working for the individual. Pincus and Minahan (1973) discussed how people and society work in three systems: informal system, formal system and public system. Pincus and Minahan (1973) developed their own framework for professionals that would support with resolving the problems and support the social worker to pin point the problem that was impacting the system. In the case of 2 the change agent system in the framework by Pincus and Minahan (1973) would see me as a local authority social worker, and would be looking at the client system which is 2. I could identify that there had been a lot of change in 2's system with his parents suddenly passing away and him moving to supported accommodation and wanting to find companionship. Then we focused on the target system with the desired outcome for him to stop sending money and personal details online to strangers and try and meet people in a safer way. Then lastly action system is the outcome of the assessment I did with 2, the capacity assessment and any intervention that was put in place to try and resolve the issue.

Strength based theory was used when supporting 2. Strength based theory is identifying that people can survive and overcome difficulties in their lives (Hutchinson, 2013), and focuses on the person having the ability to change. I felt that the strength based approach would work well with 2 as he was always willing to engage and discuss what he could do differently in the future. I decided to visit 2 more often and discuss what he wanted and what change he was willing to do. By using the strength based approach I was also able to use the 'Outcome Based Approach' where people are the experts in their own lives (Socialcare.wales, 2017). In the case of 2 we discussed that he was lonely and wanted to meet new people and possibly try and find a companion of which we could set a long term goal to get him on safer local dating websites or find local groups in the community of which he could join.

To conclude this case was quite a complex safeguarding case with a lot of developments happening in a short period of time. After completing the integrated assessment and capacity assessment and following the different legislations and framework we were able to safeguard 2 and make sure that we weren't breaking his autonomy. By listening to his views, wants and wishes (Socialcare.wales, 2017) and focusing on his strengths we were able to work together collaboratively with other agencies to make sure he was safeguarded but also look at alternatives in him finding companionship. By making use of supervision with my manager I was able to discuss the progress of the case, different theories and making sure that I'm following all the legislation and safeguarding frameworks. It ensured that my practice was person centred and that he always had voice and control throughout the process. I

will continue to try and improve on my assessment skills and develop more confidence in my professional decision making skills that I will be discussing regularly in supervision.

*Word Count: 4109*