Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Child Protection and Welfare Service

Name of service area:	Mid West
Name of provider:	Tusla
Type of inspection:	Focused CPNS
Date of inspection:	07 – 09 September 2021
Lead inspector:	Lorraine O'Reilly
Support inspector(s):	Sue Talbot Pauline Clarke Orohoe Niamh Greevy
Fieldwork ID	MON-0033950

About monitoring of child protection and welfare services

The Health Information and Quality Authority (the Authority) monitors services used by some of the most vulnerable children in the state. Monitoring provides assurance to the public that children are receiving a service that meets the requirements of quality standards. This process also seeks to ensure that the wellbeing, welfare and safety of children is promoted and protected. Monitoring also has an important role in driving continuous improvement so that children have better, safer services.

The Authority is authorised by the Minister for Children, Equality, Disability, Integration and Youth under section 8(1)(c) of the Health Act 2007, to monitor the quality of service provided by the Child and Family Agency to protect children and to promote the welfare of children.

The Authority monitors the performance of the Child and Family Agency against the *National Standards for the Protection and Welfare of Children* and advises the Minister for Children and Youth Affairs and the Child and Family Agency.

In order to promote quality and improve safety in the provision of child protection and welfare services, the Authority carries out inspections to:

- **assess** if the Child and Family Agency (the service provider) has all the elements in place to safeguard children and young people
- **seek assurances** from service providers that they are **safeguarding children** by reducing serious risks
- **provide** service providers with the **findings** of inspections so that service providers develop action plans to implement safety and quality improvements
- **inform** the public and **promote confidence** through the publication of the Authority's findings.

The Authority inspects services to see if the National Standards are met. Inspections can be announced or unannounced. This inspection report sets out the findings of a monitoring inspection against the following themes:

Theme 1: Child-centred Services	☐
Theme 2: Safe and Effective Services	☒
Theme 3: Leadership, Governance and Management	☒
Theme 4: Use of Resources	☐
Theme 5: Workforce	☐
Theme 6: Use of Information	☐

How we inspect

As part of this inspection, inspectors met with social work managers and staff. Inspectors observed practices and reviewed documentation such as children's files, policies and procedures and administrative records.

The key activities of this inspection involved:

- the analysis of data
- interview with the area manager
- focus group with two general managers
- focus group with five principal social workers including two child protection conference chairpersons
- focus group with social work team leaders
- focus group with social workers
- interview with child protection conference administration staff
- the review of local policies and procedures, minutes of various meetings, staff supervision files, audits and service plans
- observation of a child protection conference
- the review of 24 children's case files
- phone conversations with three parents
- phone conversation with one child

The aim of the inspection was to assess compliance with national standards the service delivered to children who are subject to a child protection case conference and whose names are entered onto the CPNS.

Acknowledgements

The Authority wishes to thank children and families that spoke with inspectors during the course of this inspection in addition to staff and managers of the service for their cooperation.

Profile of the child protection and welfare service

The Child and Family Agency

Child and family services in Ireland are delivered by a single dedicated State agency called the Child and Family Agency (Tusla), which is overseen by the Department of Children, Equality, Disability, Integration and Youth. The Child and Family Agency Act 2013 (Number 40 of 2013) established the Child and Family Agency with effect from 1 January 2014.

The Child and Family Agency has responsibility for a range of services, including:

- child welfare and protection services, including family support services
- existing Family Support Agency responsibilities
- existing National Educational Welfare Board responsibilities
- pre-school inspection services
- domestic, sexual and gender-based violence services.

Child and family services are organised into 17 service areas and are managed by area managers. The areas are grouped into four regions, each with a regional manager known as a service director. The service directors report to the chief operations officer, who is a member of the national management team.

Child protection and welfare services are inspected by HIQA in each of the 17 service areas.

Service area

The Mid-West is one of Tusla's 17 areas for the provision of local services. It has a population of 385,000 with 96,266 of these being children (2016 census data) which represents 25% of the total population. The Mid-West area comprises of three counties, Limerick, Clare and North Tipperary.

The area was under the direction of the service director for Tusla West, and was managed by an area manager. The child protection and welfare service was delivered by two general managers, one manager was responsible for child and family services and the second manager was responsible for performance support and both reported to the area manager. The child protection conference service was delivered by two principal social workers who reported to the general manager for performance support. Administration staff were employed to assist in the delivery of this service. Children listed on the child protection notification system (CPNS)

were case managed by five child protection and welfare teams spread across the three counties. These teams reported to the two principal social workers for the child protection and welfare teams, who in turn reported to the general manager of child and family services.

As per Children First (2017), when concerns of ongoing risk of significant harm are identified during the assessment and intervention with children and families, then Tusla is required to organise a Child Protection Conference (CPC). The scheduling of the CPC was undertaken by the duty and intake teams. Both the duty and intake team and the child protection team attended the initial case conference. The child protection and welfare team took over case management within five days of the initial CPC. In circumstances where a child had been identified as being at ongoing risk of significant harm through a CPC, their name was listed on the CPNS. There were 88 children listed on the CPNS at the time of the inspection. All children on the CPNS were allocated a social worker at the time of the inspection.

Based on the information provided by the area, there were 11 whole time equivalent vacancies of frontline social workers and one family support practitioner vacancy across the child protection and welfare teams at the time of the inspection. Three other social work posts were being filled temporarily by agency staff.

Compliance classifications

HIQA judges the service to be **compliant, substantially compliant or not-compliant** with the standards. These are defined as follows:

- **Compliant**: A judgment of compliant means the service is meeting or exceeding the standard and is delivering a high-quality service which is responsive to the needs of children.
- **Substantially compliant**: A judgment of substantially compliant means the service is mostly compliant with the standard but some additional action is required to be fully compliant. However, the service is one that protects children.
- **Not compliant:** a judgment of not compliant means the service has not complied with a standard and that considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of children using the service will be risk-rated red (high risk) and the inspector will identify the date by which the provider must comply. Where the non-compliance does not pose a significant risk to the safety, health and welfare of children using the service, it is risk-rated orange (moderate risk) and the provider must take action within a reasonable time frame to come into compliance.

In order to summarise inspection findings and to describe how well a service is doing, standards are grouped and reported under two dimensions:

1. Capacity and capability of the service:

This dimension describes standards related to the leadership and management of the service and how effective they are in ensuring that a good quality and safe service is being provided to children and families. It considers how people who work in the service are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

The quality and safety dimension relates to standards that govern how services should interact with children and ensure their safety. The standards include consideration of communication, safeguarding and responsiveness and look to ensure that children are safe and supported throughout their engagement with the service.

This inspection was carried out during the following times:

Date	Times of inspection	Inspector	Role
07 September 2021	0900 – 1700	Lorraine O'Reilly Sue Talbot Pauline Clarke Orohoe Niamh Greevy	Lead Inspector Support Inspector Support Inspector Support Inspector
08 September 2021	0900 – 1700	Lorraine O'Reilly Sue Talbot Pauline Clarke Orohoe Niamh Greevy	Lead Inspector Support Inspector Support Inspector Support Inspector
09 September 2021	0900 - 1615	Lorraine O'Reilly Sue Talbot Pauline Clarke Orohoe Niamh Greevy	Lead Inspector Support Inspector Support Inspector Support Inspector
16 September 2021	1000 – 1130	Lorraine O'Reilly	Lead Inspector

What children and parents told us about the service

Efforts were made by inspectors, in conjunction with the service area, to engage with children as part of this inspection. From what inspectors viewed, heard and observed, it was challenging for children to be involved in the child protection conference process. This was due to a number of reasons including the age of children and circumstances that children and families may have been experiencing at that point in time.

Parent's views were also sought and HIQA spoke with three parents about their experiences of the service provided to them and their children in line with the focus of this inspection. Parents shared positive experiences of the service provided to them and their children. With regard to what impact the conference had for their family, one parent said 'things are getting better'.

The three parents said that their views were sought and valued by social workers and the child protection conference chairperson. One parent told inspectors that their social worker had 'gone above and beyond', while another said 'they have been fantastic, their team leader too'. They spoke about social workers preparing them for meetings, informing them about who would be there and what would be discussed. They also told inspectors that social workers met with children on their own to get their views prior to the conference.

Parents described their experience of child protection conferences for inspectors. They told inspectors that conferences 'ran well', parents 'understood everything', 'we were able to get our points across' and 'the whole meeting was based around their (children's) safety'. One parent told inspectors that the conference 'was encouraging, it reinforced my confidence that they are there to help me'. Parents said they 'felt listened to' at the conferences and were 'happy with the way I was being talked to'.

Parents told inspectors that they received written minutes from child protection conferences and copies of the safety plans which promoted the safety and welfare of children. When asked if plans and actions made by the service were in the child's best interests, one parent stated 'absolutely 100%'.

Parents told inspectors that they were sent forms in the post by the conferencing service after they attended a conference to provide feedback about it. Inspectors reviewed 14 feedback forms completed by parents. While some parents preferred the teleconferences held during COVID-19, others preferred face-to-face meetings. Parents said they felt listened to and understood what needed to happen for their children.

Capacity and capability

Overall, the service had effective leadership, governance and management arrangements to provide a good quality service to children listed on the Child Protection Notification System (CPNS). The service performed its functions in line with relevant legislation, policies and standards. Governance systems were well-established and management implemented recommended actions from various audits and quality assurance reports. Inspectors found that the service was striving for best practice and had embedded a culture of openness and transparency which focussed on the needs of children. This ensured children received a good quality service. Furthermore, the service had systems in place to review and assess its effectiveness and to see how the service could be further improved upon for children and their families.

This inspection took place in what had been a challenging time nationally for social work teams and children and families engaging in the services due to both the risks and public health restrictions associated with the COVID-19 pandemic. In addition, Tusla had recently been the target of a major cyber-attack which had compromised their national child care information system (NCCIS) for several weeks prior to the inspection. In this context, HIQA acknowledges that services needed to adapt how they worked with children and families to ensure they continued to receive essential support to ensure safety. These issues, and how they were managed, were reviewed within the overall assessment of local governance.

The focus of this inspection was on children listed on the CPNS who were subject to a child protection safety plan and the aligned governance arrangements in place to ensure effective and timely service delivery to these children. As per Children First (2017), when concerns of ongoing risk of significant harm are identified during the assessment and intervention with children and families then Tusla is required to organise a Child Protection Conference (CPC). In circumstances where a child has been identified as being at ongoing risk of significant harm at a CPC, their name is listed on the Child Protection Notification System (CPNS). This meant that children on the list were closely monitored by the social work department to ensure they were safe and interventions were provided to children and families to reduce risks to children. Children who have child protection safety plans continue to live at home, unless it emerges that a child is at ongoing risk, or if the child protection plan is deemed not to be working. These cases may result in a decision to remove the child from the home. This inspection also reviewed children files, whose names had recently been made inactive on the CPNS, in the six months prior to the inspection. These children had been assessed as no longer being at risk of significant harm.

There was appropriate oversight of when children were deactivated from the CPNS. The general manager had completed an audit of all children deactivated on the CPNS from 2017-2019 in the months prior to the inspection. This was undertaken to develop the area's understanding and provide oversight of the primary reasons regarding decisions to deactivate children from the CPNS. The findings were that the most frequent reasons for deactivation were safety plans were achieved, children had been admitted to care or were in a private family placement. The service improvement action from this was to continue auditing deactivations every two years to track any trends/patterns emerging about reasons for deactivating children and what impact this has on children.

The CPNS comprised of a confidential list of children in the area who had been identified as being at ongoing risk of significant harm. Inspectors found that the CPNS list of the names of children was secure and well maintained in line with *Children First: National Guidance for the Protection and Welfare of Children* (2017). In line with policies and procedures, the entry of each child's name only occurred as a result of a decision made at a CPC that there was a risk of significant harm, leading to the need for a child protection safety plan. Harm was confined to physical, emotional, sexual abuse and neglect. The chairperson's administration staff had responsibility for maintaining and updating the CPNS at child protection conferences. There was a 'four eye' practice in place when the register was updated meaning that two staff members checked the information being put onto the register for quality assurance purposes.

The CPNS list was there to help a small group of relevant professionals to make decisions about the safety of a child and access was strictly confined to specific Tulsa staff. Should members of An Garda Síochána, out-of-hours general practitioners and hospital medical, social work or nursing staff require information from the CPNS, they could access this through the out-of-hours social work service. The area advised that the CPNS had not been accessed by external professionals in the twelve months prior to the inspection.

Inspectors noted that when a child was placed on the CPNS list, the abuse category could not be changed nor could more than one category of abuse be recorded on the register. This meant when one type of abuse was no longer a concern for the child but another type of abuse had emerged, the register could not accurately reflect the concern for the child. However, working practices meant that external professionals could access up-to-date information from the out-of-hours social work service when required.

The interim national guidelines on child protection case conferencing and the child protection notification system had not been subject to review at the time of the inspection and required updating by the Child and Family Agency, as a means of assuring quality and consistent practice. While this impacted on the consistency of the

service nationally, the area had effective local policies and procedures in place to guide staff, to ensure a timely service and to keep children on the CPNS safe.

The area had a comprehensive standard operating procedure which clearly outlined the procedures and practices for child protection conferences. It detailed the required actions from the point of requesting a child protection conference through to removing a child's name from the CPNS. Each task was assigned a person responsible, a timeframe for completing the task and also noted which national standard was associated with each task. For example, a social worker is responsible for requesting a conference within three days of completing an initial assessment and the area aimed to convene initial child protection conferences within 15 working days of completing the initial assessment. Another process was that the child protection safety planning form was sent to parents and professionals within seven days of the CPC. The area also invited the principal social worker to the third review conference for additional oversight of the process.

There were other areas of practice which required guidance from the national office. For example, when children listed on the CPNS went missing or it was suspected that they had left the country, the guidelines did not give any indication as to how long they remained on the CPNS. When this occurred, senior managers in this area sought advice from the national office regarding what action to take given the interim guidelines did not provide adequate information about what to do in this circumstance.

Governance arrangements were strong, clearly defined and provided assurance to senior managers that children on the CPNS were in receipt of a safe service. Organisational structures set out lines of authority and accountability and included local, regional and national levels of accountability, specific to individual roles and responsibilities. The area manager post had been vacant from December 2020 until July 2021 and the general managers of the service rotated taking responsibility for acting up in this position. Principal social workers said that this worked well for staff and frontline social work practice was not adversely impacted by this given the level of oversight and guidance provided by the general managers. The newly appointed area manager assumed position two months prior to the inspection and was very familiar with the area having worked there for several years. The area manager was assured about the quality of the service through well-established systems of oversight of the child protection conferencing service. These had been in place prior to the area manager assuming their role and included governance meetings, senior management meetings, complex case forums, staff supervision and informal communication.

There was effective oversight of the management of child protection case conferences for children on the CPNS. The area manager delegated conferencing duties to a general manager, two principal social workers who were independent child protection chairpersons and their administration team. The area manager delegated oversight of

the day-to-day implementation of child protection safety plans and monitoring of children listed on the CPNS to two principal social workers and their respective social work teams. Staff demonstrated their knowledge of legislation, policies and standards for the protection and welfare of children when talking with inspectors and this was reflected in practice. Where staff required additional support to fulfil their role, this was appropriately provided by managers in a timely manner to ensure children continued to receive a good quality and timely service.

The area had effective oversight that ensured conferences were held in a timely manner. Any delays in convening child protection conferences were recorded on a tracker. The tracker documented the date of the CPC request, the child's details, the date and time of the next scheduled conference, and the names of the allocated social worker, chair and administration staff for the CPC. There was commentary which noted the reasons for delays such as waiting for professionals to be available to attend or waiting on assessments to be completed. There were also special measures in place during COVID-19 which allowed the area to defer CPCs when it was safe to do so. The chairs told inspectors that this measure was never used for initial child protection case conferences and was only used when safety plans were efficient in ensuring children's safety and all professionals involved with the family were in agreement.

There were strategic and operational plans for the service which were aimed at delivering a good quality service. These plans took account of how to meet the needs of children and their families while also considering resources available such as external agencies, working in line with policies and standards and considering all information relevant to the provision of a safe service. The area manager had planned to review the area-wide service plan with senior managers in the weeks following the inspection. They told an inspector about their plans to expand the service improvement plan from 12 months to 18-24 months to align the new plan with Tusla's own corporate plan objectives and national service development plan.

There were several governance meetings in the area to provide assurance on the service delivered and to review the progress of actions set out to improve the quality of the service, including aspects of the service which were relevant to the theme of this inspection. For example, the general manager for performance support, CPC Chairs and administration staff met quarterly to discuss issues such as the roll-out of new forms, obtaining parents feedback and the maintenance of records. The CPC chairs and general manager met bi-monthly and had developed service improvement plans for the conferencing service. This involved liaising with key external stakeholders who worked with families who were engaged in neo-natal services, had experienced domestic violence or homelessness. The aim was to ensure that the CPC delivery provided an opportunity for children and parents to be facilitated with their advocates from external

agencies to participate in discussions at conference meetings, were supported to communicate their views and consulted during the development of safety plans.

The area manager convened twice monthly area senior management meetings in order to communicate and manage issues relevant to all teams across the service, such the strategy for service recovery from the recent cyber-attack and the management of risks to service delivery associated with COVID-19. Inspectors reviewed minutes of meetings and found standing agenda items associated to quality and risk management as well as the management of performance, HIQA briefings before and after inspections and the plan for recruiting more staff.

Complex case forums were used in the area to facilitate objective review of cases listed on the CPNS and to provide scrutiny of the effectiveness of child protection safety planning. Cases were referred into the forum for discussion by social workers and their team leaders where there were challenges and complexities which required objective review. Managers and social workers who spoke to inspectors said that these meetings were a strong mechanism for assurance and accountability in relation to practice and service delivery. Actions were agreed to ensure that appropriate measures were in place in response to risk posed to on the children on the CPNS in order to reduce the risk of harm and prevent drift in these cases.

The provision of formal supervision, as a method of providing assurance on the quality of service provided to children listed on the CPNS, was robust and effective. Inspectors reviewed case supervision notes on children's records which were up-to-date and clearly recorded with the actions required documented. Supervision between social work team leaders and principal social workers occurred in line with policy and actions arising from supervision were reviewed for progression. Discussion of cases was clearly recorded and there was evidence of continued professional development on records. General managers provided regular supervision to principal social workers and records were also of good quality. Since the area manager assumed post, two months prior to the inspection, they too had individual supervision sessions with each of the general managers, in line with the supervision policy. Given the level of supervision embedded throughout the service both at frontline and management levels, it was a robust method of ensuring a good quality service to children listed on the CPNS.

The area had systems in place to identify how improvements could be made to the service. For example, management reviewed national forms and procedures, identified where they were not child and family centred and provided feedback to the national office to try to improve these for families. National guidance stated that every child required an individual record of their conference. This meant that the parents of large sibling groups would receive several records of the same meeting. which could be overwhelming for parents. Arising from the area's review of these forms, the area decided to send a cover letter with the national forms which

explained the process of child protection conferences in a more user-friendly way.

Effective arrangements were in place to manage and learn from adverse events, complaints and serious concerns to ensure they are appropriately managed, actioned and to learn from what had occurred. Learnings from the monitoring and evaluation of the quality of the service provided to children on the CPNS was communicated to all staff effectively. Staff told inspectors that any learning from serious incidents, rapid reviews and complaints was shared with staff at all levels. Learning was shared at team meetings, peer support groups, practice intensive workshops and incident learning notices. For example, an incident learning notice was distributed to all staff and students about local processes which were implemented following a review of standard business processes and electronic forms relating to CPC's and CPC safety planning. Another example was inspectors found on children's records that there was good use of learning from incidents to review risk to children where there was resistance to change and also in relation to the impact of harm to children living with domestic violence. This meant that learning distributed to staff was used to improve service provision for children and their families.

There was good evidence of actions taken to improve the quality of the service provided to children on the CPNS. For example, the area had completed a profile of the children on the CPNS over the 12 months prior to the inspection. This highlighted that children on the CPNS were a very young and vulnerable group of children with almost 50% aged five years and under. It also noted that the majority of children are reviewed within the set timeframes. It also noted that while information such as ethnicity was not data routinely collected by national office, the general manager and chairpersons were keen to further explore such areas to enhance their knowledge of children listed on the CPNS.

Another example of actions taken to improve the quality of the service provided was the development of a quality and standards group in 2021 whose goals included increasing the focus on integration between quality assurance teams and social work teams. Other forums which demonstrated a drive for service improvement included the quality and standards group and a HIQA task group which convened before and after monitoring inspections. Briefings were also provided to all staff before and after inspections.

There was a strong culture where staff recognised the interdependency of each other's work and where appropriate information sharing was promoted. There were strong established working relationships and senior managers spoke about viewing their service as a whole area rather than just the area for which they had responsibility. Inspectors found that this led to the development of a collective thinking about what the service could offer children and their families. There was good information sharing through various forums. This was evidenced in management and governance meetings

minutes, practice intensive workshops and from discussions with the senior management team and social workers throughout the inspection.

The area also had a good relationship with An Garda Síochána who senior management met with four times per year. Examples of good management in cases between the two agencies was noted in minutes of meetings reviewed by inspectors. It was recorded that in those particular cases, children received the required urgent yet strong coordinated approach to keep them safe.

The service was monitored on a regular basis to identify and mitigate potential risks to the safety, protection and welfare of children. As already discussed, managers escalated issues to national office for guidance and to provide feedback to ensure best practice was promoted for children and their families. There was a risk register which was reviewed regularly and quarterly risk and service improvement reports were completed. There were staff vacancies in the area, however, the area mitigated against this risk for children on the CPNS by ensuring that all children listed on the CPNS had an allocated social worker. This ensured that children assessed as being at ongoing risk of significant harm received social work support to promote children's safety through adequate service provision.

The restrictions associated with COVID-19 had a significant impact on the delivery of the service in the area but these were managed well. Social workers engaged with children and families in alternative ways and there was an Interim Child Protection Conference Guidance which set out measures to mitigate against challenges in the facilitation of conferencing due to COVID-19. The area had access to appropriate technology to facilitate teleconferencing where appropriate. The area acknowledged the feedback from some parents about the conferences about their preference being to meet face-to-face. At the time of the inspection, 'hybrid' conferences were occurring. These facilitated the chairperson, administration staff, social worker, social work team leader and the parents to meet in the same room with professionals then joining the conference by phone. The area struggled to find office space which was big enough in their own buildings, however; they booked hotel rooms for conferences when bigger spaces were required to allow for social distancing.

In light of the cyber-attack in the months prior to the inspection, the area had adapted well to ensure risks were managed well and children on the CPNS continued to receive a service. For example, there were hand written notes recorded during this time and uploaded on children's files. Another example was the general manager for performance support, who reported to the area manager, created a manual CPNS register when the online register could not be accessed. The area took learning from the cyber-attack to mitigate against potential future risks. The area wanted to ensure information could be easily retrieved should the electronic system be inaccessible again. The area had decided to keep a hard copy of the most up-to-date child

protection conference record for each child. This meant that staff could easily access information about the child, be aware of the most current risks to their safety, know what the safety plan entailed and who was involved in supporting the child, in the absence of the electronic system.

Standard 3.1
The service performs its functions in accordance with relevant legislation, regulations, national policies and standards to protect children and promote their welfare.

There were governance structures in place at local, regional and national level to support the delivery of the CPNS service in line with the legislation and the standards. There were interim national guidelines on child protection case conferencing and the child protection notification systems but these had not been subject to review and required updating by the Child and Family Agency. While the area had local policies and procedures which mitigated against risks locally, the lack of review of national guidelines impacted on the consistency of the service delivered nationally.

Judgment: Substantially compliant

Standard 3.2
Children receive a child protection and welfare service, which has effective leadership, governance, and management arrangements with clear lines of accountability.

The service had effective leadership, governance and management arrangements. Management were strong in promoting service improvement and had created a culture of openness and transparency for all staff. Assurance mechanisms were robust. The area had strategic and operational plans in place.

Judgment: Compliant

Standard 3.3
The service has a system to review and assess the effectiveness and safety of child protection and welfare service provision and delivery.

There were risk management systems in place to ensure that any risks arising within the scope of this inspection would be reported on and managed. Management provided feedback to national office regarding issues as deemed necessary. There were effective systems in place to drive quality improvement.

Judgment: Compliant

Quality and safety

Inspectors found that children who were at risk of significant harm had child protection safety plans in place to protect and promote their welfare. Child protection conferences were scheduled in advance and were timely in reviewing child protection safety plans. Where there were delays, the reasons were recorded and safety plans for children were reviewed in the interim to ensure children remained safe. Child protection safety plans involved children and their families. Professionals and other support services who were supporting families worked together with social workers to form safety plans and safety networks for children.

There was good oversight in relation to the thresholds for the requirement of a child protection case conference. The two principal social workers managed requests for child protection conferencing from social workers and determined their suitability for conference. Inspectors found that there were good levels of consultation between the chairperson and social work staff and managers and cases reviewed by inspectors were appropriately referred for CPC. When requests were declined, the reasons were clearly recorded and the referring team, including their principal social worker, were informed of those reasons.

The service held timely initial child protection conferences for children who had been assessed by social workers as being at ongoing risk of significant harm. The service had a local policy in place which noted that the initial child protection conference should be convened within 15 working days from when the request for a conference was approved. Inspectors reviewed 16 children's records for the timeliness of the initial child protection conference and found that 12 children had their initial child protection conference held within three weeks. There were delays the remaining four children two of which had ICPCs scheduled within four weeks and a further two children scheduled within six weeks. Rationales for delays were clearly recorded and justified. Reasons for extending beyond the three weeks were recorded on children's files and referred to professionals not being available to attend and the complexity of children's needs. Other reasons for delays, included lack of availability of specific professionals involved with the family, children transferring to another area or court proceedings. This meant that all 16 children had their safety needs assessed in the most suitable way to their circumstances and child protection conferences happened in the most-timely manner to meet their individual needs.

Child protection case conference reviews were timely in the vast majority of cases reviewed by inspectors for that purpose. Inspectors saw this on children's records and were told by staff that CPC reviews were scheduled at the initial CPC which greatly assisted in ensuring they occurred within six months of the previous CPC. This meant

that families, their support network and professionals working with the family had plenty of notice about when the next conference would occur.

When children were no longer assessed as being at significant risk of harm, their status changed from active to inactive on the CPNS. Inspectors reviewed six inactive cases on the CPNS. Inspectors found that families were appropriately informed when children were no longer active on the CPNS and the reasons why this had been decided. The decision and rationale to make children inactive was also formally recorded on the child protection case conference record. Inspectors also reviewed three reactivated cases on the CPNS. The decisions which led to children becoming active again were documented on children's records. Reasons included safety plans not being effective and children's increased exposure to risk impacting on their safety.

Child protection conferences were held to formulate child protection safety plans where children were identified as being at significant risk of ongoing harm. The conferences were chaired by appropriately trained persons who were not directly involved in the assessment and management of the child protection cases. External agencies attendance at child protection case conferences was evident in all 24 files reviewed by inspectors which ensured a comprehensive assessment of children's needs.

Prior to the initial CPC, social workers met with children and parents on their views and to explain what would happen at the conference. Social workers said they routinely went through their assessment/case conference report and recommendations with parents in advance of the review case conferences. This was important in order to facilitate input from families and to strengthen collaboration practice between social workers and children and families. Inspectors found that these consultations were clearly recorded on children's records and were also recorded on parent feedback forms.

There was evidence of the representation of children's views found on most files reviewed by inspectors. In most cases, inspectors found the use child friendly tools, which were used as part of the national approach to practice, to help social workers engage and gather information in a child friendly way. There was evidence of direct work with children including observation of children over the course of multiple visits to elicit views of children less able to articulate their wishes.

Of the 24 children's records reviewed by inspectors, 10 children were five years old or younger and this meant it was a challenge to engage children in the conferencing process. Where children were too young or unable to express their views, social workers described what a typical day would look like for children and what their needs would be given their circumstances. The area had developed two child-friendly cartoon videos which explained safety planning and children's rights. Social workers

told inspectors that they showed children these videos and described them as useful. The service was keen to explore how children could be more active participants in conferencing and told inspectors about their efforts in seeking advice from colleagues in disability services to widen their skills when communicating with children with additional needs. Inspectors read on children's records that a multidisciplinary approach was used to communicate with children. For example, for two children, speech and language therapists provided advice to social workers.

Child protection case conferences held to formulate child protection safety plans were of good quality. Inspectors saw good recording in children's files as well as receiving positive feedback from staff. The detailed CPC records showed that the chair carefully facilitated conferences in order to maximise the involvement of parents, professionals and family members in determining the nature of the risk posed to children and the impact of harm to children. Inspectors found that CPCs were well attended by professionals from external services. Social work staff and managers told inspectors that the attendance of professionals at CPC conferences increased during the period when COVID-19 pandemic restrictions were in place when they could use teleconferencing rather than travelling to a meeting in person. The area planned to continue with this option for professionals going forward. Records showed that there was detailed discussion and the chair summarised and clearly communicated risks to parents and family. Past harm as well as current risks were discussed. Chairs ensured parents and children's views and concerns were heard while keeping the experience and impact for the children at the centre when discussing risks. Chairs clearly identified what needed to change to keep children safe with their families. An inspector observed a review CPC and heard clear discussions about what people were concerned about as well as what was working well for the family. Risks were openly discussed and an appropriate plan was put in place to maintain the child's safety. The chair clearly described the reasons for decisions made and provided everyone with the opportunity to contribute to the discussion.

Child protection safety plans were based on social work assessments of what children need and they involved the family and their support network. These plans were explained to children depending on their age and understanding. Social workers and parents told inspectors that parents and members of the support network received a copy of the plan after the child protection case conference. These were sent by registered post and should they be returned in the post to the office, social workers hand-delivered them to families. A child protection safety plan considered the child's immediate and long term needs. Decisions were clearly recorded in the child protection safety plan which identified roles, responsibilities, monitoring and review arrangements.

The development of comprehensive child protection safety plans was strong and centred around child-centred outcomes to effectively manage the impact of safety planning. They were recorded on standardised templates which provided a comprehensive record of each plan. The template prompted the social worker to reflect on key components of safety planning such as the identification of existing strengths and safety of the situation and the identification of short-term and long-term goals to be achieved to secure the protection and welfare of the child. Child protection safety plans were formulated at the CPC if possible. Otherwise, they were agreed after the CPC had occurred. When the plan was formulated following the CPC, it was developed with the family, the identified safety network and relevant professionals involved with the child.

Child protection safety plans were monitored, implemented and updated in the vast majority of children's records reviewed. The details of how plans would be monitored were discussed at CPCs in line with local policies, along with the frequency of social work visits and safety planning meetings. These details were dependent on children's individually assessed needs and this was clearly recorded on children's files. Of the 21 children's records reviewed for safety planning, 20 had good quality child protection safety plans which were reviewed and updated when required. In these cases, inspectors found that there was good multi-agency consultation between social workers and a vast range of services involved with children listed on the CPNS. This provided a level of assurance to social workers as to the safety and welfare of children utilising these service in the community. There were regular visits by social workers to monitor children and records showed that appropriate support and challenge was provided to families to ensure that child protection safety plans were adhered to. The timing of visits was carefully considered when other professionals were also visiting the family. There was timely response to rising risks in these cases and responsive actions were taken to protect and safeguard children. Managerial oversight was clearly recorded and there were evidence based decisions being made on the closure and or delisting of cases from the CPNS.

There was poor implementation and oversight of a safety plan for one child whose record was reviewed for this purpose. Social work visits had not occurred in line with the safety plan and the support network had not been active since the safety plan had been agreed six weeks prior to the inspection. Both of these actions had been further impacted upon by circumstances outside of the control of both the social worker and the family. Inspectors sought and were provided with satisfactory written assurances before the inspection ended. These assurances set out that the child would be visited by the social worker and their team leader during the week of the inspection, the safety plan would be reviewed and appropriate actions taken to ensure the child's safety. The poor finding on this case was an exception to the overall findings of the inspection. There was a delay in the case transferring from the duty and intake team

to the child protection and welfare team. The case transferred one month after the initial CPC which was not in line with local policy which stated that a transfer should occur within five days of the initial CPC. The general manager acknowledged the concerns relating to the case and told inspectors that the delay in transfer was due to staff being on leave following the initial CPC.

Where there were safety networks identified to support children and families, child protection safety planning meetings were used to monitor the implementation of child protection safety plans. Inspectors found that the recording and frequency of network meetings were of good quality. Safety plans were also reviewed and updated at child protection case conferences.

The service clearly supported and promoted interagency and inter-professional cooperation and input to ensure children's safety needs were met. Effective working relationships were noted, information was shared as required through meetings, letters and phone calls on a regular basis. Social workers told inspectors that working with other agencies 'happens all of the time' and inspectors found this clearly recorded on children's files. Good quality information was gathered from professionals in preparing to meet with families or following visits with families. This meant that social workers had a greater understanding of the child's needs which in turn meant that the child received interventions at the most appropriate time to meet their needs.

Standard 2.6
Children who are at risk of harm or neglect have child protection plans in place to protect and promote their welfare.

Child protection conferences were managed and facilitated. The timeliness of child protection case conferences was good and ensured reviews occurred as appropriate to the child's needs. Actions and bottom lines to keep children safe were clearly identified and the vast majority of safety plans were monitored and overseen as had been agreed at the conference. Decisions and judgments made to protect the safety and welfare of children listed on the CPNS were supported by strong analysis and assessment of potential harm and accumulative harm to children. Responsive decision making ensured that children's safety was prioritised by the service.

Judgment: Compliant

Standard 2.7 Children's protection plans and interventions are reviewed in line with requirements in Children First.
The area reviewed child protection safety plans and interventions in line with the requirements of Children First. There were good oversight and monitoring systems in place to track the timeliness of reviews. In instances where reviews were delayed, the rationale and managerial oversight was clearly recorded and it was assessed to be in the child's best interests. In such instances, all professionals were required to be in agreement that rescheduling reviews would not impact the child and that the safety plan in place was efficient in maintaining the child's safety.
Judgment: Compliant

Standard 2.9 Interagency and inter-professional cooperation supports and promotes the protection and welfare of children.
Inspectors found that the area had a strong working in partnership ethos with local agencies and commissioned services. There was a strategic approach towards partnership working and engagement between the service and external stakeholders in the area. Interagency working was found in all of the cases reviewed and it was evident that this was embedded strongly in the area.
Judgment: Compliant

Compliance Plan for Mid-West Child Protection and Welfare Service OSV – 0004401

Inspection ID: MON-0033950

Date of inspection: 07 September 2021

Introduction and instruction

This document sets out the standards where it has been assessed that the provider is not compliant with the National Standards for the Protection and Welfare of Children 2012 for Tusla Children and Family Services.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which Standard(s) the provider must take action on to comply.

Section 2 is the list of all standards where it has been assessed the provider is not compliant. Each standard is risk assessed as to the impact of the non-compliance on the safety, health and welfare of children using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider has generally met the requirements of the standard but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider has not complied with a standard and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of children using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of children using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Standard Heading	Judgment
Standard 3.1	**Substantially compliant**
Outline how you are going to come into compliance with Standard 3.1: The service performs its functions in accordance with relevant legislation, regulations, national policies and standards to protect children and promote their welfare. This Compliance Plan relates entirely Tusla's interim national guidelines for "Child Protection Conferences and the Child Protection Notification System", which is dated July, 2018, and was scheduled for "full review" in April, 2019, and is outstanding. This is an issue for Tusla at a national level and outside of the control of the Mid-West Area. A meeting between HIQA and Tusla at a national level is scheduled for 18/10/21 to consider and address this issue.	

Section 2:

Standards to be complied with

The provider must consider the details and risk rating of the following standards when completing the compliance plan in section 1. Where a standard has been risk rated red (high risk) the inspector has set out the date by which the provider must comply. Where a standard has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.
The provider has failed to comply with the following standards(s).

Standard	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Standard 3.1	The service performs its functions in accordance with relevant legislation, regulations, national policies and standards to protect children and promote their welfare.	Substantially Compliant	Yellow	