Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of Child Protection and Welfare Service.

Name of service provider:	Child and Family Agency
Name of network:	Kerry North Cork
Type of inspection:	Announced
Date of inspection:	12-15 May 2026
Service ID:	OSV-0009388
Fieldwork ID	MON-CPW-KNC-260512

About this inspection

The Health Information and Quality Authority (HIQA) 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 national 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 continual improvement so that children have access to better, safer services.

HIQA is authorised by the Minister for Children, Disability and Equality 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.

HIQA monitors the performance of the Child and Family Agency against the *National Standards for the Protection and Welfare of Children* (2012) and advises the Minister and the Child and Family Agency.

This inspection was a monitoring inspection of Kerry North Cork to monitor compliance with *the National Standards for the Protection and Welfare of Children*. The scope of the inspection included standards 2.2, 2.4, 3.3 and 4.1 of the *National Standards for the Protection and Welfare of Children*.

This inspection found that significant progress had been achieved by Kerry North Cork since the amalgamation of the area to include North Cork, and, while some improvements were required, no child was identified by HIQA inspectors as being at risk due to the improvements needing to be made by the service.

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
- review of local policies and procedures, minutes of various meetings and service plans
- observation of the integrated front door team
- observation of planning meeting
- observation of team meeting
- interview with business support staff
- interview with quality, risk and service improvement team
- focus group with two principal social workers
- focus group with four social work team leaders
- focus group with eight social workers and social care leaders
- review of 42 children's case files
- conversations with staff members.

The aim of the inspection was to assess compliance with national standards of the service delivered to children who are referred to the Child Protection and Welfare Social Work Service.

Acknowledgements
HIQA wishes to thank the staff and managers who spoke with inspectors during the course of this inspection.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the standards under three sections which are:

1. Views of people who use the service.
2. The dimension of capacity and capability.
3. The dimension of quality and safety.

The standards are organised for ease of reporting under each of these dimensions.

1. Views of people who use the service

This section of the report describes the experiences of children who have been supported by the service. It provides a summary of responses to the children's surveys received before or during the inspection, our interactions and conversations with children, families and staff, and our observations during focus groups and during the inspection.

It describes in general terms how children describe and talk about their daily lives, what the service is like and how the service provider and staff support them.

2. Capacity and capability of the provider to deliver a safe quality 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.

3. 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.

A full list of all standards and the dimension they are reported under can be seen at the end of this report.

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, Disability and Equality. 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 protection and welfare services
- educational welfare services
- psychological services
- alternative care
- family and locally-based community supports
- early years services.

Child and family services are organised into 30 networks and are managed by area managers. The networks are grouped into six regions, each with a regional manager known as a regional chief officer. The regional chief officers 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 30 networks.

Network
The information in this section of the report was provided by the service area for inclusion in the report.

Reform Programme
In January 2026, Tusla commenced operating through newly configured regional and network structures. This represents a significant period of organisational change, aimed at improving governance, strengthening service delivery, and ensuring more equitable allocation of resources across the regions.

A central component of this reform programme is the implementation of the Local Integrated Service Delivery (LISD) model, which supports a more coordinated and integrated approach to service provision. This includes the establishment of

Integrated Front Door (IFD) Services within each network to ensure that children and families can access the right service, at the right time, in the right place and by the right professional.

The Kerry North Cork Network forms part of Tusla's Southwest Region, which includes South Tipperary, Kerry and Cork. The Southwest Region is comprised of five networks: Cork Southwest, Cork Northwest, Cork East, Kerry North Cork and South Tipperary North Cork.

Service Provision

Tusla provides a range of services within the Kerry/North Cork Network, including child protection and welfare service, family support, and alternative care services. Additional services available within the region include early years inspection, educational welfare services and adoption.

The Kerry North Cork Network operates an Integrated Front Door (IFD) service which provides a single point of access for referrals and initial assessment across the network. There are also two Local Integrated Teams (LITs) delivering ongoing support and intervention. Services are delivered across three main locations: Tralee, Killarney and Mallow.

Service delivery within the network is structured in line with the LISD model, supporting integrated, multidisciplinary working across child protection, welfare and family support services. This model promotes improved coordination of services and more effective responses to the needs of children and families.

Governance and Staffing:

The Regional Chief Officer has overall governance responsibility for the Southwest Region. Within the Kerry North Cork network, operational service delivery is managed by the Area Manager. The Kerry North Cork Network is staffed by a multidisciplinary team supporting service delivery across the Integrated Front Door (IFD) and two Local Integrated Teams (LITs). The Network is supported by a management structure which includes one Principal Social Worker (PSW) assigned to the IFD and PSW oversight of the LITs. At present, there are 32 staff members returned on the March 2026 HR census report as assigned to the Integrated Front Door and the LIT Safety & Welfare teams, including business support, working across the Network.

Integrated Front Door
The IFD the team comprises of:

- 1 Principal Social Worker*
- 2 Team Leaders
- 1 Senior Children and Family Support Network (CFSN) Co-ordinator
- 1 Children and Family Support Network (CFSN) Co-ordinator
- 1 Domestic Violence Support Officer
- 8 Social Workers
- 1 Social Care Leader
- 3 Business Support Staff

Local Integrated Teams (LITs)- Safety and Welfare
Staffing within the LITs includes:

- 1 Team Leader
- 5 Social Workers
- 3 Social Care Leaders
- 1 Children and Family Support Network (CFSN) Co-ordinator
- 2 Family Support Practitioner
- 1 Deputy Social Care Manager
- 1 Business Support Staff

*The Principal Social Work post is vacant.

This staffing structure supports the delivery of integrated child protection, welfare, and family support services across the network.

The service is operating with gaps in staffing provision (particularly at management level) within the network which are actively managed and monitored at both local and regional level.

The network is required to respond to varying levels of need across the network, including areas of socio-economic disadvantage and increased service demand, necessitating ongoing prioritisation, workload management and resource allocation.

Socio Demographic Profile:
The Kerry North Cork Network is one of 30 networks within Tusla, the Child and Family Agency. The network spans a large geographical area across County Kerry and Northwest County Cork.

The 2022 Census data indicates that the total population for the network is approximately 185,000, with a child population of 41,800. The network covers both urban and rural communities, resulting in a diverse population with varying levels of need.
Furthermore, CSO figures indicate that the Kenmare Local Electoral Area (LEA) has experienced a significant influx of Ukrainian refugees and has consistently been among the highest concentrations nationally. Figures fluctuated between approximately 1800 and 2800 individuals during 2024 to 2025, which has had implications for local service demand.

Deprivation Profile:
According to the Pobal HP Deprivation Index (2022), the Kerry North Cork network demonstrates an average socio-economic profile. Most of the population falls within the marginally above average (48.5%) and marginally below average (46.75%) categories.

A smaller proportion of the population is classified as disadvantaged (3%), while a very small proportion identified as very disadvantaged (0.25%) in Killarney and Listowel, representing a localised pocket of higher socio-economic need. Affluent areas account for 1.5% of the population.

Overall, while the network is characterised by average levels of deprivation, there are localised areas of concentrated disadvantage which may contribute to increased service demand and complexity, particularly in relation to child protection and welfare.

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.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
12 May 2026	09:00hrs to 17:00hrs	Catherine Linehan	Lead Inspector
	09:00hrs to 17:00hrs	Susan Geary	Support Inspector
	09:00hrs to 17:00hrs	Bernadette Neville	Support Inspector
	09:00hrs to 17:00hrs	Lorraine O'Reilly	Support Inspector
13 May 2026	09:00hrs to 17:00hrs	Catherine Linehan	Lead Inspector
	09:00hrs to 17:00hrs	Susan Geary	Support Inspector
	09:00hrs to 17:00hrs	Bernadette Neville	Support Inspector
	09:00hrs to 17:00hrs	Lorraine O'Reilly	Support Inspector
14 May 2026	09:00hrs to 16:00hrs	Catherine Linehan	Lead Inspector
	09:00hrs to 16:00hrs	Susan Geary	Support Inspector
	09:00hrs to 15:00hrs	Bernadette Neville	Support Inspector
	09:00hrs to 16:00hrs	Lorraine O'Reilly	Support Inspector
15 May 2026	09:00hrs to 17:00hrs	Catherine Linehan	Lead Inspector
	09:00hrs to 17:00hrs	Susan Geary	Support Inspector
	09:00hrs to 17:00hrs	Bernadette Neville	Support Inspector
	09:00hrs to 17:00hrs	Lorraine O'Reilly	Support Inspector

Views of children who use the service

During the inspection of a children's service, it is important to gain an understanding of what it is like for children to experience that service. Inspectors sought to understand children's experiences through the review of their files to determine whether children's views were sought and considered in decisions which impacted them. The review of case files provided evidence of the experience of children and families in receipt of a child protection and welfare service in the Kerry North Cork Network. Inspectors saw evidence that staff generally used children's files to capture their experiences through comprehensive notes, capturing phone calls, meetings and engagement with children. Their voices and their wishes in the assessment and planning of actions impacting them was seen on file, though this was not consistently the case across all files reviewed. Inspectors saw evidence of direct work taking place with children and the sharing of plans and actions with children. Inspectors did not have the opportunity to speak directly to children or families during this inspection, however, we also spoke to staff and managers to further establish the service provided to children.

This inspection found that children and families at immediate risk were responded to appropriately and in a timely manner. A well-timed response aimed to ensure that risks were identified, assessed and managed and that children received the right supports. The absence of a waiting list for a service was a further indication of the prompt initial response when a referral was received. Inspectors reviewed cases where there was a delay in the completion of initial assessments, the timeline of which is 40 days as set out in Tusla's standard business processes[1], for example, a delay of twenty days in the completion of an initial assessment with no noted rationale for the delay. However, the review of these files indicated that, while there were delays, there was no negative impact on children.

On this inspection there were no children's cases or systems risks escalated by HIQA for an immediate response by the network, which was an indication of the service being managed effectively and safeguarding children.

There was good follow through of actions agreed at supervision and attention paid to hearing and portraying the voice of the child within the assessment. Examples of good practice seen by inspectors included;

- age appropriate and child-friendly tools to support children and ensure their views were sought

[1] The Tusla Standard Business Process (SBP) is the national framework for child welfare and protection in Ireland

- evidence of supervision of cases completed by team leader with social worker, and also by principal social worker with team leader

- referrals appropriately screened and actioned

- a large family unit allocated between two practitioners to ensure the individual needs of each child were addressed

- referrals which did not meet the threshold for child protection services being appropriately diverted to family support services

- good quality supervision with actions agreed which were appropriate in determining the safety of children

- good interim safety plans in place pending completion of initial assessment which aimed to ensure the safety of children.

There were some gaps identified;

- when cases transferred to the children in care team the standard business processes were not followed – however, there was no impact on the child

- significant case drift found in cases transferred from the previous area resulting in children waiting prolonged periods for a service; since coming to Kerry North Cork network these were reviewed promptly and safety was established

- initial assessments which did not capture all the risks and significant time delays in between meetings at initial assessment stage were found on some files.

These examples demonstrate that, overall, the Kerry North Cork Network was well managed with good use of limited resources and a timely response being offered to children and families. Despite significant staff shortages, particularly at team leader and principal social worker level, there continued to be a service provided to children and families that was of good quality. Case records showed that workers used age appropriate and child-friendly tools to support children to share their worries and this helped to capture children's voices and consider them when carrying out assessments.

While still at this early stage of the Tusla reform programme, which commenced on 01 January 2026, this network was managing to provide a quality service in the face of significant challenges. Some services, which were previously provided at an area level, are now provided across networks and at a regional level. The loss of staff availing of promotional opportunities provided by the expansion of the network and also the addition of North Cork into this network to form this new network, Kerry North Cork, were all issues which presented challenges. The expansion of the area also presented a challenge to staff who had to manage caseloads over a wider catchment area resulting in increased travel. However, despite these challenges, the area manager and their management team, as well as staff working directly with families, were handling these challenges appropriately.

Capacity and capability

On the 1 January 2026, Tusla reorganised their local and regional services. This resulted in the number of Tusla networks increasing from 17 service areas to 30 networks. This reform created a single point of entry through the introduction of an integrated front door (IFD) team in each network for all referrals related to child protection, family support, and Meitheal[2]. Two local integrated teams (LIT) were also established in every network. The aim of this reform is to enhance accessibility by ensuring children and families connect with the right service quickly.

HIQA's inspection of the Kerry North Cork service area focused on four standards. In this inspection, HIQA found that, of the four national standards assessed:

- two were compliant
- two were substantially compliant.

There were good governance and management arrangements in place to assure management at local, regional and national level. Despite shortages in management staff and the area manager's awareness of the risk such shortages posed in the network, there were contingency plans in place which were aimed at addressing these gaps with the continued focus on trying to fill the vacant posts. Team leaders and principal social workers maintained oversight of children's cases, the assessment of their needs and presenting risks, and records showed that

[2] Refers to Tusla-led early intervention practice model designed to identify and respond to the strength and needs of children and their families by bringing together various support services to improve children's outcome.

appropriate discussions took place to consider the child's circumstances and any actions required. However, this oversight was not always timely.

Staff who engaged with inspectors spoke positively about the changes the reform had brought to the service being delivered to families. They also felt positively about their engagement with their colleagues and inspectors evidenced shared learning and development amongst staff in a formal setting as well as hearing from staff about informal opportunities to engage and learn from colleagues through case discussions.

There was good oversight of cases found, with supervision taking place and discussions noted in supervision records, though not always captured in a case note on the child's file. Files were largely up to date with good case notes and management oversight evident. Standard business processes, which set out the expected pathway for managing child protection and welfare referrals, were largely adhered to, though when timelines were not met it was not always clear why there were delays; inspectors did not see evidence of any such delays having a negative impact on children.

There were systems in place to review and assess the effectiveness and the safety of the child protection and welfare service provision and delivery.

The Kerry North Cork Network sought to ensure that children and families were provided with a prompt response to referrals and provided a child-centred service to children. Staff demonstrated understanding of their role and responsibilities and spoke to inspectors about management being available to them, despite shortages in management staff.

While oversight systems were in place in the network, it had not been identified that 64 of 113 referrals to the children in care team remained at intake stage. While team leaders were aware of the referrals, they were not being managed through Tusla's standard business processes; while the cases were being worked and there was no risk to children, Tusla's own processes were not capturing this work. Improvements were required to ensure this was captured and oversight of the business processes was provided.

There was good management oversight of cases that were awaiting allocation.

Despite staff shortages, the Kerry North Cork service managed its available resources effectively and distributed them according to identified need and risk.

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.

The Kerry North Cork service had systems in place to review and assess the effectiveness and the safety of the child protection and welfare service provision and delivery. These included case management between practitioners and team leaders which was thorough and sought to address concerns and provide monitoring and oversight of cases. Supervision between team leaders and principal social workers provided further oversight. Despite management shortages, staff spoke about supervision taking place, both formally and informally, as well as group supervision, which was an indication of the effectiveness of the contingency plans in place. However, staff also felt the additional pressures of assisting with the training and support of apprenticeship social workers was an added pressure that was not given due consideration by management.

This network was operating within the context of newly established teams, which required the appointment of new managers, some of whom were still developing experience in their roles. Inspectors found that managers were committed and engaged, and while some areas for improvement were identified, inspectors found no evidence that these had adversely impacted children. However, it did highlight the need for continued support and oversight for new managers to ensure accuracy in decision making. The area manager was aware that management training was still outstanding for some new managers in the network and the completion of this training was identified as a priority for the network.

The Kerry North Cork network sought to ensure that children and families were provided with a prompt response to referrals and provided a child-centred service to children. Staff demonstrated understanding of their role and responsibilities and spoke to inspectors about management being available to them, despite shortages in management staff.

There was evidence of developing governance and reporting arrangements to support oversight of service performance. The area manager had several mechanisms in place to support her governance and oversight, and these were still being embedded and developed further under Tusla reform. These included the information manager providing monthly performance reports to the area manager, and these reports were provided weekly during the reform period to support closer monitoring. Data provided to the area manager was an important governance and oversight tool. The availability of performance information supported the area manager to monitor activity, identify pressures and make informed decisions about resource allocation. However, some minor inaccuracies

were identified in the data provided to inspectors. While data provided indicated that there were 334 open child protection and welfare (CPW) cases, six of these were over 18 years and should not have been included, two were children in care and one was a duplicate. These inaccuracies did not relate to the diligence of the information manager compiling the information, but rather reflected limitations in the way the data can be extracted and collated. This meant that while the data was valuable, further assurance and validation was required to ensure that reports provided to the area manager were reliable. The information manager told inspectors that young people over 18 are removed from the data prior to it being given to the area manager and that the business information unit plan to implement a process for reviewing over 18's that are at the child protection and welfare stage going forward.

According to the area manager, every area manager can request different information to be provided by their business support team, and this was something that needed further clarity to ensure that the information provided was meaningful and aligned with what was required to support the oversight of the service. The area manager was satisfied with the information provided by the business information unit and felt it informed oversight but acknowledged that this needs further discussion amongst all five network managers to ensure consistency nationally. Business support also provided reports to managers on the use of TCM (Tusla Case Management)[3] which assisted managers to have oversight of recording practice and updating of case notes and promoted accountability to ensure key information was available on children's files, to inform decision making. The TCM user liaison officer also provided training to team leaders on the running of reports from TCM for monitoring purposes.

The Quality, Risk and Service Improvement (QRSI) role was changing significantly under Tusla's reform and the team was in its infancy at the time the inspection took place and was not yet fully staffed; the QRSI manager was in place and one principal social worker. Two more principal social workers were onboarding to become part of the QRSI team. As a result, it was too early to assess this team's impact on service delivery. Decisions regarding the structure and division of responsibilities within the team remained at the planning stage. The key priorities identified for the role included supporting the implementation of the Tusla reform, oversight of the risk register, and progressing actions within the service improvement plan. While there was an intention to develop a standardised approach to QRSI across all regions, this had not yet been agreed or implemented at the time of inspection. This meant that arrangements remained at a planning stage and were not yet embedded in practice. Inspectors reviewed a draft service

[3] Tusla's digital case management platform

improvement plan which set out core actions to promote consistency, standardisation and equitable service delivery across all networks. This draft demonstrated that the service had begun to identify key priorities for improvement and had set out actions to strengthen service delivery. The QRSI team also planned to go through reports provided to the area manager and highlight any issues arising. Plans were also afoot to conduct audits and make recommendations to the area manager. Although the plan was not yet finalised, the draft provided a useful framework to support planning and oversight of progress and what is planned by the QRSI team will support meaningful oversight and governance across the area.

Team leaders and principal social workers maintained oversight of children's cases, the assessment of their needs and presenting risks, and records showed that appropriate discussions took place to consider the child's circumstances and any actions required. However, this oversight was not always timely. Inspectors found delays by team leaders in reviewing and signing off some cases, which impacted on the prompt progression of work. While management oversight was evident, improvements were required to ensure that reviews and sign offs were completed in a timely and consistent manner. The network had significant vacancies at management level, and this meant that managers had more cases and staff to oversee, this in turn impacted their capacity to carry out all tasks in a timely way. Inspectors found that while managers were providing oversight, the number of supervisees they were responsible for may have placed pressure on their capacity to do so consistently and in a timely way, which contributed to some delays in sign off and to some decisions where rationale was not always robust.

Despite gaps in staff, the network was very thorough in the plan devised to manage referrals that had previously been North Cork cases and which were now the responsibility of the area under their newly formed Kerry North Cork network. Dedicated staff were assigned to manage these referrals, effectively deploying staff to meet prioritised needs of unknown families and protect children. The risk posed by these unknown referrals and the long waiting periods these families endured prior to receiving a service from Kerry North Cork featured on this network's risk register and addressing these referrals was a key priority for the network to establish safety with families unknown to them. The principal social worker assigned to manage these cases conducted a thorough review of all cases and assigned work to three staff who focused solely on establishing the appropriate service to be provided to those families. Inspectors found responsible, proactive management oversight in respect of these cases and, while there was a significant delay in these referrals being worked in the previous social work service area, once they arrived within this network, they were rigorously reviewed,

addressed and managed in a timely and appropriate manner. This demonstrated a proactive and accountable child-centred approach to managing delayed referrals and ensured that children and families received an appropriate response once the referrals came under the remit of Kerry North Cork.

Records reviewed showed that discussions took place between front line staff and team leaders regarding children's needs, presenting risks and the actions required to support and protect them. Team leaders and principal social workers provided clear direction to staff and supported decision making through supervision and case discussion. This helped to ensure that children's circumstances were considered, risks were understood and appropriate next steps were identified to promote children's safety and welfare. Inspectors saw evidence of effective and layered management oversight. Cases discussed between case workers and team leaders were subsequently reviewed during discussions between team leaders and principal social workers. This provided an additional level of scrutiny. While there was evidence that case discussions were taking place within supervision, this was not always reflected in corresponding case notes on the child's file. Caseloads were appropriately managed, with inspectors finding that workers did not have significantly high caseloads. This demonstrated effective management oversight, as managers had clear visibility of workloads and were allocating work in a way that supported safe, timely and good-quality practice. Appropriate caseloads also meant that workers had capacity to progress referrals, complete assessments and respond to children without unnecessary delay. Data provided to inspectors showed that the highest case load being held by a social work practitioner was 24 cases.

Team leaders provided effective oversight and appropriately challenged or amended outcomes. However, there were some weaknesses in the effectiveness and timeliness of management oversight at team leader level. Inspectors found delays in team leaders signing off records, which impacted on the timely progression and closure of work. In addition, the sign-off process did not always provide sufficient quality assurances as team leaders had not consistently identified errors in risk classification. For example, in some cases, social workers had recorded the risk classification as medium when the information on file indicated that a low classification was more appropriate. This meant that management review was not always effective in identifying inconsistencies, ensuring accurate risk recording, or providing timely oversight of practice. Inspectors also reviewed a case that was prioritised as medium and when transferred to another team leader who reviewed the case, it was changed to a category of high. This resulted in prompt action and a joint home visit with the

transferring social worker and the newly appointed social worker and a timely response to identified risks.

Inspectors found that when cases were reviewed by management and it was agreed that immediate allocation was required, this was progressed without delay. Inspectors reviewed some files which showed that team leaders reviewed decisions made by social workers and, where necessary, changed the outcome to ensure that children's needs and presenting risks were responded to appropriately. Evidence also showed discussions taking place between management when there was disagreement regarding the outcome of an assessment and the outcome reflected the needs of the child. This demonstrated active management oversight and a focus on promoting children's safety and welfare.

There was an effective system in place to escalate risks. Inspectors reviewed the Need to Know[4] (NTK) reports and management were clear in their escalation of the concerns to ensure children's needs were highlighted and to ensure that issues impacting the service were escalated appropriately. The network's risk register was also reviewed by inspectors. This was maintained by the information manager who brings this to the senior management team for review and discussion. Risks highlighted included the impact of assigned referrals from the North Cork area and staff vacancies. The area manager was clear that staff shortages were a big risk in the network and placed this issue on the risk register[5] and the matter had also been highlighted directly with the Chief Executive Officer (CEO). The risks were particularly due to the dilution of governance and oversight as already indicated. Significant efforts were made at regional level to address managerial staffing shortages, with substantial support provided to the network by regional operational management colleagues.

The regional operations risk management and service improvement committee (RORMSIC) meetings were attended by the area manager. These provided further oversight and minutes were reviewed by inspectors which demonstrated thorough discussion, including practice assurance and service monitoring (PASM) reports being shared with the committee for learning purposes, as well as service improvement plan discussions taking place. This forum was also used to highlight concerns and areas that needed prioritisation, such as unallocated cases. NORMSIC (National Operations Risk Management and Service Improvement Committee) meetings were also attended by the area manager and ongoing issues of concern were discussed and raised at this forum. Senior management meetings held looked at areas such as commissioning of services and the Tusla reform,

[4] Process of escalating incidents and issues to senior management which might pose a risk to individual children or to the organisation

[5] A list commonly used to manage the risks throughout a service

unallocated cases or any matters for the risk register. Management meetings took place and minutes reviewed by inspectors indicated that thorough discussions were held. Inspectors found these meetings to be particularly productive in the sharing of information and issues arising around the bedding down stage of the new network and the reform process. Issues were highlighted with clear follow up plans and actions were revisited at subsequent meetings to ensure progress.

A HIQA standards framework project was a further governance structure that looked at national compliance plans and addressing any deficits, reviewing of HIQA inspection reports and actions and matters arising from these. A good example of this was the network's development of a process to ensure timely Garda notifications were completed, which was a gap identified on a previous inspection. The network tracked garda notifications on a monthly basis and the impact of this was evident on this inspection.

While oversight systems were in place in the network, it had not been identified that 64 of 113 referrals to the children in care team remained at intake stage. While team leaders were aware of the referrals, they were not being managed through Tusla's standard business processes; while the cases were being worked and there was no risk to children, Tusla's own processes were not capturing this work. This indicated that monitoring arrangements were not sufficiently effective in this team to identify delays in completion of intake records. However, this did not have any impact on the child. There were examples reviewed whereby a referral was appropriately screened and actioned and Garda notifications sent, but, once the case went to the children in care team the standard business processes and associated TCM stages were not followed; however, this did not result in any risk to the child and is noted by HIQA as an area for improvement.

There was good management oversight of cases that were awaiting allocation. Data received prior to inspection indicated that there were 163 cases awaiting allocation to a professionally qualified social worker, in line with national standard requirements. However, of those 163 cases awaiting allocation, 84 (51%) of them were allocated to another professional, such as a social care leader or domestic violence worker. This demonstrated that the network was proactive in utilising the skills and capacity of other professionals to ensure that children and families received a service. Seventy-nine children were awaiting a service as opposed to 163 and this number had further decreased by the time the inspection commenced. Inspectors reviewed cases worked by professionals other than social workers and found that assessments were of good quality with intake records and initial assessments being completed in a timely manner. The transfer of information from one team to another was also found to be thorough. Inspectors

also reviewed a case allocated to a student social worker and saw very good oversight of their work by their supervisor, with clear actions noted for completion by the student. The case was then re-allocated back to the original social worker once the student had finished their placement.

In summary, a child-centred approach was used in Kerry North Cork, where staff effectively incorporated the voices of children into assessments. There were specific data inaccuracies and delays in administrative sign offs that required further refinement. The network demonstrated proactive resource allocation by utilising various professional roles to mitigate against high caseloads and ensure children awaiting a service received attention and were not placed on a waiting list. There were extensive meetings held where learning and development was shared from a national and regional level. The management team, while depleted, provided oversight and support to their staff and had systems in place to assist them. Ultimately, the service reflected a system with strong foundational oversight which was still evolving at the early stages of Tusla reform. It is for these reasons that the standard is judged to be substantially compliant.

Judgment: Substantially Compliant

Standard 4.1
Resources are effectively planned, deployed and managed to protect children and promote their welfare.

The Kerry North Cork child protection and welfare service managed its available resources effectively and distributed them according to identified need and risk. This was despite staff shortages, most significantly in the areas of governance and management.

The Kerry North Cork Network operated with one Integrated Front Door (IFD) team and two Local Integrated Teams (LITs). According to the network's organogram submitted prior to the inspection, the integrated front door team was managed by a principal social worker. However, vacancies for a family support team leader and a senior social work practitioner existed on the integrated front door team. The local integrated team (LIT) 1 had a vacancy for a principal social worker, a family support team leader, and three social work team leaders. The LIT 2 had a vacancy for a principal social worker and a family support team leader.

While these gaps in management roles were recognised as a risk for the network and featured on their risk register[6] there was a clear contingency plan in place. The integrated front door was managed by a principal social worker who was also providing cover in the absence of a family support team leader; they were monitoring family support and Meitheal referrals along with a senior Child and Family Support Network (CFSN) coordinator. Experienced staff within the integrated front door spoke of having the confidence and professional competence to support their professional decisions and the area manager also acknowledged the importance of having their most experienced staff at the front door. While recruitment for a principal social worker for the two LIT teams was ongoing, regional support was provided through the interim allocation of a principal social worker from another network redeployed to provide cover and these arrangements were subject to monthly reviews by senior management.

The area manager was aware of the gaps that management vacancies can create in terms of governance and oversight but also regarding staff learning and development. To address this, the involvement of Tusla's regional implementation lead was assisting with staff learning and development and was a further contingency in the absence of management staff. Inspectors viewed planning meetings taking place with the various leads and the planned facilitation of twelve support sessions to take place between February and May 2026 addressing issues such as case support, practice workshops, screening, mapping[7] and safety planning. These sessions were taking account of some lack of experience and knowledge amongst some newer staff in areas such as naming harm in domestic violence cases, child sexual abuse, and also took account of the capacity of staff to attend training. With vacancies in management posts these sessions provided further learning opportunities, guidance and professional support to workers and was a further contingency plan put in place by the area manager.

The area manager submitted business cases for vacant posts. Considering the larger area the network now served, the additional travel involved for staff was also being captured within these requests. Inspectors viewed documents recording the low uptake of job vacancies across the network, Kerry North Cork being low ranking in terms of ability to fill posts nationally.

The allocation of two workers to focus on supporting contact arrangements for children in care with their families was also a beneficial use of resources, aiming to

[6] A list commonly used to manage the risks throughout a service

[7] Mapping is a structured way of organising information about a child and family, it looks at what people are worried about, what is working well and what needs to happen to build safety.

ensure social work practitioners were not being drawn into covering contact visits and increased travel when they needed to focus on assessments.

Further gaps in staffing were noted where Kerry North Cork was endeavouring to establish an Area Based Therapy Team and had made numerous attempts to recruit an occupational therapist and a senior psychologist; these were thus far unsuccessful. However, it was an ongoing focus for the Kerry North Cork area manager to fill these positions. The area manager was flexible about location if this would facilitate the filling of vacancies. Despite these staff shortages, the network had fourteen Family Resource Centres as well as a dedicated budget to fund counselling services and a regional therapy manager to avail of, if required.

Staff spoke positively about the reform and the changes in service provision. The more accessible route to availing of family support and Meitheal services was highlighted as being very positive and the closer working relationships with family support colleagues was described as constructive. However, staff did express the view that the reform has brought an element of disruption and feelings of disillusionment. Staff felt that retention of workers should be a focus for the network and the cultivation of a grounded, well-informed staff was seen as a priority for the teams. Positively, caseloads were noted by staff to be within manageable range and this was also highlighted in the data submitted for review prior to the inspection.

The IFD and LIT teams were located across two locations with one social worker based in a third location in an office in North Cork. While staff voiced some dissatisfaction about how the movement of staff and teams transpired under the reform, the teams were seen by inspectors to work collaboratively in their response to children and families. In preparation for the reform programme, the senior management team reviewed data, metrics and the geographical distribution of community and voluntary organisations across Kerry and North Cork. This informed the geographical boundaries of each LIT. To address the fact that staff were based in the three locations, departmental meetings were planned to take place bi-monthly providing an opportunity for the whole staff team to come together, however, at the time of this inspection these had not yet started.

When reviewing cases on a wait list inspectors reviewed a case categorised as high priority. Although the referral was recorded on the dataset as high priority and unallocated, this was only for a short period of one month. During this period, an interim safety plan was in place which was known to the parents and to the wider network, and a safety order was secured. This demonstrated that, while the case should not have remained unallocated at high priority, there was evidence of

protective action and safety planning to mitigate any risk. This demonstrated that, even when placed on a waiting list, work and safety actions were taken to promote child safety.

The area manager met regularly with the family support agencies providing support to families in the community. A planned opportunity for inspectors to observe such a meeting had to be cancelled due to other operational matters. However, the area manager spoke of the important role played by family resource centres in supporting the provision of services to vulnerable children and families.

The implementation of the Tusla reform represented a significant change in management arrangements for the area manager also, their remit expanded to include a larger geographical area in which they had less established local knowledge. Some key supports that had previously been readily available within the network were reallocated to provide services across the wider region. For example, the QRSI (quality, risk and service improvement) role which was a direct support to the area manager prior to the reform, had now grown to a larger team supporting the whole region. While these changes were positive and intended to strengthen service delivery, their implementation also presented challenges for frontline staff and senior managers alike as they too adjusted to new structures, wider areas of responsibility and changes in the availability of established supports.

The expansion of the area meant that team leaders and principal social workers in this network would now be joining practice development forums and benefitting from shared learning and the exchange of professional knowledge and experience with their counterparts across the networks; forums which had previously not been available to the Kerry management team.

While the reform programme was still relatively new at the time of the inspection the network had worked consistently to bed down the new way in which the service to children and families would be delivered. Despite staff shortages, the Kerry North Cork Network had contingencies in place to manage the teams and to provide a service to children and families using available resources effectively. The network struggled to fill vacancies, but it was clear from plans reviewed, meeting minutes read and discussion with the area manager that filling vacancies and staff retention was a high priority which was being given due attention with recruitment campaigns and initiatives ongoing. The area manager was very aware that, despite contingencies, there were gaps in terms of governance and oversight as well as staff learning and development and they were continuing to focus on filling vacant posts and sustaining safe service delivery.

Overall, the inspection found that child protection and welfare services in Kerry North Cork were not adequately resourced but, despite this, they managed to provide a quality service to children in families in the network. For these reasons this standard is judged to be compliant.

Judgment: Compliant

Quality and safety

Overall, Kerry North Cork network managed child protection and welfare referrals in a timely way in line with *Children First* : *National guidance for the Protection and Welfare of Children* (2017) and Tusla's standard business processes. Screenings were completed in a timely manner, and assessments were generally moved onto the next business process stage in a timely way. Children deemed most at risk were responded to and prompt actions were taken to ensure safety. The network ensured that safety was established for children in need of a service with safety plans in place while awaiting an initial assessment. The notification to An Garda Síochána of suspected child abuse was prompt, supporting effective safeguarding responses.

Referrals were generally categorised and prioritised correctly. However, there were a small number incorrectly categorised which indicated a gap in management oversight and quality assurance, as the sign off process did not consistently identify errors in categorisation. While there were some delays in the completion of assessments, there was no impact on children. The standard of assessments reviewed was of a high quality and oversight was provided by a depleted management team who demonstrated a commitment to being available to staff to provide support.

Under Tusla reform there are now additional outcomes to consider after completing an assessment. These outcomes included referring families to family support services. Inspectors saw family support services being effectively used, where appropriate, and where the threshold for intervention by child protection was not met. This successful integration of family support services, as well as the use of a domestic violence worker in assessments, was a positive use of resources and reflected the successful rollout of this element of the Tusla reform.

Overall, the majority of referrals were appropriately categorised and prioritised and children with high levels of need were promptly responded to. Intake records and initial assessments were of good quality; these were completed by both social workers and other professionals and were thorough documents, though not always within timelines. There was no negative impact on children to these delays. A sample of closed cases was also reviewed, and these were appropriately closed and families were promptly informed.

Despite the upheaval that such a reform can bring, staff were managing their caseloads well, they had a good understanding of the processes and they felt supported by their management team.

Standard 2.2
All concerns in relation to children are screened and directed to the appropriate service.

The Kerry North Cork network had effective systems in place to ensure that referrals were processed in a timely manner. Referrals were reviewed for immediate risk and screened within five workings days as per Tusla's interim standard business processes. The network received 850 referrals between January and March 2026. Of these 850 referrals, 733 were screened for immediate risk by close of business the next working day and 802 of the 850 were screened within five working days. This data demonstrated a service that was predominantly timely in its response to reviewing referrals. While the service had suffered the loss of experienced practitioners, as well as significant changes in the geographical area covered by the network, staff still managed to respond to referrals, children and families in a timely and appropriate manner.

The implementation of a duty calendar ensured constant cover at the front door with management ensuring that practitioners were always on site to provide timely screening of referrals. Social workers at the front door had a good knowledge of the standard business processes and timeline expectations and, while they spoke of the busyness of the front door service, they felt confident that all actions were captured. A call log and the tracking of walk-ins to the service was also used, which captured information for tracking purposes as well as identifying patterns or themes.

For the most part, referrals were correctly categorised and prioritised, though a small number of screenings reviewed were not correctly categorised by the social worker and this was not picked up by the team leader when it came to signing off

for approval. For example, a screening was categorised as emotional abuse which was evidently physical abuse, as indicated by the details in the referral; however, this was subsequently changed to the correct category following the intake record being completed. This indicated a gap in management oversight and quality assurance, as the sign off process did not consistently identify or correct errors in categorisation. However, screenings were of good quality overall and recommendations were clear and considered all available information. The observation of the integrated front door by an inspector demonstrated staff's awareness of the standard business processes and the prompt action taken when referrals were received. Staff reported the effectiveness of the diversion processes within the new network area which promoted a quick and appropriate response to families. At the integrated front door, the use of an informal consultation log was reviewed by the inspector which captured the nature and demand for the service.

When completing preliminary enquiries, inspectors viewed evidence on file of workers consulting with other stakeholders to assess the risk and inform interventions with families. Support networks were actively consulted and other professionals, such as An Garda Síochána, were promptly referred to.

Staff who participated in a focus group described the impact of losing local knowledge when experienced, long standing staff left the service. This highlighted that the network had individual staff members holding information on families due to their long-standing engagement with families and then applying this knowledge in practice. While such knowledge is valuable, it also underlined the importance of ensuring that relevant information, rationale and decision making are clearly recorded on children's files so that understanding of family history, risk and protective factors is retained and accessible to other staff and not lost when staff leave their posts.

Under Tusla's interim business process there are now several outcomes for referrals following an intake record being completed. This facilitated an appropriate response for families based on their needs. As identified earlier in this report, timeframes required a team leader to review a referral for immediate and serious risk within 24 hours of receipt of the referral. Data provided to inspectors prior to the inspection showed that of the 850 referrals received between January 01 and March 31, 733 (86%) were screened for immediate risk by a team leader within the required 24-hour period. Social workers then had five days to complete the screening process and of the 850 referrals, 802 (94%) were screened within the required five-day period.

Of the 850 referrals received since the start of January, 332 (39%) required an intake record, 61 required family support, 10 required Meitheal[8] support, 189 were linked to another open referral and 209 were closed. Inspectors reviewed 33 referrals to review timelines and the quality of screening and found them to be of varying quality, generally containing good information and giving clear rationale for decisions at outcome stage and directed to the appropriate team or outcome. Inspectors did view intake records which were significantly outside of the timeline with no obvious explanation for this, however, the work contained within the intake record was extensive and so there was no negative impact on children, therefore, it is an area that requires improvement from a business process point of view only.

The Kerry North Cork network placed a focus on providing a service to families with as few professional changes as possible. This focus was particularly evident when reviewing referrals which the region assumed responsibility for under their new network. These legacy cases, transferred from North Cork, involved families who had already experienced significant delay in accessing services. The principal social worker applied a child centred approach minimising the number of social workers involved with each family where possible. This was achieved by allocating these cases to three identified workers who retained responsibility for the cases and progressed them through the standard business processes. The principal social worker had reviewed all the cases now under their remit and aimed to ensure that assessments were completed in a way that was sensitive to family's previous experience of delay.

It is a requirement of Children First (2017) that An Garda Síochána are notified of suspected physical and sexual abuse and wilful neglect in a timely manner. Inspectors found the network's adherence to the policy on notifying An Garda Síochána to be of an excellent standard. A report run by the network on 3 March 2026 noted 31 referrals received required a Garda notification to be submitted, and these were all completed. Only three referrals during March 2026 identified at screening as requiring a Garda notification did not have notifications completed at the time the report was run, and inspectors reviewed these three referrals to determine the reason for the delay. Two of these notifications were submitted only marginally outside the expected timeframe and this minimal delay did not have any adverse impact on the progression of the case or the outcome for children and families. The third had been correctly re-categorised and therefore no longer required a Garda notification. Of note, when the report was run again on 12 May

[8] A Tusla early intervention practice model used to identify the strengths and needs of a child or family, bringing together relevant services to provide a coordinated support plan

2026 at the request of inspectors, it showed that all Garda notifications were completed.
While screening practices were timely overall, minor improvements were required to ensure that prioritisation decisions were accurate, consistent and subject to effective review. Screenings also redirected families to appropriate community and family support services. There was good tracking of actions to progress cases efficiently. Garda notifications were completed appropriately and within required timeframes with effective oversight and systems in place to monitor the submission of information to An Garda Síochána and supporting a multi-agency response to child protection concerns. It is for these reasons that this standard is judged to be compliant.

Judgment: Compliant

Standard 2.4
Children and families have timely access to child protection and welfare services that support the family and protect the child.

The service provided by Kerry North Cork was delivered in line with Tusla's new local integrated service delivery model, which included an integrated front door and two local integrated teams. This model was effectively applied across the network and supported timely access to services for children and families, despite staff shortages. The timely assessment of referrals aimed to provide families with appropriate support at an early stage and ensure that children had access to protection and welfare services appropriate to their needs.

Tusla's reform policies aimed to promote early intervention. Families who did not meet the threshold for child protection services in Kerry North Cork were not left without support but were instead directed to services that could potentially better suit their needs. Inspectors heard from staff of the close ties with community services in this network and staff also spoke of the seamless transition to these supports for families. The network took an active role in informing local services about the reform and integrated service plans, and staff spoke to inspectors about engaging in really impactful and more meaningful work with families. While directing families to alternative services had been a cumbersome process before Tusla reform, staff spoke of the current arrangements enabling families to access the right service in a more timely and coordinated way. Directing to family support teams and community services reduced the number of cases progressing through the social work teams and demonstrated that the integrated front door was

actively screening, redirecting and ensuring families were linked with the most appropriate service. The Kerry North Cork network also benefitted from close working relationships with the services of Barnahus[9].

Initial assessments reviewed were timely, thorough and of good quality, capturing relevant information to inform decision making and taking account of cumulative harm; all staff had been trained in recognising cumulative harm in 2024 and 2025 and this training was planned to be rolled out again. However, there was room for improvement in ensuring all information gaps were addressed and that risks were clearly identified, named and recorded on the child's file.

Eighty-three of the referrals received since January 2026 required an initial assessment. A good quality case transfer was completed between the IFD team and the LIT team, supporting continuity and clear communication of the risks and required actions. Inspectors identified cases where there were some gaps in information recording within the assessment. For example, the full detail of incidents not being fully captured within the assessment which had the potential to limit the network's understanding of the incident and meant that all relevant circumstances may not have been fully explored or investigated. However, when inspectors spoke with the allocated worker, it was evident that the relevant information was known and had informed their understanding of the incident, however this was not clearly recorded on the child's file. Linking with support networks was evident from the review of initial assessments and the rationale for decisions was typically clear. Inspectors did find that where there were several children in a family the individual needs and description of each child needed some improvement to differentiate between the needs of a sibling group, but overall, the review of initial assessments showed good quality work. Inspectors noted that safety plans were found within intake records and initial assessments even though they had moved on to process stage of safety planning. This did not have any impact on the safety of the child but was a standard business process or TCM issue that required improvement. The network was providing timely access to services to children and families. Assessments were taking place and appropriate diversions, closures and the offering of information to families was taking place.

Prior to the inspection data provided to inspectors indicated that there were 13 children awaiting an initial assessment. Of these, five were secondary allocated to another worker, therefore, work was ongoing on these cases. Inspectors sampled the remaining cases and found they were only wait listed for a short period and

[9] A child-friendly, multidisciplinary model designed to support children who may have experienced sexual abuse.

were reviewed by the principal social worker during that time and allocated if required.

The directing to support services assisted in the reduction of waiting lists meaning that children and families were accessing supports without any significant delay. This access to supports was without discrimination and based on identified need. There was evidence that particularly vulnerable groups were actively supported by this network, with two specific workers identified to engage and work with the Ukrainian and International Protection Accommodation Services (IPAS) communities. The network also had the benefit of a worker with specialist knowledge of domestic violence which strengthened the network's response to children and families as they provided informed risk assessments, and safety planning. This worker was also a valuable resource to colleagues, sharing knowledge and providing information and guidance to support assessments. The network further benefitted from the skill set of a worker trained in specific interventions which were aimed at supporting parents to develop their capacity to respond to their child's needs through everyday interactions. Inspectors observed this worker being facilitated during a team meeting to share learning with colleagues. This supported reflective practice and strengthened colleagues' understanding of relationship-based interventions. Inspectors also saw evidence of social workers holding cases open temporarily to allow families the opportunity to engage and letting them know that if they did not make contact they would forward them information on local supports, therefore providing information on services that they could access themselves if they felt the need and ensuring that information on supports were easily made available to children and families.

Staff spoke about diversions to support services being seamless and a more efficient method of getting families involved with supports while also working jointly with child protection if necessary; this was also found in file reviews where joint working was recorded. Staff also spoke of the informal consultations with family support colleagues which informed decisions about whether family support was needed. This supported shared decision-making and better oversight when determining whether a service was appropriate for a family. This collaborative approach also had a positive impact on staff morale. Staff were supported to discuss families' needs with colleagues, which reduced the sense of working in isolation. It created opportunities for peer support, professional discussion and learning which, in the context of organisational change and uncertainty for staff, provided opportunities to collaborate positively with colleagues and build connections. As previously noted in standard 3.3 the allocation of referrals to other professionals within the service ensured that children were not waiting extended periods for a service and such files reviewed by inspectors provided good

assessments and timely responses to referrals allocated to professionals other than social workers.

There was evidence of good joint working between the integrated front door and the social worker allocated to conduct the assessment. For example, joint home visits were conducted, ensuring all information was shared by the screening worker and all available information was available to the assessing social worker. Historical concerns were appropriately considered by the assessing worker alongside the presenting referral information which supported an informed understanding of cumulative risk for the child. Safety plans were put in place, and inspectors saw evidence of some safety plans being tested.

A priority highlighted by the network was for children and families to receive a service from the smallest number of workers possible. This supported continuity of relationship and reduced the need for families to repeat their experiences to multiple professionals and promoted a more coordinated response.

As also previously identified under standard 3.3, new referrals about children in care were effectively screened at the integrated front door, however, once they were allocated to the children in care social worker the standard business processes were not consistently followed. Between January and March there were 113 referrals for children in care and 64 (56%) of these were still at the intake record stage. While the process stages were not moved on, the work had been completed and therefore there was no risk to children found.

A review of closed cases found that decisions to close were appropriate, clearly recorded and communicated with the families. Closure letters were available in a range of languages, which supported accessible communication and helped ensure families understood the outcome.

There was room for improvement in the quality and reviewing of safety plans. While safety plans were in place, they were not always reviewed regularly, and it was not clear if they were updated following further events. Inspectors found the names of safety persons were recorded; however, there was not always a clear record that the plan had been discussed with them, that they understood their role, or that the plan had been tested to ensure it was effective. In addition, the involvement of children in safety planning was not consistently recorded. It was therefore unclear in some cases whether children had been consulted, whether their views had informed the plan or whether they understood the safety arrangements in place. This required improvement to ensure safety plans were

active, understood by all relevant people, reviewed regularly and updated in response to changing circumstances.

Initial assessments were generally of good quality. The network demonstrated strong support for particularly vulnerable groups, including Ukrainian and IPAS communities and it also benefitted from specialist knowledge in areas like domestic violence and relationship-based interventions.

The collaborative approach of the new model had a positive impact on staff morale, reducing the isolation and providing peer support. Additionally, for children in care, standard business processes were not consistently followed once cases were allocated to a social worker. Safety planning was identified as an area for improvement. Safety plans were not always reviewed regularly or updated following new events and it was not always clear if children were involved in safety planning or if they understood the safety plan. It is for these reasons that the standard is deemed to be substantially compliant.

Judgment: Substantially Compliant

Summary of standards assessed and judgments made on this inspection

National Standards for the Protection and Welfare of Children (2012)	Judgment
Capacity and capability	
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.	Substantially compliant
Standard 4.1 Resources are effectively planned, deployed and managed to protect children and promote their welfare.	Compliant
Quality and safety	
Standard 2.2 All concerns in relation to children are screened and directed to the appropriate service.	Compliant
Standard 2.4 Children and families have timely access to child protection and welfare services that support the family and protect the child.	Substantially compliant

Compliance Plan for Kerry North Cork Child Protection and Welfare Service OSV – 0009388

Inspection ID: MON-CPW-KNC-260512

Date of inspection: 12-15 May 2026

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. In this section the provider must consider the overall standard when responding and not just the individual non compliances as listed in section 2.

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 3.3 The service has a system to review and assess the effectiveness and safety of child protection and welfare service provision and delivery.	**Judgment:** **Substantially compliant**

Outline how you are going to come into compliance with Standard 3.3:

The Senior Management Team will ensure all managers complete core management training including:

- Everyday Personal Effectiveness Programme
- People Management Legal Framework
- Tusla Coaching Skills Programme
- Management: An Introduction for First-Time Managers
- Supervision Training
- Social Work Team Leader Development programme

A management training tracker will be maintained and reviewed by the Area Managers Office.

Person responsible: Principal Social Workers
Timeframe: 31/12/2026

The Senior Management Team will support the attendance of all line managers attend the Regional Practice Development Forum (Team Leader and PSW). The forum will support the dissemination of learning from audits, inspections, complaints, TCM performance data and national guidance, promoting consistent management oversight, and continuous quality improvement across the Network. It encourages facilitative peer learning by supporting managers to share new learning and information from colleagues. This will bolster the confidence of managers and will sustain a learning environment for all managers.

Person responsible: Principal Social Workers
Timeframe: Quarterly- 30/06/2026; 30/09/2026; 31/12/2026

The PSWs will monitor the timely closure of referrals relating to young people aged over 18 years through a monthly TCM advanced find to ensure only open referrals relating to children remain on the system.

Person responsible: Principal Social Workers
Timeframe: 30/12/2026

The Southwest Regional Information Manager and General Manager of Regional Services are conducting a review of metrics dissemination in the region including assessment of the awareness of the I.T. tools available to managers in the area. This work is expected to conclude at the end of September 2026 and will further enhance governance and compliance."

Person responsible: Southwest Regional Information Manager and GM for Regional Services.
Timeframe: 30/09/2026

The Kerry North Cork Service Improvement Plan will be monitored through quarterly governance meetings to ensure actions are reviewed and implemented. Progress will be monitored through an action tracker.

Person responsible: Area Manager, Principal Social Worker, QRSI Principal Social Worker
Timeframe: Quarterly review: 01/07/2026; 28/09/2026; 14/12/2026

A Regional Guidance Document for Team Leaders on standard business process forms on the Tusla Caseload Management system (TCM) has been updated and disseminated across the Southwest Region. This document includes practice and governance requirements for team leaders in signing off TCM forms. This document has been discussed at team meetings across the network and going forward will form part of ongoing dissemination of practice documents in Kerry North Cork.

Persons responsible: Principal Social Workers and Social Work Team Leaders
Timeframe 09/06/2026 complete

Compliance with the sign-off of TCM forms and any overdue forms will be monitored through supervision between the Principal Social Worker and Team Leaders, with agreed actions recorded and monitored to completion. The PSW will evidence this in their Pillar Report for the Monthly SMT.

Persons responsible: Principal Social Workers and Social Work Team Leaders
Timeframe Monthly, commencing 31/07/2026

A TCM workshop will be facilitated with the Care Team to strengthen staff knowledge in completing SBP forms on TCM. The workshop will focus on the accurate recording, timely completion of forms and management sign-off requirements.

Person responsible: User Liaison Team Leader and the PSWs.
Timeframe: 31/10/2026

To ensure timely processing of referrals in the Children in Care team in line with Standard Business Processes, the PSWs will have a monthly review of referrals using the DQAT Tool. Any delays or trends identified will result in agreed improvement actions which will be identified through the Principal Social Workers' Pillar Reports and reviewed by the Area Manager to provide assurance that actions have been implemented and sustained.

The BIU team will facilitate a workshop on the use of DQAT for all Social Work Team Leaders and PSWs.

Persons responsible: Business Unit & Principal Social Workers
Timeframe Monthly, commencing 31/10/2026

A targeted 'shut down day' will be facilitated to support the completion of outstanding standard business process forms for children in care. The Signs of Safety Learning and Development Practice Leads will provide support staff in completing outstanding forms, and each social worker will receive an individualised list of outstanding forms. Progress will be reviewed by the Team Leader and Principal Social Worker, with any remaining forms monitored through supervision until completed.

Persons responsible: Principal Social Workers
Timeframe 31/10/2026

The Senior Management Team will work in partnership with the HR Department to progress the recruitment of approved vacancies. Recruitment progress will be reviewed monthly by the Senior Management Team to identify barriers, escalate delays and ensure vacancies are filled at the earliest opportunity.

Persons responsible: Senior Management Team and HR Manager
Timeframe Ongoing

Standard 2.4 Children and families have timely access to child protection and welfare services that support the family and protect the child.	**Judgment: Substantially compliant**

Outline how you are going to come into compliance with Standard 2.4:

The PSWs in conjunction with the Regional QRSI Team, will undertake an audit of Initial Assessments to evaluate the quality of recording, risk analysis, identification of cumulative harm, recording of information and differentiation of individual children's needs within sibling groups. Audit findings and learning will be shared with all teams within the network, and an action plan will be developed to address any identified learning.

Persons responsible: Regional QRSI Team and Principal Social Workers
Timeframe 30/11/2026

The Senior Management Team will support that Social Work Team Leaders attend the Safety Planning days to support the consistent implementation of the national approach to practice. Learning from these workshops will be incorporated into supervision and practice discussions to strengthen management oversight and the quality of safety planning across the network.

Persons responsible: Senior Management Team
Timeframe 23/09/2026; 11/11/2026

Social Care, Social Work and Family Support personnel within the Kerry North Cork Network will be supported to attend Signs of Safety workshops such as 'Safety Planning in Action', 'Building Confidence in Analysis and Assessment at IA', 'Support to identify and respond to Cumulative Harm', 'Applying Signs of Safety to the SBP at IR and IA' and 'Analysing Harm'.

Persons responsible: Principal Social Workers
Timeframe: 31/12/2026

To ensure timely processing of referrals in the Children in Care team in line with Standard Business Processes, the PSWs will have a monthly review of referrals using the DQAT Tool. Any delays or trends identified will result in agreed improvement actions which will be identified through the Principal Social Workers' Pillar Reports and reviewed by the Area Manager to provide assurance that actions have been implemented and sustained.

The BIU team will facilitate a workshop on the use of DQAT for all Social Work Team Leaders and PSWs.

Persons responsible: Business Unit & Principal Social Workers
Timeframe Monthly, commencing 31/10/2026

A targeted 'shut down day' will be facilitated to support the completion of outstanding standard business process forms for children in care. The Signs of Safety Learning and Development Practice Leads will provide support staff in completing outstanding forms, and each social worker will receive an individualised list of outstanding forms. Progress will be reviewed by the Team Leader and Principal Social Worker, with any remaining forms monitored through supervision until completed.

Persons responsible: Principal Social Workers
Timeframe 31/08/2026

To ensure that cases are processed in line with the Standard Business Processes, the Social Work Team Leaders and PSWs, will through relevant tools available (TCM Dashboard, Reports, DQAT and MTP), review and monitor the data to identify any emerging trends and themes.

Findings will be reviewed by the Senior Management Team, with progress monitored through supervision.

Person Responsible: Principal Social Workers and Team Leaders.
Timeframe: Monthly

All workshops facilitated by the Signs of Safety Learning and Development Leads will include discussion on strengthening staff skills in engaging children in the development and review of safety plans, including ensuring children understand, participate in and, where appropriate, receive a copy of their safety plan.

Person Responsible: Signs of Safety Learning and Development Practice Leads
Timeframe: 31/12/2026

The Regional QRSI team will undertake a review of 'Adherence to the Supervision Policy' within the Kerry North Cork Network. Findings will be reported to the senior management team, with any required improvement actions agreed, implemented and monitored.

Person Responsible: Regional QRSI Team
Timeframe: 31/12/2026

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	Judgment	Risk rating	Date to be complied with
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.	Substantially compliant	Yellow	31/12/2026
Standard 2.4 Children and families have timely access to child protection and welfare services that support the family and protect the child.	Substantially compliant	Yellow	31/12/2026

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