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:	Cork
Name of provider:	Tusla
Type of inspection:	Focused CPNS
Date of inspection:	18th – 21st April 2023
Lead inspector:	Hazel Hanrahan
Support inspector(s):	Sue Talbot Susan Geary Lorraine O'Reilly Sharon Moore
Fieldwork ID	MON-0039637

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-centered Services	☐
Theme 2: Safe and Effective Services	X
Theme 3: Leadership, Governance and Management	X
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
- interview with the family welfare coordinator
- interview with two child protection conference chairs
- one focus group with six principal social workers
- one focus group with seven social work team leaders
- one focus group with eight social workers
- 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 34 children's case files
- phone conversations with eight parents
- phone conversations 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

Cork is the largest county in Ireland with a significant urban population and rural spread. The census figures in 2016 showed that the overall population for the area was 542,868, and this represented 11% of the national population. Based on the 2016 census and in comparison from the 2011 census, Cork city grew by 5.4% in population and Cork County grew by 4.4% population. The total child population of Cork in 2016 was 134,015 (24.6%). This figure represented 45% of the southern region total child population and 11% of the national child population. Cork is the highest child populated area in the Child and Family Agency. The population in Cork from the census 2022 is 581,231, this has showed a further increase of 7% from the 2016 census.

The service area is under the management of the regional chief officer for the South West region, and is managed by an area manager. The majority of CPNS cases are referred and managed by four principal social workers and nine team leaders. However, the service area had nine principal social workers in place who reported to the area manager. This included principal social workers for the intake and assessment teams, child protection and welfare

teams and child protection conference chairpersons. In addition there was 24 social work team leaders in position who reported to the principal social workers.

The service area is delivered through four social work departments throughout the Cork area. This is broken down into two city teams, North Lee and South Lee and two rural teams that cover the geographical areas of North Cork and West Cork social work departments.

Following the decision being taken to place a child on the child protection notification system (CPNS) the named social worker has lead responsibility for the ongoing monitoring and review of the effectiveness of safety plans including making regular visits to children and supporting the development of safety networks to support families in building protective capacities. The outcome of this work and evidence of progress, informs future decisions made at the review child protection conferences. There was an identified need to provide additional support to social workers in organizing and facilitating safety network meetings due to competing case priorities. In light of this, the service area was at the initial stages of piloting a family welfare coordinator role that supported the identification and involvement of people in network meetings for children on the CPNS as part of the safety planning process. All cases listed on the Child Protection Notification System are managed by a social worker who is supervised by a Team Leader, with some cases benefiting from the allocation of a social care worker to support the Child Protection Safety Plan.

As of the 31st March 2023, the service area had 89 children on the Child Protection Notification System and all of these children were allocated to a social worker. By the time of the inspection, this number had increased by a further four children, which brought the total number to 93. The area had three Child Protection Conference (CPC) Chairpersons in place who were delegated this responsibility by the Area Manager. The CPC Chairpersons were fully independent and were supported by dedicated administration staff. At the time of the inspection, one chairperson position was vacant however, the recruitment to the position was underway.

Compliance classifications

HIQA judges the service to be **compliant, substantially compliant or non-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
18/04/2023	09.00hrs -17.00hrs	Hazel Hanrahan Sue Talbot Susan Geary Sharon Moore	Lead Inspector Inspector Inspector Inspector
19/04/2023	09.00hrs -17.00hrs	Hazel Hanrahan Sue Talbot Lorraine O'Reilly Sharon Moore	Lead Inspector Inspector Inspector Inspector
20/04/2023	09.00hrs -17.00hrs	Hazel Hanrahan Sue Talbot Lorraine O'Reilly Sharon Moore	Lead Inspector Inspector Inspector Inspector
21/04/2023	09.00hrs – 17.00hrs	Hazel Hanrahan Sue Talbot Lorraine O'Reilly Sharon Moore	Lead Inspector Inspector Inspector Inspector

Views of people who use the service

Hearing the voices of children and families is very important in understanding how the service works to meet their needs and improve outcomes in their lives. Children who were consulted with were provided with the freedom to choose to participate or not in speaking with the inspectors. Efforts were made by inspectors, in conjunction with the service area, to engage with children as part of this inspection. However, it was challenging for children to be involved. 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.

The inspectors spoke with one child and eight parents and listened to their experiences of the service. These parents had experienced going through the child protection conference (CPC) process and their children were, or had been, listed on the Child Protection Notification System (CPNS).

A child told the inspector that they understood why the social work department was involved with their family. They said they see their social worker about every three weeks and felt comfortable speaking to them. They said that the social worker had met with them in school and explained the worries for their safety and reasons for the child protection conference meeting. The child said their social worker had told them they could go to the meeting and "I could say what I wanted". They said the social worker also explained what would happen at the meeting and who would be there.

The child said that they attended the first child protection conference meeting but they were told they had to leave the meeting before it fully started and their voice was not heard "I didn't get a chance to say what I wanted to say in the meeting as I left before it fully started" and "I was kinda upset as I didn't get a say and I thought I would". The child said that they also attended a review child protection conference, their voice was again not heard and they did not get to participate in the meeting. "I went and the same thing again I was kicked out again and didn't have a say". The child said that they planned to speak to their social worker about this before the next review and tell them that "I would like a voice at the next meeting" and also said that their parent could help them to talk to the social worker about this. The child said that they had never heard anything about their safety plan or anything about the safety network.

The majority of the parents spoken to felt they, and their children were supported and encouraged to participate in the child protection conference process. Most parents said

that their children did not attend the child protection case conference meeting. Reasons parents gave for this was because the children were too young, the child decided they did not want to attend or a decision was made with the social worker that attending was not in the best interests of the child. Most parents said that social workers met with their children before the conference to get their views and these were presented at the meeting by the social worker.

All parents said they understood the reason for social work involvement with their families and why a child protection conference was requested. All parents had a good understanding of the CPNS and reason why their children were listed on the CPNS. The majority of parents also described a service that promoted children's rights and the rights of parents.

Parents described good communication between themselves and the social work department. The majority of parents said that the social worker met with them in person before the first child protection conference to explain Tusla's worries and concerns for their children, and prepare them for the meeting. For one parent this conversation was by telephone. All parents confirmed that social workers read though their report, explained who would be at the meeting and what would be discussed.

Parents said that social workers made regular home visits to check that the child protection safety plan was working and that everyone was doing what was agreed .Two parents said they would like more regular direct contact with the social worker, while other parents said that visits to the family home took place while they were in work, or that the social worker sees the children at the times they are in the care of the other parent.

All parents reported positive contact with child protection conference chairpersons and said that the chairperson either contacted them by phone or met with them in advance of both the first child protection conference and review meetings. The chair explained the process, told parents who would be there and answered any questions. Parents described positive experiences of the CPNS process as:

"it is about finding solutions it is not about blame"
"reassured me that it would be fine, went through all the scaling, safety, goals, danger statements".
parents described the chairpersons as fair, helpful and likeable.

All parents attended child protection conference meetings and most felt treated with dignity and respect and that their voice was heard. One parent said "the meeting was very professional and I felt listened to at the meeting". Another parent commented

that the meeting “wasn’t too bad as I had concerns and worries, happy with the meeting and how it went”. One parent however said they did not feel treated with dignity and respect during the child protection conference process and said they had made a complaint about this.

Some parents told inspectors that the initial child protection conference was a particularly difficult experience. Some of the comments parents made included:

“great support offered but I couldn’t take my eyes off the floor as I felt like a disgraceful mother”
“the first meeting felt like an investigation, spent two hours in the room, process was quite negative for me “
“ I feel I am never heard in those meetings, shutting me off straight away”
“found the meetings frustrating”
“not very nice, turned into a trial against me”
“it would have been helpful for someone to check in with me after the meeting “.

Feedback from parents included that there “should be more support for parents going through that” and said they planned to talk to the chairperson about this before the next planned review child protection conference.

All parents had a good understanding of the child protection safety plan that was developed and decisions made at the meeting. All parents said that they received written minutes from child protection conferences and copies of the safety plans. Inspectors were told that “I got the whole meeting in writing, word for word sent to me”. Parents also received updated safety plans in writing and parents viewed this as important so that everyone was clear on any changes to the plan.

All parents spoke about safety networks being clearly established and safety plans being actively reviewed. Positive comments included the “safety network was very helpful, the plans put in place and the extra supports put in place”. A negative was the difficulty of getting a safety network set up as they had no family living in the area and they currently had a safety network of professionals.

The majority of parents felt the child protection conference process had a positive impact on their children’s lives. Positive comments from parents included:
“the benefit for my child is they are not still stuck in the environment that they were stuck in all their life, getting abandoned”
and “ If Tusla had not got involved would not have improved, Tusla have done a good job to be honest”
“an eye opener, Tusla didn’t waste time stepping in when the child was in danger”

- "supported the child but also supported the parent"
- and "a massive benefit the supports for the child and the safety network, it was brilliant and well handled by Tusla "
- "myself and my family are all the better for them in our lives ".

Capacity and capability

The focus of this inspection centred on children placed on the CPNS, who were subject to a child protection safety plan, and the governance arrangements in place to ensure there was effective and timely service delivery to these children. As outlined under *Children First: National Guidance for the Protection and Welfare of Children* (2017), where there are serious concerns of a child being at ongoing risk of significant harm following Tusla's assessment of a child protection concern, a Child Protection Conference (CPC) must be convened. Where a child has been identified as being at ongoing risk of significant harm at a CPC, their name will be placed on the CPNS. The CPNS is a secure database that contains a national record of all children who have reached the threshold of being at ongoing risk of significant harm and where there are ongoing child protection concerns. The list helps to support professionals such as An Garda Siochána, make decisions about the safety of a child. Children who have child protection plans continue to live at home, unless it emerges that a child is unsafe despite a child protection plan being in place.

As well as children currently listed on the CPNS, this inspection also reviewed children whose names had been de-activated on the CPNS in the last six months. For these children a decision was made that the children were no longer at ongoing risk of significant harm. Additionally, children who had been relisted or re-activated on the CPNS due to re-emerging child protection concerns were also examined.

The Cork service area child protection and welfare service provided a good quality service to children identified as at ongoing risk of significant harm in the area. There was strong leadership and governance arrangements in place that ensured that children listed on the Child Protection Notification System (CPNS) received a safe and effective service. All children who were listed on the CPNS as active were allocated to a social worker at the time of the inspection. It was identified that for two children delisted from the CPNS their status of being allocated to a social worker changed where they no longer had an assigned social worker. However, these cases were appropriately managed with robust safety plans in place. The service had a dedicated and passionate senior management team that aspired to deliver high performance and high quality outcomes for children on the CPNS and translated strategic direction into operational practice. The culture of the organisation promoted strong

child-centred practice, with effective engagement of families and partner agencies. Managers were striving to strengthen joint working with housing and health partners, and recognised there was more to do.

The service had and were experiencing staff vacancies in the area, however, the area managed this risk for children placed on the CPNS by ensuring they were all assigned to a social worker. There was one senior social work practitioner vacancy on the child protection and welfare team at the time of the inspection. In January 2023 there were four social work team leader vacancies that had been recruited to and in position at the time of the inspection. Staff vacancies had been identified as a risk for the service area, and had been escalated to senior management.

Further work was needed to embed audits into practice to capture the quality of safeguarding practices and compliance with statutory responsibilities. In addition further improvement was required in staff and managers practice when gathering information to determine the likelihood of a child experiencing cumulative harm.

The service area was managed by an area manager who was in position since 2022 and had strengthened the accountability systems to ensure that children and young people benefited from safe and effective services. This included the continuation of group supervision, the introduction of individual supervision to six principal social worker and the expansion of the family welfare coordinator role to incorporate a network co-ordinator function. The area manager reported on metrics for the service area to Tusla's national office to measure performance, and at quarterly forums. The area manager provided group supervision to three CPC Chairpersons and six principal social workers in the service area. The area manager also provided individual supervision to the six principal social worker's. During interview, the area manager described the service as having made a lot of progress since the previous inspection and how they were continuing to strive in building a culture and service that transformed and improved the lives of children on the CPNS. Since the previous inspection the service area were working with a new national guidance, *'National Guidelines for Tusla – Child Protection Conference and Child Protection Notification System 2022'* and had implemented standard operating procedures and practice learning days to support and embed the practice changes.

There was a focused service improvement plan in place that was tailored to the service areas organisational priorities. The service improvement plan was aligned to the practice theme within Tusla's Corporate plan and was an integral component of the Business plan for 2022, to embed the National Approach to Practice. Actions outlined in the plan included conducting audits and a commitment to ensuring children were consulted with as part of the CPNS process.

The area manager had established a culture of collaboration within and between the area teams to improve problem solving, communication, knowledge sharing and innovation. This ensured that the teams were not working in silos but communicated effectively with each other to enhance practices. The area manager had a good understanding of the services strengths and areas for development. The area manager had identified possible discrepancies across the four Cork area offices in the application of thresholds for requesting CPC's in 2022. As a result, a request was made to the Practice Assurance and Service Monitoring (PASM) Team to carry out a review surrounding the thresholds for determining if a CPC was required and were being applied appropriately and consistently. This review was undertaken from the 1st March to the 28th March 2022 and identified areas for further improvement in the application of thresholds, learning needs and the impact of cumulative harm. Some but not all of the improvements outlined in the PASM report were captured in the service improvement plan. However, managers had introduced a guidance document on the definitions of significant harm in 2022. Inspectors found upon speaking with the area manager that cumulative harm had not been identified or raised by managers needing further development within the team in contrast to the PASM findings. Consequently this did not form part of the service improvement plan for 2023. Inspectors found that further improvement was required to strengthen practice in the assessment of cumulative harm, the long-term nature of neglect and the need to explore the child's prolonged exposure to this.

Some of the senior management team in place were relatively new with one principal social worker recruited to their position in 2021 and three in 2022. All managers demonstrated a good knowledge of legislation, regulations, policies and standards appropriate to their role and responsibility and this was reflected in all aspects of their practice. Managers were committed to maintaining and improving social worker skills, knowledge and competencies to fulfil their roles and responsibilities to deliver high quality, child-centred service. This was facilitated through training, practice forums, supervision and departmental days. Inspectors found that the CPC Chairpersons had vast experience and possessed considerable knowledge of their role. New and existing legislation and national policy was reviewed on a regular basis through different platforms to determine possible changes required, how changes or challenges impacted on practice and to address any gaps in compliance. These included the need for consistency of network meetings and development of trajectories.

The senior management team provided strong leadership in the service and worked collectively and steadily to build workforce capacity and capability in managing workforce changes. Senior managers had a comprehensive workforce strategy that promoted the continual professional development of the workforce and sought to

reduce the risks associated with staff turnover. They had developed a programme of targeted training for new and existing staff alongside a mentoring programme to support staff to respond to the needs of children and families quickly and effectively. However, principal social workers told inspectors that the turnover of new social workers and team leaders had placed significant pressure on their role in managing competing case priorities that resulted in *'micro managing'*. This in turn required a lot of time from the managers. The impact of micro managing may restrict learning and may negatively influence social worker productivity.

There was a clear commitment to organisational learning, partnership development and collaboration with other organisations. Inspectors reviewed a sample of seven completed *'Professionals Child Protection Conference Evaluation Forms'* completed by An Garda Siochána, psychologist, Guardian Ad Litem and a drugs and alcohol project worker, that helped to inform practice learning by looking at what worked well and areas for improvement. Also, principal social workers were assigned as gatekeepers, lead representatives, to specific organisations in building and maintaining partnerships and to build joint working. The senior management team offered ongoing support and clarity to their teams. Principal social workers told inspectors that the CPC Chairpersons consulted with them regarding the development of safety planning guidance. This approach promoted collaboration between staff in working towards promoting the delivery of high quality practice in meeting the needs of children on the CPNS.

A review of management documents indicated there was good leadership in implementing recommendations from inspection reports, with evidence of learning from serious incidents. This was echoed by the CPC Chairpersons to inspectors on how inspection reports were used to support practice improvement within the service. Furthermore, inspectors reviewed a sample of ten *'Child Protection Conference Evaluation Forms'* completed by families and one completed by a child. It was found that all family members were spoken to by either the social worker or the CPC Chair about the process involved in CPC's.

The staff and managers were working creatively to strengthen the engagement of parents and or extended family members in the CPC process. Managers had identified pressure on the role of social workers following child protection conferences in the facilitation and monitoring of safety network meetings and that this had contributed to a lack of consistency and standardisation in the implementation of the safety network meeting. To improve governance and oversight of safety network meetings for children on the CPNS, a pilot project was devised and commenced, where this work would come under the remit of the Family Welfare coordinator.

At the time of the inspection, this pilot project was at the initial stages of implementation.

The regional chief officer had good oversight of the performance of the service area through regional risk management meetings and their supervision with the area manager.

Inspectors reviewed the minutes of a wide range of senior management meetings that were in place in the service area, and occurred on a regular basis. These forums encompassed both regional, area and internal management meetings. A range of matters were discussed from each team or service area depending on the type of meeting. Minutes of regional and national CPC chair meetings indicated that the service area discussed the effectiveness of how they participated in and implemented the local arrangements for CPC's alongside any barriers being faced. In addition CPC chairpersons shared learning and worked together for consistency both nationally and across the Cork teams. The CPC Chairpersons were involved in various working groups such as reviewing the national invites to CPC's and providing feedback to national office about them. They were also involved in a new working group to progress trajectories of CPC's. Inspectors found that minutes of other senior management meetings consisted of updates from each team and captured the number of children on the CPNS, vacancies, national guidelines, emerging issues, interagency meetings and feedback from audits. The range of meetings in place in the service area provided further oversight to the area manager of each team and strengthened the lines of accountability.

The area manager had good oversight of the *'Joint Protocol for interagency collaboration between the Health Service Executive and TUSLA to promote the best interests of children and families'* (Joint protocol) and was kept briefed of any shortcomings of the interagency and regional meetings by the principal social worker who attended. There was a local standard operating procedure in place in the service area that detailed the process for escalating concerns. The area manager attended and was a member of the panel with the HSE and other organisations that included hospitals and mental health services. These panels discussed cases that required further escalation to determine the next steps in meeting the needs of children with additional or complex needs. The area manager was aware of the challenges faced to meaningfully implement the Joint protocol, based on the shortfalls in accessing support services, due to the lack of availability and the financial cost of securing such services. However, Tusla had and continued to facilitate privately funding children on the CPNS in accessing these services and this was done on a case-by-case basis.

Audits were undertaken by senior managers within the CPNS service however, this needed to be further strengthened. Inspectors found evidence of case audits undertaken by principal social workers and placed on the child's file on the case management system. Inspectors were told by staff that the findings from audits were reported back to each team to improve practice and the quality of the service provided. It was found that departmental days were organised with teams whereby they met to discuss the findings, with the intention of improving outcomes for children and young people through a process of continuous learning from audits. A quality assurance role was established in September 2022 to provide support for managers in their quality assurance function. Furthermore managers promoted and cascaded good practice to the teams so that there was a growing understanding of what was working well. This was done through in house workshops and a mentoring programme. However, there was evidence of shortfalls in the quality of audits undertaken as they did not always identify that actions had not been completed in a timely manner to safeguard children or that agreed social work visits had been undertaken. Strengthening of practice and learning from audits of children on the CPNS was still evolving within the teams and required further improvement.

There was a tracker in place that monitored appeals lodged in respect of child protection conferences. The tracker was reviewed by the inspectors and found to be of good quality with six appeals recorded for 2022 and one for 2023. Two appeals were sampled that were detailed and had minutes of meetings held with the complainants to have a voice in the proceedings, as well as detailed background information completed along with an outcome of the findings and recommendations.

The service operated a complex case forum where senior managers came together to provide advice and direction on how to address risks and the management of these risks to the child. Inspectors found that practice and record keeping in this area was of good quality and detailed. Practice in the area required that children who were active on the CPNS 12 months with unmanageable child protection concerns to be presented to the complex case forum for review. Inspectors reviewed this tracker and found that it was detailed and captured referrals to the complex case forum for children that had been active on the CPNS 12 months or longer. This strengthened oversight for managers in monitoring the progress of cases sent through to the forum. Inspectors reviewed two cases that had been presented to the complex case forum, and found that a detailed referral form had been completed. The complex case forum provided clear and concise feedback and recommendations however, inspectors found that there was potential to further strengthen the use of complex case forums in cases of cumulative neglect.

Inspectors reviewed the complaints log and found that there were five listed that related to the remit of the inspection. Inspectors found that the management of complaints was good with thorough and fair consideration taking place that demonstrated that complaints were taken seriously, with actions of how these could be resolved where appropriate.

There were good systems in place for the management and oversight of child protection conferences by the CPC Chairpersons. There was an established register in place since 2021 that was updated daily and tracked the schedule of CPC's convened, the review date and any delays experienced. In addition, the CPC chairpersons held a tracker of any delays in convening CPC meetings. This tracker outlined the reasons for any delays or cancellation of CPC meetings.

Staff worked in a supportive and reflective environment. They had opportunities, through supervision, departmental days and practice forums that explored their training needs in areas of interest that enhanced their practice. Inspectors found that staff had regular supervision and the quality of the supervision across teams was good in terms of agenda items discussed and the recording of the meeting. It was clear what was needed to progress planning for children and that this helped inform staff practice and monitored the care provided to children. Supervision provided oversight of decision-making and progression of tasks that ensured that progress was regularly monitored and understood by all, and decisions were not made in isolation. There were clear lines of communication that allowed for information to be shared efficiently and effectively between area teams. This was confirmed by staff members, and they said that they felt supported and were kept up-to-date by managers.

There was a strong culture of promoting multi-agency collaboration to drive improved safeguarding approaches for children on the CPNS, through better information sharing and high quality and timely safeguarding responses. The area manager held regular meetings with commissioned services to review service provision. This resulted in areas of need being highlighted so that the appropriate resources could be allocated for. The area manager increased the financial budget for two additional services to provide support in areas where social work teams identified an increased demand for family support for the children open to child protection teams. The CPW service worked in collaboration with other agencies involved in a child and families life and there was a strong presence of professionals from different backgrounds in attendance at CPC meetings.

At the time of the inspection the area had submitted two 'Need to Know' notifications to the regional office in the previous six months. These two 'Need to Knows' related to the remit of this CPNS inspection. The 'Need to Know' reporting procedure is Tusla's national incident management system and is used to notify Tusla's national office of serious incidents and adverse events in relation to children in care and known to Tusla. The service area had identified a number of risks, had detailed recording of these risks, and the impact and some actions were outlined in response to such risks. Inspectors found the 'Need to Know' log to be detailed however, required further improvement in the recording of the manager's response. Inspectors reviewed the two 'Need to Knows' to examine their effectiveness. Inspectors found that the practice of recording 'Need to Knows' varied. In one case the actions outlined in response to one of the 'Need to Knows' was detailed, with some having been completed, others remained outstanding and a review date was scheduled. There was an absence of management response being clearly defined in the second 'Need to Know' recorded.

The area had appropriate systems in place to identify, report on, manage and escalate risks as required. Inspectors reviewed the area's risk register that had six items that related to the remit of the inspection and found that it was detailed and of good quality. The risk register had one new item that related to the challenges faced from Tusla's new case management system, TCM, in that the governance and oversight of cases was significantly compromised. In addition, the area had long standing items that related to staffing issues and the lack of availability of appropriately qualified staff, since 2019, and also the risk to children with a disability not being able to access appropriate disability services to meet their needs in a timely manner, since 2018. For each risk identified, additional control measures were put in place apart from one. This was in relation to the disruption caused to management oversight of cases from new case management system, TCM. At the time of the inspection there were no definite timelines or actions of how the case management system would offer greater governance. In relation to the risk to children accessing disability services there was a resolution between the HSE and Tusla in the demarcation and issues around responsibility for funding.

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.

Staff and managers demonstrated a good knowledge of legislation, regulations, policies and standards for the protection and welfare of children appropriate to their role and responsibility. Learnings from audits and inspections were shared with teams in the area. The new *'National Guidelines for Tusla – Child Protection Conference and Child Protection Notification System June 2022'* was also being embedded into practice.

Judgment: 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.

There were clearly defined governance arrangements and structures in place that set out lines of authority and accountability. Managers demonstrated leadership and a commitment to continuous improvements to the service through different forums. Audits were undertaken however, they were still at the initial stages of being embedded into practice to achieve better outcomes for children. There were effective arrangements in place that monitored adverse events and complaints to ensure that they were appropriately addressed. The service area was working to creatively strengthen the engagement of parents and extended families through expanding support network arrangements.

Further improvement was required in implementing recommendations made by PASM in relation to cumulative harm.

Judgment: Substantially 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.

The area had appropriate systems in place to identify, report on, manage and escalate risks as required. The service placed a strong emphasis on the monitoring of the service it provided to children and families. Learning from audits, feedback and other service information was shared across the teams to improve the quality and safety of services.

Judgment: Compliant

Quality and safety

In general, inspectors found that there were effective systems in place for the management and review of children on the child protection notification system. However, improvements were required in relation to the timeliness of ICPC and RCPC's being convened and the monitoring of child protection plans in the absence of safety network meetings. In addition, further development was needed in the identification of cumulative harm and the consideration given at each stage when new information is received about a child listed on the CPNS. Although the Joint Protocol was in operation, the practice of using the escalation procedures in a timely manner needed to be further strengthened in accessing services for children living with moderate to severe disabilities.

Data provided to inspectors prior to the inspection showed that all children placed on the child protection notification system had an allocated social worker. At the time the data was returned there were 89 children on the CPNS, and by the time of the inspection this had risen to 93.

The service area were working with a new national guidance, *'National Guidelines for Tusla – Child Protection Conference and Child Protection Notification System'* after it was introduced and came into effect from June 2022. This provided new guidance in the management of child protection conferences and the management of and access to the CPNS. Upon review of documentation and speaking with senior managers, the service area had experienced an interim challenge in convening child protection conferences in 2022. This was due to an administration position becoming temporarily vacant due to a leave of absence.

The risk to the delivery of service that was impacted by the vacant position was placed on the areas risk register by the area manager, in August 2022, and remained on the risk register at the time of the inspection. The area manager had identified the direct impact on children, as conferences that were scheduled could not go ahead and the circulation of 14 children's conference records were significantly delayed. Additionally, there was the potential for the cancellation of Initial Child Protection Conference's (ICPC) and a significant impact on the timeliness for holding ICPC's. Evidence that a temporary administrator was requested to fill the vacant position was provided, to facilitate the ongoing convening of child protection conferences and that existing administration colleagues provided assistance as an interim measure.

Inspectors reviewed a business case that was submitted in August 2022 for additional administration support as the current team was insufficient to provide an effective service due to increased workload. This had led to a delay in timeliness of plans, records and child protection conference invitations being issued.
Inspectors reviewed 34 children's case files as part of the inspection. Out of the 34 children's files, 31 were reviewed for the purpose of the timeframes for convening initial child protection conferences.

In relation to the convening of ICPC's for children who had been assessed as at ongoing risk of significant harm, in the majority of cases reviewed, these were not held in a timely manner. Inspectors found that where social workers identified that there were concerns that a child was suffering or was likely to suffer significant harm, a request for an initial child protection conference was made. However, there was varied performance in relation to the timeliness of ICPCs following the request and approval by conference chairs. In the sample of files reviewed by inspectors, one request for an ICPC was made in March 2022, was approved by the conference chair seven days later yet the ICPC did not take place until July 2022. In addition, a further case was identified whereby a request for an ICPC was requested in January 2023 but was not held until March 2023. Overall, it was identified by inspectors that significant delays were experienced in 22 cases for the convening of ICPC's. These delays ranged from two, three and five months, following the outcome of an initial assessment and a determination that a child was at ongoing risk of significant harm. This practice was not in line with best practice or national guidance that a request is made in a timely manner. In a separate case where the seriousness of risk was identified, the case was met with delays with the ICPC not convened until five months after the initial request. Although the rationale for the delay was recorded and proportionate and the risks to the children were monitored through an interim plan, concerns remained surrounding the significant delay in convening of an interdisciplinary, interagency meeting.

The above delays did not place the children at any additional risk as social work involvement had continued to ensure the children were monitored. However, the practice of convening timely ICPCs was not in line with Tusla national guidance or the national standards.

Inspectors examined two cases where there were concerns that a child in utero may be at ongoing risk of significant harm following their birth. This was to determine if these cases were assessed in line with the child protection and welfare processes. A pre-birth child protection conference is an ICPC concerning an unborn child. Inspectors found that requests for a pre-birth ICPC were made in a timely manner after a pre-birth assessment gave rise to concerns that an unborn child may likely suffer significant harm. The requests were approved within days by the conference chairs and the convening of the ICPC was prioritised within 14 days.

Inspectors observed a pre-birth initial child protection conference that was attended by the parents, social worker, team leader, public health nurse, hospital social worker, An Garda Siochána and members from the family safety network. The conference chair emphasised to all present that they would present the views of the unborn child in terms of their best interests. The discussion at the pre-birth ICPC was in-depth and focused on a number of areas that included strengths, resilience, protective factors that would have a positive effect on the unborn child's life, actions taken by the parents which promoted safety for example; attendance at appointments and engagement with services. Additionally, discussions were had about the current concerns for the unborn child, harm they may experience and the impact of this on their short and long term development. Good practice was found with the CPC chairperson not only focusing the conference on the above areas but also on the context of the family's history. Both parents were provided with the opportunity to engage in the conference, to have a voice, and respond to professional feedback and give their opinion. A comprehensive safety plan was devised at the conference and family and their extended network were supported to play a central role in ensuring the child would be safe and protected from harm. The parents were also informed of the appeals process by the CPC chairperson.

In addition, two cases were reviewed where the request for child protection conference was withdrawn to determine if this was appropriate and in line with national standards and guidelines. It was found that for these two cases the decision to withdraw the request for a child protection conference was appropriate and a rationale was documented, that outlined that the risk had reduced, and there was management oversight of any continuing actions to be completed.

The service area had three child protection conference chairpersons in position who were experienced at facilitating the meetings and who were not directly involved in

the assessment and management of the child protection case. A third position was vacant however, the process for recruitment to the role was already underway. The CPC chairpersons facilitated the sharing and analysing of information about the children and their parent's capacity to safely care for them, within the context of wider family support, and their environment, at these meetings. The CPC chairpersons established the context of the likelihood of children suffering significant harm and what needed to happen to safeguard and promote the children's welfare. The CPC chairpersons told inspectors that the area had continued to maintain a blended approach that was introduced during the COVID-19 pandemic, when convening child protection conference meetings, whereby the family were in the room with the CPC chairperson and some professionals, with other professionals joining through teleconference. This ensured a greater attendance of professionals who were involved with the family.

The CPC chairperson offered to meet with parents in advance of the conference to explain the process. From a review of children case files inspectors found good evidence of this, in one case the chairperson met with a mother of an unborn baby in person to develop a genogram and identify potential support persons. In addition, inspectors also saw evidence that CPC Chairpersons had spoken with parents through telephone, when a meeting with them in person could not be arranged. Reports prepared prior to the conference by professionals were talked through with the parents by either the social worker or chairperson so that they were not met with any surprises, and a partnership was created with them. Parents were also provided with a booklet that explained the child protection conference in easy accessible language. Inspectors found good recognition of additional supports provided to families from different ethnic backgrounds and parents with literacy and or learning needs. Social workers ensured that key documents that included safety plans and child protection records were translated into the families' first language.

The conference records reviewed clearly showed that the chairperson ensured the involvement of children, parents, network members and professionals. However when concerns arose in relation to both parents attending the conference, then this was well managed, such as where domestic violence was a concern and both parents planned to attend. The CPC chairpersons liaised with domestic violence services and parents, and consideration was given to splitting the conference into different parts. Conference chairs told inspectors that managing domestic violence concerns at conferences was an ongoing challenge and that a national protocol was being developed.

Inspectors found that the service area promoted parents and members of the safety network's right to be heard by using interpreters to tackle the language difficulties

met, so that one language could be translated into another. This enabled the parent and safety network members to give, receive and understand information.
There was good practice in the promotion of children rights to participate in conferences and have their voice heard. Inspectors found that the CPC Chairpersons took into consideration children's age and understanding whether it was in the child's best interests to attend. The CPC Chairpersons explained to inspectors that participation of children was about finding different ways for children to have their voices heard and attendance at the meetings was one form. Upon reviewing case files inspectors found that the conference chairs provided opportunities for children to contribute and express their views prior to the conferences taking place and also during the meeting. The chairpersons took into consideration the child's age, ability and developmental capacity to determine if it was in their best interests to attend. For children who were too young, and unborn babies, professional assessments and observations of the child were the primary source used as the child's voice.

Additionally, evidence of child friendly tools were used to elicit the voice of the child. However, documenting the voice of the child in minutes of conferences and safety plans, particularly in relation to the experience of babies and younger children, required further improvement. Staff told inspectors that the practice of recording evidence of child participation within the teams 'was not good' and were looking at how to 'improve this for the child'.

Inspectors found that not all children choose to attend the conferences and the reason for this was documented. The service area was seen to promote the child's preferred means of communication and this resulted in positive engagement. From review of files, inspectors found evidence of children attending the conferences, and conveying their wishes and feelings at the meeting. In another case, a child decided not to attend the conference and their views were relayed at the meeting by the social worker. Inspectors found two cases where obtaining the views of the children occurred in the presence of a parent. Although this approach was a necessary step on the journey to more respectful and meaningful engagement with the children and the parent, it would have limited the children's ability to speak openly. Inspectors did not find evidence that alternative options were explored to get the child's views.

Children were provided with child friendly booklets that explained the child protection conference in simple language and pictures.

The chairpersons told inspectors that child participation training had been and was continuing to be rolled out to the social work teams and inspectors had an opportunity to review this training record during the inspection. The training discussed the Child and Youth Participation Strategy and looked at the Lundy model of participation that provided guidance on the steps to take to give children and

young people a meaningful voice in decision-making. Figures provided by the chairpersons highlighted that 24 out of 42 children attended the child protection conference meetings in person in 2022.

The child protection conference records reviewed by inspectors used child focused language about the child's lived experience of what was working well, what professionals were worried about, what needed to change, and how this change could be achieved. Discussions at conferences focused on the severity and source of the harm, parenting practices, including interaction patterns with the child, ability to meet the child's basic needs, parenting knowledge and skills, ability to protect, mental health needs and substance misuse. Inspectors found that parents were provided with an opportunity to respond to the information professionals presented and this was well documented. The conference records contained a clear rationale for why children were listed on the CPNS and they also indicated that the outcome of the conference was promptly shared with parents and relevant agencies.

Immediate child protection plans (CP Plans) were put in place for children awaiting their initial child protection conference and a clear picture was provided of the risks and actions required to keep them safe. CP plans were routinely discussed in supervision and were generally implemented within two weeks of the ICPC. Staff told inspectors that child protection plans were discussed as an agenda item in supervision and that training had been rolled out in this area to the teams. CP plans reviewed by inspectors were clear and comprehensive and took account of the safety goals for the child in relation to the dangers and or worries and risks identified, and the actions needed to be taken to address them. The CP plans outlined the actions required to ensure the safety and developmental needs of children were met. CP plans also provided clear direction to manage developmental delay in older children and ensure their health needs were met. Additional support was provided through social care leaders to families where there were concerns about parental capacity to promote safe routines and boundaries in handling incidents of children missing from home, or children with offending behaviour. Inspectors found that the safety planning addressed the minimum requirements to be met to keep the child safe and included how people from the safety network would manage keeping the child safe over time. However, inspectors found that the process for reviewing and updating CP plans varied and was directly impacted by the frequency and effectiveness of safety network meetings. Barriers had been faced in parents identifying individuals to participate so that safety network meetings could begin.

Inspectors found that further improvement was needed in the identification of cumulative harm and the consideration given at each stage when new information was received about a child listed on the CPNS. Particular attention was required for

children living in neglect and in environments with high levels of substance-misuse and domestic violence related harm. Although cumulative harm was identified as an area that required additional training and guidance in the findings of the PASM report 2022, this was not part of the service improvement plan for 2023, as discussed in the previous section under capacity and capability.

The practice of convening Review Child Protection Conferences (RCPC) earlier than the scheduled date where the risks to a child had escalated varied across the teams. Good practice was seen where a RCPC was held three months earlier due to the parents not engaging in the child protection process, while in three cases RCPCs were held earlier where concerns for children in utero were identified. However, managers were not always making effective use of its powers to call an earlier RCPC where significant new risks had been identified following the ICPC. Evidence was found in two cases where the CPC Chairperson raised the possibility of holding a RCPC with the team leader, but this was never progressed resulting in the cumulative harm in two cases not being assessed and the risks continued to escalate. Alternatively, in a separate case there was no evidence that the potential for convening an earlier RCPC had been considered following a significant event. Inspectors found that in seven cases the convening of RCPC was one month outside of the timeframe and not in line with national guidance. The CPC chairpersons told inspectors that the *'social work team leaders are the risk managers'* when making decisions about RCPC's. Further improvement was needed in strengthening practice across the four teams in the use of RCPC where new risks present themselves.

When children were no longer assessed as being at significant harm, they were appropriately de-activated from the CPNS in a timely way. Inspectors reviewed the records of seven children who had been removed from the CPNS in the six months prior to the inspection. All records reviewed indicated that the decisions were appropriate and provided a clear transition from child protection safety planning to an ongoing safety planning approach. There was evidence of the revised safety plan being discussed in full with parents and network members and agreed following children being de-listing.

Good practice was found where regular visits were made to a family home, including unannounced visits from point of the children being listed on the CPNS to the decision being made to de-list. The records clearly outlined whether children were seen and provided an analysis of the quality of parenting observed. These home visits helped to reinforce the expected standards of care as set out within the safety plan, focused on parental awareness of the bottom lines and ensured an open discussion of progress was had.

Inspectors reviewed four children's cases that were re-activated on the CPNS in the previous six months, as part of the inspection. These cases demonstrated that the social workers and managers had taken appropriate action to remove children from the care of their parents into the care of Tusla, when required.

Supervision orders were also used to strengthen the oversight and monitoring of the impact of the child protection safety plans. It was found that timely action was taken to seek legal advice on three of the cases reviewed, with the exception of one, to secure supervision orders to gain access to assess the needs of children and their home environment. Further improvement was needed to ensure that no child listed on the CPNS is subject to delays in securing such protection.

Inspectors reviewed three children's case files where the expansion of the Family Welfare Coordinator role extended to support the facilitation of safety networks was used. Although the new pilot was at its initial stages of being embedded, inspectors found that it added further support to the family and to the convening of network meetings.

The social workers and managers worked with external agencies in building partnerships, so that additional support was made available to children active on the CPNS, and their families. The service had built up strong co-operation with other agencies that included schools, public health nurses, maternity services and domestic violence services. There was good evidence of inter-agency working between relevant professionals and other agencies, as seen in two cases reviewed, to build and strengthen two mothers parenting capacity. This included access to parenting assessments and substance misuse services. Good practice was also seen in a case where professional's meetings were scheduled to take place on a monthly basis with the school and disability services to strengthen the monitoring of the children's welfare and promote them to avail of the specialist services the children required.

Furthermore, it was found that child protection conferences included the participation of culturally specific advocates, where appropriate, to help raise awareness of the specific needs of families from different ethnic backgrounds that included traveller liaison. Inspectors found that this platform offered parents the opportunity to be involved in the process and to express their views about their circumstances, wellbeing and need for support. Inspector's review of children's records indicated that there was a strong joint working approach with An Garda Siochána in circumstances where children were exposed to parental substance misuse and domestic violence within their home with the Gardaí undertaking safety and welfare checks to support and manage any safeguarding risks. As discussed under the capacity and capability section, the area manager was working closely with other organisations in

identifying and securing joint partnerships to deliver a tailored service in areas that had the greatest need.
Inspectors found that the *'Joint Protocol for interagency collaboration between the Health Service Executive and TUSLA to promote the best interests of children and families',* was in operation. Inspectors found from document review and interviews that the interagency and regional meetings with the HSE had taken place and acted as a referral pathway to services for children living with moderate to severe disabilities. Inspectors reviewed three case files to determine the effectiveness of staff and managers use of the Joint Protocol. It was found that practice varied in the use of the Joint Protocol. Good practice was found in one case where the escalation procedure was used by managers that resulted in several support services being approved and put in place, this included respite care and occupational therapy. However, in a separate case it was identified that where a child and family experienced delays in accessing services and interventions, senior managers were slow to utilise the Joint protocol escalation procedures to gain further direction of how the child's needs would be followed up. Inspectors found that from the three cases reviewed, more progress was needed in implementing the Joint Protocol escalation procedures or a resolution through the local disability teams in accessing services for children living with moderate to severe disabilities placed on the CPNS.

The inspectors observed the live CPNS register of children within the service area who had been identified as being at ongoing risk of significant harm during the CPC process. Inspectors found that the register of children's names was secure and well maintained. 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 an ongoing risk of significant harm to the child, leading to the need for a child protection plan. The chairperson's administration staff had responsibility for maintaining and updating the CPNS at child protection conferences and this was overseen by the chairperson. Access to the CPNS was strictly confined to Tulsa staff and members of An Garda Síochána. Additional relevant services that required access to the CPNS could access this through the Tusla out-of-hours social work service. Inspectors found that of the files reviewed, the children's status in relation to the CPNS had been updated in line with the CPNS national guidelines.

Standard 2.6

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

Further improvement was needed in the convening of ICPCs in a timely manner and in line with national guidance. There were independent and experienced CPC Chairpersons facilitating the conferences. Participation of children and parents at the conferences was practiced by the CPC Chairpersons. For children this was dependent on their age and understanding. CP plans reviewed by inspectors were clear and comprehensive but the process for reviewing and updating CP plans varied and was directly impacted by the frequency and effectiveness of safety network meetings.

Further improvement was needed in the identification of cumulative harm and the consideration given at each stage when new information is received about a child listed on the CPNS. The CPNS was updated and managed in line with Children First National Guidance.

Judgment: Substantially Compliant

Standard 2.7

Children's protection plans and interventions are reviewed in line with requirements in Children First.

Making effective use to convene RCPCs earlier than the scheduled date where significant new risks had been identified following the ICPC, required further improvement. Where RCPCs were held they were not always convened within the six month timeframe. Clear rationale was given where children had remained active on the CPNS for an extended period of time. Decisions made to remove children from the CPNS was done in a timely manner and it provided a clear transition from child protection safety planning to an ongoing safety planning approach.

Judgment: Substantially Compliant

Standard 2.9
Interagency and inter-professional cooperation supports and promotes the protection and welfare of children.
There was good evidence of inter-agency working between relevant professionals and other agencies. There were communication systems in place to ensure that information was appropriately shared with the relevant professionals. Culturally specific advocates participated in the child protection conferences that supported awareness of the specific needs of families from different ethnic backgrounds. Further improvement was needed in utilising the '*Joint Protocol for interagency collaboration between the Health Service Executive and TUSLA to promote the best interests of children and families'* escalation procedures in accessing services in a timely manner for children living with moderate to severe disabilities.
Judgment: Compliant

Compliance Plan for Cork Child Protection and Welfare Service OSV – 0004383

Inspection ID: MON-0039637

Date of inspection: 18th – 21st April 2023

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 3.2	Substantially Compliant

Outline how you are going to come into compliance with Standard 3.2: Children receive a child protection and welfare service, which has effective leadership, governance and management arrangements with clear lines of accountability.

1. **Action**: The Significant Harm Guidance document developed by the Area in 2022 will be re-circulated to all staff and will be on the agenda for team meetings, supervision and the Team Leader practice development Forum across the area.

   Responsible: Principal Social Workers in the four Child Protection Welfare and Alternative Care teams.
   Completion: 30/6/2023

2. **Action**: Cumulative Harm is on the Agenda for the Dissemination of Learning group who are planning a workshop.
   Responsible: Dissemination of Learning Group
   Completion: 30/12/2023

Standard 2.6	Substantially Compliant	

Outline how you are going to come into compliance with Standard 2.6: Children's protection plans and interventions are reviewed in line with requirements in Children First.

1. **Action**: The Area will continue to monitor timeliness for Conferences on a quarterly basis with the aim of convening Conferences within a 4 to 6 week timeframe.

   Responsible: Child Protection Conference Chairpersons
   Completion: Ongoing

2. **Action**: The reports on timeliness of conferences will be presented at the Child Protection Conference Area Forum meetings on a quarterly basis. They will be presented to the Principal Social Workers as required to inform practice, safety planning and Audit requirements in the event of timelines not being met.

   Responsible: Child Protection Conference Chairpersons
   Completion: Ongoing

3. **Action**: Risk assessments will be completed where timelines are not compliant with the guidelines and the local Standard Operating Procedure

   Responsible: Child Protection Conference Chairpersons
   Completion: Ongoing

4. **Action**: Child Protection Conference Chairpersons will continue to discuss timelines for Conferences in Group Supervision on a 6 weekly basis.

   Responsible: Child protection Conference chairpersons
   Completed: Ongoing

Standard 2.7	Substantially Compliant

Outline how you are going to come into compliance with Standard 2.7: Children's protection plans and interventions are reviewed in line with requirements in Children First.

1. **Action:** The Supervision guidance document 2021 for team leaders will be updated to include a prompt for review Child Protection Conference where new risks have been identified or Child Protection Conference safety plans cannot be implemented.

   Responsible: Principal Social Worker Quality Assurance in conjunction with the Area Principal Social Workers and the Child Protection Conference chairpersons
   Completed: 30/6/2023

2. **Action**: The Guidelines for Social Workers and Team Leaders responsible for children active on the Child Protection Notification System Tusla South East and South West Regions issued in February 2023 will be re-issued.

   Responsible: Principal Social Worker Area teams
   Completed: 30/6/2023

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 3.2	Children receive a child protection and welfare service, which has effective leadership, governance and management arrangements with clear lines of accountability.	Substantially Compliant		30/12/2023
Standard 2.6	Children's protection plans and interventions are reviewed in line with requirements in Children First.	Substantially Compliant		Ongoing
Standard 2.7	Children's protection plans and interventions are reviewed in line with requirements in Children First.	Substantially Compliant		30/06/2023