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:	Galway-Roscommon
Name of provider:	Tusla
Type of inspection:	Focused CPNS
Date of inspection:	11 – 14 July 2022
Lead inspector:	Pauline Clarke Orohoe
Support inspector(s):	Una Coloe, Sharron Austin
Fieldwork ID:	MON-0037045

About monitoring of child protection and welfare services

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 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, Equality, Disability, Integration and Youth 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.

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

Theme 1: Child-centred Services	☐
Theme 2: Safe and Effective Services	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 submitted by the area
- interviews with:
  - the area manager
  - the chair of child protection case conferences
  - the principal social workers
- focus groups with:
  - social work team leaders
  - social workers
  - social care leaders
- the review of:
  - local policies and procedures, minutes of various meetings, staff supervision files, audits and service plans
  - 15 children's case files
- phone conversations with:
  - five parents.

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
HIQA 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 six regions, each with a manager known as a regional chief officer. The regional chief officers report to the national director of services and integration, who is a member of the executive management team.

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

Service area

Galway Roscommon is one of 17 areas within Tusla's Child and Family Agency. The geographical county of Galway is divided into two distinct administrative areas: Galway City and County Galway. County Galway is the second largest county in Ireland, with County Roscommon being the 11th largest county by area. Galway city has been Ireland's most rapidly developing urban area and is the only city in Ireland to have experienced above average population growth during 1996-2016. County Roscommon is predominantly rural in character.

The Galway\ Roscommon area is under the direction of the Regional Chief Officer for Tusla's West North-West region and is managed by the Area Manager. Two Principal Social Workers in the Area have responsibility for the Child Protection and Welfare Service. In addition, the PSW for Child Protection and Welfare Services in Galway holds responsibility for the management of the retrospective team. The area manager delegated child protection and welfare conferencing responsibilities to one principal social worker.

Administration staff assisted in the delivery of the service. All three principal social workers reported directly to the area manager.

There were eight child protection and welfare teams across the two counties, with six in Galway and two in Roscommon. When at full complement, all social work teams had one social work team leader, one senior social work practitioner and three to five social workers.

At the time of the inspection, there were 40 children listed as active on the CPNS and 14 children had been delisted in the previous six months. All children listed as active on the CPNS had an allocated social worker. There were eight whole time equivalent (WTE) social work vacancies, one WTE team leader and one WTE senior social work vacancy on the child protection and welfare team.

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
07 July 2022	14:30pm – 16:00	Pauline Clarke Orohoe	Lead Inspector
11 July 2022	09.30 – 17:00 9:30 – 17:00 9:00 – 17:00	Pauline Clarke Orohoe Una Coloe Sharron Austin	Lead Inspector Support Inspector Remote Inspector
12 July 2022	08:30 – 17:00 09.00 – 17.00 09.00 – 17.00	Pauline Clarke Orohoe Una Coloe Sharron Austin	Lead Inspector Support Inspector Remote Inspector
13 July 2022	09.00 – 16.00 09.00 – 16.00 09.00 – 17.00	Pauline Clarke Orohoe Una Coloe Sharron Austin	Lead Inspector Support Inspector Support Inspector Remote Inspector
14 July 2022	10.30 – 11.15	Pauline Clarke Orohoe	Lead Inspector

Views of people who use the service

Efforts were made by inspectors, in conjunction with the service area to speak with children. Of the 40 children listed as active on the Child Protection Notification System (CPNS) at the time of the inspection, 62.5% were under 10 years of age. Older children decided not to speak with inspectors during the inspection fieldwork. The area were given 10 questionnaires to distribute to children listed on the CPNS. Inspectors received one completed questionnaire from a child, who said that their social worker visited them regularly. They felt that the social worker had made a difference to their life, and that they talked to the child about why the service was working with their family. The child felt listened to, and said that their views were taken into account when their safety plan was developed.

HIQA inspectors spoke with five parents who had experienced the child protection conference (CPC) process, and whose children were, or had been listed as active on the CPNS. All of the parents who spoke to inspectors had an allocated social worker, and were aware of the CPC process.

Parents said that social workers met with them prior to process and shared their report. The CPC chairperson also made contact with families in advance of the conference. Parents told inspectors that they felt respected, and were able to have their say at the conference. Parents said that they were enabled to bring a support person with them to the conference, and they "felt respected and listened to". One parent said that while they found the CPC meetings stressful, their social worker had spoken to them before the meeting about the process. In addition, another parent said that the positive actions they were taking were discussed at the conferences. A parent told inspectors that while their children choose not to attend the conference, the social worker had met with them before and after the CPC meeting to gather their views and share information with them. Another parent said that the social worker visited their child every fortnight.

Parents felt that social work services had helped their families. They said they understood the role of other services and professionals who attended the conference. Parents spoke positively about the involvement with social work and other support services during the CPC process. One parent told inspectors that there had been a great improvement in their family situation, and they were grateful for the services that were provided to their family. Parents said that social workers "gave me every opportunity", while a second parent felt that if they phoned the social worker "they listen to me".

All of the parents said that they were aware of the child protection safety plan that was developed, and the information that it contained. However two of the parents said they had not received a copy of it.

Capacity and capability

The service had strong and effective leadership, governance and management arrangements in place which ensured that children listed on the Child Protection Notification System (CPNS) received a consistent, good quality service that was well led. The service performed its functions in line with the relevant legislation and standards, and was generally compliant with policies. There was an open, transparent culture within the service where learning was valued. Governance systems were well established within the area, and the recommendations from audits were implemented. The service had systems in place to gather feedback on the service provided to children and families involved with the CPC process. The Tusla interim national guidelines on CPC's and the CPNS had been reviewed and updated by the Child and Family Agency, however these updated guidelines had not been implemented at the time of the inspection.

The focus of this inspection was on children placed on the CPNS and who were subject to a child protection safety plan and the aligned governance arrangements in place to ensure effective and timely service delivery to these children. As per *Children First: National Guidance for the Protection and Welfare of Children* (2017), when concerns of ongoing risk of significant harm are identified during the assessment and intervention with children and families then Tusla is required to organise a CPC. In circumstances where a child has been identified as being at ongoing risk of significant harm at a CPC, their name is placed on the CPNS. This meant that children on the CPNS were closely monitored by the social work department to ensure they were safe and interventions were provided to children and families to reduce risks to children. Children who have child protection plans continue to live at home, unless it emerges that a child is unsafe despite a child protection plan being in place. This may result in a decision to remove the child from the home to the care of Tusla. This inspection also reviewed children whose names had been made inactive on the CPNS in the last six months. These children had been assessed as no longer being at risk of significant harm.

The Tusla interim national guidelines on CPC's and the CPNS guided practice in the area. These guidelines had recently been reviewed and updated by the national office of Tusla, though the updated guidelines had not been implemented at the time of the inspection. Inspectors found that the area had developed a local guidance document which provided staff with clear direction on the actions required and associated timelines, from the point of requesting an initial CPC through to monitoring the child protection safety plan. Social workers and managers had a clear understanding of their responsibilities in relation to the CPC process. They demonstrated a clear understanding of local and national policies, procedures and standards in relation to

the CPC process. Inspectors found that discussions regarding the local and national processes took place at team meetings in the area, and cases were appropriately referred for CPC.

The service area had strong governance arrangements in place, with clearly defined roles and responsibilities identified across the team. The area was managed by an experienced area manager and the management team consisted of two principal social workers with responsibility for eight team leaders across the child protection and welfare teams in the area. The area manager had overall responsibility for the governance of the child protection notification system. Each child listed as active on the CPNS had an allocated social worker. The area manager delegated the conferencing duties to a principal social worker, who carried out the role of CPC chairperson. The chairperson was responsible for ensuring that requests for CPC's met the required threshold for a CPC. They also held responsibility for ensuring that CPC's were scheduled, organised and facilitated in a timely manner. The service had an administrative staff member who updated and maintained the CPNS with oversight from the CPC chairperson.

Inspectors found that the CPC chairperson had good systems in place for the management and oversight of child protection conferencing. They maintained a tracker of CPC's convened in the area, which included the date for the next review. In addition, the CPC chairperson held a tracker of any delays to CPC meetings. This tracker outlined the reasons for any delays or cancellation of CPC meetings. Inspectors found that CPC meetings were held in a timely manner, and CPC meetings were promptly rescheduled when required. At the time of the inspection, the service was continuing with a blended approach to CPC's as this allowed the family to be in the room with the chairperson, and it also allowed professionals to join remotely. The service facilitated CPC meetings through teleconference. The CPC chairpersons said that this approach allowed a greater number of network members and professionals to attend the meeting.

The management team had robust governance systems in place which provided appropriate assurances to the area manager on the quality of the service provided to children on the CPNS. The area manager maintained a tracker of children on the CPNS, and reported on metrics for the service to Tusla's national office and through the national adequacy report. The service presented the metrics for the area at Tusla's performance conferences. The area manager provided supervision to the three principal social workers in the area, and he in turn received supervision from the regional chief officer for the area. The area manager had oversight of the CPNS, and received notifications when the CPNS for the area was accessed by the relevant services. The CPC chairperson held quarterly meetings with the principal social workers for child protection and welfare. The purpose of these meetings was to

ensure consistent practice that was in line with local and national policies and procedures. This information was reported at the monthly area management team meetings with the area manager and other principal social workers in order to communicate and develop plans to manage issues arising for the teams across the service. The CPC chairperson also attended these meetings. Areas for service improvement were identified and discussed. These included the need for consistency regarding the frequency of visits to children listed on the CPNS, and adherence to Tusla's standard business process in relation to the use of specific template on NCCIS. The area manager told inspectors that these governance arrangements assured them that children listed on the CPNS service were in receipt of a good quality, safe service.

At the time of the inspection, the service were developing the integrated business plan for the area. The area manager told inspectors that nine planning meetings had been held throughout the area in order to develop the plan, which was due for completion in the coming weeks. The business plan for the area was aligned to Tusla's corporate and regional business plan. The plan outlined key priorities for the service for the coming 12 months. Actions outlined in the plan included the continued participation of children in the CPC process, and the discussion of cases involved in the CPC process at each supervision session. Families and professionals were routinely asked for feedback in relation to their experience of the CPC process. The CPC chairperson told inspectors that she reviewed the completed evaluation forms when returned, and plans to complete a full review of all evaluation forms at the end of the year to observe themes and learnings. The CPC chairperson told inspectors that seeking feedback from families can present a challenge, and this is an area that the service will continue to focus on developing. Inspectors found that while the business plan was at development stage, actions from the plan were being progressed within the area.

There was a culture of openness and service improvement within the service. There were good communication systems in place, and the senior management team were committed to learning and development. Management meetings and local team meetings were held on a monthly basis in order to share learnings, areas for service development, relevant information and ensure that the service provided was in line with national policy, legislation and standards. For example, the area manager told inspectors that he held a tracker of cases on the CPNS in order to identify trends across the service. Through this process the area manager identified that the service area had a low number of children listed on the CPNS when compared to the population of the area, and the number of referrals to the service. The area manager held a meeting with the management team regarding thresholds for bringing cases to the CPC process, which brought about an increase in the number of cases appropriately referred to the CPC process in the area. Social work staff told inspectors

that the service was well managed, and said that there was open communication with senior managers.

Inspectors found that staff and managers had appropriate knowledge of legislation, regulations, policies and standards for the protection and welfare of children in line with their role and area of responsibility. Learnings from HIQA inspections and audits were discussed across the various staff meetings. The CPC chairperson had completed training sessions with business support staff to ensure consistent practice in relation to recording the minutes from CPC meetings. The area manager told inspectors that staff supervision was used as an opportunity to discuss practice, and as a means of ensuring that children and families received a safe and consistent service. The service had also held workshops with the lead for Tusla's national service delivery model with a focus on embedding this practice into the CPC process.

The service operated a complex case forum which met on a quarterly basis. The purpose of the complex case forum was to have an objective review of cases by senior management, where advice and consultation was provided. Practice in the area required that children who were having their third CPC review meeting needed to be presented to the complex case forum for review. Inspectors found that this had not been implemented in the area, and was identified as an area that required improvement during a local audit of CPNS cases. Inspectors reviewed a case that had been presented to the complex case forum, and found that a detailed referral form had been completed in advance of the case being presented at the forum. The complex case forum provided clear and concise feedback and recommended actions for consideration in relation to the case presented. While clear actions were outlined following the review, inspectors found that there had been delays in progressing these actions. This case was escalated to the area manager for assurances at the time of the inspection.

Supervision was embedded within local practice but improvements were required in its frequency. Inspectors found that supervision records generally evidenced good analysis of the child's situation and the relevant risks that were present. However, improvements were required to ensure that supervision took place in line with Tusla policy and that records were signed off by both the supervisor and supervisee. The principal social worker and team leaders told inspectors that cases listed on the CPNS, and those that may need to be referred to the CPC process were discussed at each supervision session. In addition, the supervision template had been amended to reflect these discussions. This was evident from the team leader supervision files that were reviewed. Inspectors found that improvements were required to ensure that case management records were consistently available on children's files, to allow management to have access to the relevant information in relation to a case. Where case management records were available, there were clearly recorded discussions

regarding the progress of the case, and detailed actions that required follow up, evidencing good management oversight of the case.

The service area placed a strong emphasis on quality improvement. The area used auditing as a means of providing assurance of the quality of the child protection service. Inspectors found that managers consistently followed up with staff in relation to actions that were required following audits to ensure consistent practice, and adherence to policies, procedures and guidelines across the service area. The area were monitored by Tusla's national practice assurance and service monitoring (PASM) team, who had completed an audit on notifications of suspected child abuse to An Garda Síochána and referral pathways to a local service. The service completed regular local audits on different areas of practice, including file reviews of children listed as active on the CPNS and staff supervision, by managers with appropriate levels of experience and expertise. Inspectors found that actions arising from audits were followed up on by managers, for example where staff were requested to use the relevant templates to record safety plans and visits to children, and upload the necessary documents on children's files in a timely manner. The CPC chairperson and principal social workers for the child protection and welfare service maintained oversight of the local auditing and monitoring activity for the service. They developed action plans following the completion of each audit in the area. Managers told inspectors that they were aware of areas of practice that required improvement including the use of consistent naming conventions and uploading the relevant documents onto children's files. These issues were followed up on through supervision, audits, team meetings and training. Inspectors found evidence of these discussions and follow up actions through a review of case files and documents.

The area had appropriate systems in place to identify, report on, manage and escalate risks as required. There was a risk register which was up to date and reviewed as required. Risks were appropriately escalated. Risks relating to the CPNS service included the risk of children on the CPNS not being seen regularly by social workers, lack of specific services and staff vacancies. The service also operated a "need to know" system whereby individual cases involving significant risk were escalated to senior management. Staff told inspectors that risks were shared across the teams.

There were staff vacancies in the area, however, the area mitigated against this risk for children on the CPNS by ensuring that all children listed on the CPNS had an allocated social worker. There were eight WTE social work vacancies, one WTE team leader and one WTE senior social work vacancy on the child protection and welfare team. The area manager acknowledged that while he was assured that children and families were receiving a safe service, the staff vacancies across the child protection and welfare team had an impact on social workers ability to meet with children and

families more frequently. This issue had been identified as a risk for the area, and had been escalated to senior management.

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 knowledge of legislation, regulations, policies and standards for the protection and welfare of children appropriate to their role and responsibility. Inspectors found that learnings from audits and inspections were shared with teams in the area. The area had developed a local guidance document for staff in relation to the CPC process. However, while the interim national guidelines on child protection case conferencing and the CPNS had been reviewed and updated by Tusla's national office, these updated guidelines had not been implemented in the area at the time of the inspection.

Judgment: Substantially compliant

Standard 3.2

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

The service had robust governance systems in place which ensured that service delivery was reviewed, actions from audits were progressed and there was a consistent flow of information across the service and the various teams. There were clearly defined roles and responsibilities identified across the team.

Judgment: Compliant

Standard 3.3

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

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 and auditing of the service it provided to children and families. The service were in the process of developing a specific integrated business plan for the service.

Judgment: Compliant

Quality and safety

Overall, 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 frequency of visits to children listed as active on the CPNS, and the quality and monitoring of safety plans. In addition, there were delays in completing and uploading the required forms onto the child's file, and challenged in service provision in the area had resulted in the needs of a child with complex needs not being met.

The service convened initial CPC meetings for children who had been assessed by social workers as being at ongoing risk of significant harm or neglect in a timely manner. Local practice in the area was that initial CPC meetings were convened within 15 working days from approval of the CPC request. Inspectors reviewed five children's files for the timeliness of initial CPC's, and found that one initial CPC was held within this 15 day timeline, with two cases having their initial CPC with four weeks of the request being approved. The initial CPC for a fourth case was delayed due to reasons outside of the areas control. The initial CPC for the fifth case took place four months following the request for the CPC being approved, with no reason for the delay noted on file. However, these delays did not place the children at any additional risk as social work involvement had continued to ensure the children were monitored. Social workers and managers told inspectors that they have a robust CPC process in the area, which progresses cases in a timely manner taking account of the needs of children and families.

The CPC's held in the area were comprehensively facilitated by appropriately trained, independent professional. While the CPC chairperson had management responsibility for the family welfare conference coordinator and the NCCIS team leader, the area manager was assured of the independence of the role through regular communication with the chairperson. The CPC records reviewed clearly showed that the chairperson of the conference ensured the involvement of children, parents, network members and professionals. The CPC chairperson offered to meet with parents in advance of the conference. They outlined the risks for children during the conference, and what needed to happen to keep children safe with their family. Inspectors found that CPC's were well attended by professionals from external services. The CPC chairperson told inspectors that the area had continued to maintain a blended approach to CPC meetings, whereby the family were in the room with the CPC chairperson, while the professionals joined the meeting through teleconference. This ensured a greater attendance of professionals who were involved with the family.

Parents and children were encouraged to attend and participate in their child's CPC meeting. Social workers told inspectors that they met with parents to share their reports with the family in advance of the CPC meeting. This practice was in line with the areas local practice guidance document. Parents were facilitated to attend the CPC, and to have people from their support network, including extended family members or friends attend also. Inspectors found that the CPC records detailed discussion of the risk for the child. While the CPC chairperson said that children were invited to attend the CPC meetings where appropriate, inspectors found that the children in the cases that were reviewed had not attended their CPC meetings. However, as noted earlier 62.5% of the children listed as active on the CPNS in the area were 10 years or under. Social workers had used appropriate tools in order to gather the views of children for the meeting. Staff said that tools such "Me and My Conference" booklet were useful in explaining the child's story to them, and capturing their worries and wishes for the future. The service had identified increased children's participation in the CPC meeting process as an action for their integrated business plan for the year. Inspectors found that the CPC meeting records were appropriately shared with parents. Team leaders said that social workers give feedback to the children and parents following the CPC meeting. Inspectors found that parents received a written copy of the CPC records.

Tusla guidelines for CPCs direct that regular safety planning meetings are convened following the CPC to develop a more detailed child protection safety plan, to review the safety of the child and also monitor the progress made in relation to the case. The local guidance document in the area indicated that the child protection safety planning form was to be launched on NCCIS within seven days of the CPC meeting. The principal social worker told inspectors that file audits have shown that records of network meetings have not been consistently available on children's files. Inspectors found evidence of this during case file reviews. Management and staff acknowledged that the priority for the social work teams was to ensure that safety was in place for the child, and at times this resulted in delays completing and uploading the required forms onto the child's file.

Where a child was listed as active on the CPNS, it was the responsibility of the allocated social worker to develop a child protection safety plan, together with the family, their network and the professionals involved. The quality of child protection safety plans in the area was mixed. Inspectors reviewed seven files for the quality of child protection safety plans, and found that the frequency of visits to children and families, and network meetings was not consistently recorded on the safety plans. In addition, the actions required to be taken by the network to keep the children safe had not been recorded on one of the safety plans. In a second file reviewed, inspectors found that there was a delay of almost three months in launching the safety plan on NCCIS. While this did not present a risk for the child, management

were unable to have the necessary oversight of the current safety plan for the child. In addition, inspectors had to request an up-to-date child protection safety plan on a third file, as the plan had not been appropriately updated following the previous review CPC meeting to reflect the current situation for the child. Improvements were required to ensure that there were clear plans in relation to the schedule of visits and network meetings that were required to take place to ensure that child protection safety plans were keeping children safe.

Inspectors found that child protection safety plans were less effective where a child's own behaviour was placing them at risk. Inspectors reviewed one child's file where there was agreement by the services involved that the child needed a specialised, alternative care placement to address their complex needs. However, the service was unable to identify a suitable placement for this child, and they remained at home at the time of inspection.

Social workers completed announced and unannounced home visits to children and families. Where timeframes for visits had been set out on a child's safety plan, inspectors found that visits did not take place in line with the timeframes set out on the child's file. However, there was evidence of frequent contact with the family through phone calls and by additional services. The area manager acknowledged that staff vacancies across the child protection and welfare teams had an impact on social workers ability to meet more frequently with children listed as active on the CPNS. Management in the area acknowledged that practice across the teams had varied in relation to how often children listed as active on the CPNS needed to be visited. On some of the areas teams, it was agreed that children were to be visited fortnightly, while on the other teams the timeframes for visiting children was decided on a case by case basis. The principal social worker told inspectors that when a child was recently listed as active on the CPNS, visits were to be completed on a fortnightly basis. The timeframe between visits could then be extended as safety developed around the child. The area had also developed a template to record statutory visits to children listed on the CPNS. However, inspectors found that this template had not been used consistently across the area. Improvements were required to ensure that there was a consistent practice in relation to visiting children listed on the CPNS to ensure their safety was maintained.

Child protection safety plans were reviewed at network meetings, as well as during the review CPC meetings. Cases where children were listed as active on the CPNS were also discussed during staff supervision sessions. Staff told inspectors that safety plans were reviewed on a monthly basis. Inspectors found that network meetings to review the progress of the child protection safety plans did not take place in line with the timeframes agreed within the plan. In addition, inspectors found that social workers used creative means of supporting families to identify support networks, including the use of family welfare conferencing. Additional actions were taken by the

area to keep children safe, including the decision to apply to court for a supervision order. However, improvements were required to ensure that network meetings took place on a regular basis to monitor the progress made in relation to the safety plan.

Inspectors found that there was good evidence of multidisciplinary involvement and cooperation across the service area. Generally, there were effective communication systems in place to ensure that information was appropriately shared with the relevant professionals, and the progress of interventions by other services was monitored and reviewed. Strategy meetings and contact with relevant professionals was evident on children's files. There was good attendance by other professionals at CPC meetings. Inspectors found evidence that training and briefing sessions were held across the service area with social work teams and other professionals. A training needs analysis had been completed for the senior local management liaison forum in the area, and discussions were ongoing regarding briefing sessions and online training being delivered by Tusla and An Garda Síochána. This ensured that good working relationships were maintained with services in the area with a focus on keeping children safe.

The area presented and discussed relevant cases under the Joint Protocol for Interagency Collaboration Between the Health Service Executive and Tusla – Child and Family Agency to Promote the Best Interests of Children and Families. These meetings took place on a regular basis. Staff told inspectors that at times there can be challenges in ensuring that the needs of children with complex or additional needs are met. Inspectors reviewed one case file that had been discussed at this forum. While agreements had been made in relation to addressing the needs of the child, at the time of the inspection there was no evidence that progress had been made in progressing the necessary actions. The area manager told inspectors that the case had been escalated to senior management. This case was escalated to the area manager during the inspection fieldwork where satisfactory verbal assurances were provided. Following the inspection, satisfactory written assurances were provided by the area in relation to the actions to be taken to ensure the child's needs were being appropriately addressed.

Review CPC meetings were held in a timely manner, in the majority of cases reviewed. Inspectors reviewed six files for the timeliness of reviews, and found that in five of the files, reviews occurred within six months of the previous CPC. There was a delay in holding the review for one of the six cases, and the reasons for the delay were recorded on the child's file. The rationale for the delay was appropriate, and ensured management oversight of the case due to the complexity of the child's needs. The CPC chairperson maintained a tracker which provided oversight of the schedule for all CPC meetings held across the service area. This tracker clearly outlined the reasons for changes to the dates of CPC meetings. Inspectors also found evidence that, where appropriate, due to an increased risk to a child, review

CPC meetings were held earlier than the six month timeline. This ensured that appropriate actions were taken to keep children safe. Inspectors observed a review CPC through teleconference. The CPC chairperson was found to be appropriate in their role, and ensured that the concerns, strengths and progress made in ensuring the children were safe were clearly discussed at the meeting. All participants were given the opportunity to participate, and relevant reports and information was shared.

At the time of the inspection, three children had been listed as active on the CPNS for longer than 12 months. Inspectors reviewed two of these files focusing on the length of time they had been active on the CPNS. Consideration had been given to the length of time that the children had been listed as active on the CPNS in both files. There was detailed discussion and analysis in relation to the progress that had been made, complicating factors relevant to the case and the risks that remained. As noted earlier, cases that were at their third review were required to be presented to the complex case forum. However, inspectors did not find evidence that either case had been presented to the forum.

Inspectors reviewed five cases that had recently been made inactive on the CPNS. There were clear rationales and decision-making recorded for the decision to delist each child which were appropriate. Inspectors found that where children were taken into care while on the CPNS, there was a clear administration process whereby the principal social worker for child protection and welfare notified the CPC chairperson that the child needed to be de-listed. Families were appropriately informed when children were no longer active on the CPNS. Inspectors reviewed three cases that had been reactivated on the CPNS in the last 12 months. Inspectors found that appropriate steps had been taken to bring the case back to the CPC process. The decisions which led to the children becoming active on the CPNS again were appropriate as the risks for the children had significantly increased. The service had appropriate systems in place to manage appeals and complaints made in relation to the CPNS service. At the time of the inspection, the area had received two complaints in relation to cases listed on the CPNS. Inspectors reviewed the complaints that were received, and found that all were managed in an appropriate and timely manner. The area had not received any appeals in relation to the CPC process.

Inspectors found that when a child was placed on the CPNS, the abuse category could not be changed nor could more than one category of abuse be recorded on the CPNS. This meant that when one type of abuse was no longer a concern for the child but another type of abuse had emerged, the register did not accurately reflect the concern for the child. The CPC chairperson told inspectors that while additional information could be recorded in the commentary box on the child's record on the CPNS, this had not been the practice in the area. The CPC chairperson and the area

manager said that as the out of hours social work service have access to NCCIS, they are assured that, when required, services have access to relevant information about the child.

The CPNS was held as a confidential 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. Harm was defined as physical, emotional, sexual abuse and neglect. The chairperson's administration staff had responsibility for maintaining and updating the CPNS at child protection conferences and this was overseen by the chairperson. The CPC chairperson completed a decision sheet which contained the information that the administration staff used to update the CPNS. The CPNS was updated immediately following each CPC meeting. 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 they could access this through the Tusla out-of-hours social work service. The service received notifications from the national CPNS support lead in relation to when a CPNS search was requested on a child in the service area and this was monitored and overseen by the CPC chairperson. Inspectors found that on one of the files reviewed, a child's status in relation to the CPNS had been amended prior to the CPNS being updated. The CPC chairperson that this had occurred as an error, and had been addressed with the teams. At the time of the inspection, the CPC chairperson had effective systems in place to ensure that the child's status on NCCIS was updated in line with the CPNS.

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

Initial CPC meetings were scheduled without delay, and robust child protection safety plans were put in place to keep children safe. The CPC meetings held in the area were comprehensively facilitated by appropriately trained, independent professional. Parents and children were encouraged to attend and participate in their CPC meeting. The quality of child protection safety plans in the area was mixed. The service ensured that children who were assessed as being at ongoing risk of significant harm or neglect were referred to the CPC service in a timely manner. Improvements were required to ensure that there were clear plans in relation to the schedule of visits and network meetings that were required to take place to ensure that child protection safety plans were keeping children safe. At times there were delays in completing and uploading the required forms onto the child's file.

Judgment: Substantially compliant

Standard 2.7
Children's protection plans and interventions are reviewed in line with requirements in Children First.

Review CPC meetings were timely in the vast majority of cases reviewed. Where delays occurred, the reasons for these delays were recorded on the child's file on NCCIS. Clear rationale was given where children had remained active on the CPNS for an extended period of time. Children were appropriately delisted with clear rationales provided for the decision to delist the child.

Judgment: Compliant

Standard 2.9
Interagency and interprofessional cooperation supports and promotes the protection and welfare of children.

The service supported and promoted multidisciplinary involvement and cooperation to ensure that the needs of children were met in a timely way. There were communication systems in place to ensure that information was appropriately shared with the relevant professionals. Challenges in the provision of suitable alternative care placements in the area had resulted in the needs of a child with complex needs not being met.

Judgment: Not Compliant

Compliance Plan for Child Protection and Welfare Service OSV – 0004398

Inspection ID: MON-0037045

Date of inspection: 11 July 2022

Introduction and instruction

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Standard Heading	Judgment
Standard 3.1	**Substantially compliant**
Outline how you are going to come into compliance with Standard 3.1: The service performs its functions in accordance with relevant legislation, regulations, national policies and standards to protect children and promote their welfare. • The National Guidelines for Child Protection Conferences and the Child Protection Notification System has been updated. • The local area has been advised by the Chief Social Worker that the updated National Guidelines will be launched nationally on the 30th of September 2022. • The Area Manager will ensure that all local teams are briefed accordingly and will replace the locally developed child protection conference guidance document with the updated National Guidelines. • This process will be completed by the 30/11/2022.	

Standard Heading	Judgment
Standard 2.6	**Substantially compliant**
Outline how you are going to come into compliance with Standard 2.6: Children who are at risk of harm or neglect have child protection plans in place to protect and promote their welfare. • The local area has organised a safety planning learning and development program workshop on the 27th & 28th of September with Workforce Learning and Development. This workshop will focus on helping social workers to create robust safety plans that are tested over a specific time frame. The workshop will also review how network members are involved in the monitoring and reviewing of safety plans. The workshop will assist social workers to develop a clear understanding of when to escalate a case if safety is not being achieved. This workshop will include links to the HIQA standards. This process will be led at a local	

level by the PSW's for Child Protection and the PSW who chairs the Child Protection Case Conferences.

- Schedule of visits: The local area will endeavor to achieve better consistency around the frequency of visits to children on the CPNS. The local Area will prioritize that all children listed on the CPNS will initially be visited fortnightly and thereafter at intervals in line with their specific safety plan. The Area will record the details of these visits on the statutory visit template for children listed on the CPNS. This process will be led at a local level by the PSW's for Child Protection and the PSW who chairs the Child Protection Case Conferences.
- The PSW's for CP and the PSW for CPC's will conduct a departmental briefing by the 30/11/2022 with all social workers and SWTL's on the CP teams to go through all documentation on NCCIS specific to CPC's. The local NCCIS support persons will participate in this briefing. In addition, a review of all locally developed templates will take place to agree consistency of use going forward for the Area. The local SWTL's and PSW's will evidence the implementation of these processes through on-going supervision and audits.
- The PSW's for CPC will consult with SWTL's and business support staff to develop a plan to ensure that documents are uploaded in a timely manner for children listed on the CPNS. This process will be completed by the 30/11/2022.

Standard Heading	**Judgment**
Standard 2.9	**Not Compliant**

Outline how you are going to come into compliance with Standard 2.9: Interagency and interprofessional cooperation supports and promotes the protection and welfare of children.

The local Area is committed to following up on all the assurances provided in the correspondence dated the 28th of July 2022. This includes:

- The HSE have agreed to convene and lead a clinical team to review and plan for the specific needs of the young person subject to the review by HIQA. The local Area will be represented on this team by the SWTL and the PSW for CP in Galway. The progress of this team review will be monitored at the interagency joint protocol meeting, with the next meeting taking place on the 8/09/2022.The local Area Manager attends these meetings on behalf of Tusla.
- If the review team determines that this young person requires a residential placement, Tusla will work cooperatively with the HSE to identify a suitable placement and will meet its full obligations under the terms of the interagency protocol including funding and governance responsibilities.
- The Tusla Regional Chief Officer for the area has scheduled a regional inter agency joint protocol meeting with the HSE CHO2 Chief Officer on the 19/09/2022. The progress of this case will be reviewed in full at this meeting.

- If Tusla is unable to achieve progress on this case at a local or regional level, the case will be further escalated by the RCO for resolution at a national level under the terms of the interagency protocol.
- At a local team level, the case will remain an open allocated case and work will continue with the family around their support needs.

Section 2:

Standards to be complied with:

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

Standard	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Standard 3.1	The service performs its functions in accordance with relevant legislation, regulations, national policies and standards to protect children and promote their welfare.	Substantially Compliant	Yellow	30/11/2022

Standard	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Standard 2.6	Children who are at risk of harm or neglect have child protection plans in place to protect and promote their welfare.	Substantially Compliant	Yellow	30/11/2022

Standard	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Standard 2.9	Interagency and interprofessional cooperation supports and promotes the protection and welfare of children.	Not Compliant	Orange	Progress on this case will be monitored via the local area and regional joint inter agency protocol meetings. If there is no clarity on progress by the 30/09/2022, the case will be escalated for resolution at a national level by the RCO.