



Report of an inspection of a Child Protection and Welfare Service

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| Name of service area: | Dublin North City Child Protection and Welfare Service |
| Name of provider: | Child and Family Agency-Tusla |
| Type of inspection: | Focused CPNS |
| Date of inspection: | 10 August 2021 |
| Lead inspector: | Jane Mc Carroll |
| Support inspector(s): | Erin Byrne Caroline Browne Sabine Buschmann |
| Fieldwork ID | MON-0033737 |

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:

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|---|--------------------------|
| Theme 1: Child-centred Services | <input type="checkbox"/> |
| Theme 2: Safe and Effective Services | X |
| Theme 3: Leadership, Governance and Management | X |
| Theme 4: Use of Resources | <input type="checkbox"/> |
| Theme 5: Workforce | <input type="checkbox"/> |
| Theme 6: Use of Information | <input type="checkbox"/> |

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 and two principal social workers
- interview with the child protection conference chairperson
- focus groups with social work team leaders
- focus group with 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 20 children's case files
- phone conversations with two 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

The Authority wishes to thank 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 for 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

Dublin North City is one of Tusla's 17 areas for the provision of local services. It has a population of 252,358, with 44,927 of these being children (2016 census data) which represents 17.8% of the total population. It is a small, densely populated urban area incorporating the Dublin's North Inner City, Cabra, Finglas, Ballymun, Whitehall, Fairview & Clontarf. There is a high level of need in the area, as demonstrated by the highest rate of referral under Children First; highest rate of children on the CPNS and highest rate of children in Care across all 17 areas (Tusla data from Q4 2020).

The area is under the direction of the service director for Tusla Dublin North East, and is managed by an area manager. The child protection conferencing service was delivered by one principal social worker and administration staff who were employed to assist in the delivery of service. A second principal social worker post for the child protection conferencing service was unfilled at the time of the inspection. The social work service was delivered through seven social work teams which covered the areas of Dublin 1, 3, 7, 9 and 11. These teams reported to two principal social workers for child protection and welfare in the area.

There were 60 children listed on the CPNS at the time of the inspection and these cases were allocated across the seven social work teams. All children on the CPNS were allocated a social worker at the time of the inspection.

At the time of the inspection, there were 12.5 whole time equivalent vacancies of key frontline social work/care vacancies across the child protection and welfare service. Five of these vacancies were being temporarily filled by agency staff.

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 |
|----------------|---------------------|--|--|
| 10 August 2021 | 09.30 to 17.00 | Jane Mc Carroll Erin Byrne Caroline Browne Sabine Buschmann (remote) | Inspector Inspector Inspector Inspector |
| 11 August 2021 | 09.00 to 17.30 | Jane Mc Carroll Erin Byrne Caroline Browne Sabine Buschmann (remote) | Inspector Inspector Inspector Inspector |
| 12 August 2021 | 09.00 to 17.00 | Jane Mc Carroll Erin Byrne Caroline Browne Sabine Buschmann (remote) | Inspector Inspector Inspector Inspector |

Views of people using the service

Efforts were made by inspectors, in conjunction with the service area, to engage with children as part of this inspection. Children chose not to speak to inspectors.

Parent's views were also sought and HIQA spoke with two parents about their experiences of the service provided to them and their children in line with the theme of this inspection.

Both parents shared positive experiences of the service provided to them and their children to inspectors. Parents described good levels of open communication between them and social workers. One parent said that the social workers explained everything about the CPNS to them and the reasons why their child's name was listed on the CPNS register. Another parent said that the social worker explained their role and remit very clearly and the parent understood why the social worker was worried about the safety of their children.

Both parents said that their views were sought and valued by social workers and the child protection conference chair. One parent said, "I can give my views at the child protection conference, they don't judge me, they support me." The other parent also said that their views were listened to and considered at all times. One parent said that they were routinely asked for their feedback on quality of service provided to them, whilst the second parent said that they were not routinely asked.

Parents told inspectors that they received written minutes from child protection conferences and copies of safety plans devised by social workers to promote the safety and welfare of children. This supported their sense of inclusion and participation in the service being provided and they were aware of the actions to be taken to reduce risks to children.

The support received by parents from social workers was described positively by both parents. They used descriptors such as 'brilliant', 'available' and 'supportive' to explain the way in which social workers engaged with them.

Both parents said that their families had benefitted from access to a range of support services provided to them through their social worker, such as family support services and children's support programmes.

Capacity and capability

Overall, the service needed to improve and strengthen governance arrangements in order to provide a consistent and compliant service to children listed on the Child Protection Notification System (CPNS). Governance arrangements were established but their effectiveness varied. Risks to the service persisted over time and this hindered the provision of a responsive and consistent service to all children deemed to be at ongoing risk of significant harm. This inspection found non-compliances in the service's ability to perform its functions in line with relevant legislation, national policies and standards. The lack of responsive pathways for children on the CPNS who required alternative care posed major risk to the quality and safety of the service.

The focus of this inspection was on children placed on the CPNS register who were subject to a child protection safety plan and the aligned governance arrangements in place to ensure effective and timely service delivery to these children. As per Children First (2017), when concerns of ongoing risk of significant harm are identified during the assessment and intervention with children and families, then Tusla is required to organise a Child Protection Conference (CPC). In circumstances where a child has been identified as being at ongoing risk of significant harm at a CPC, their name is placed on the Child Protection Notification System (CPNS) register. This means that children on the register are closely monitored by the social work department to ensure they are safe and interventions are 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 at ongoing risk, or if the child protection plan is deemed not to be working. These cases may result in a decision to remove the child from the home. This inspection also reviewed children whose names had recently been removed from the CPNS in the last 6 months.

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

During this inspection, the area manager and senior managers identified that there were a variety of challenges impacting upon the delivery of child protection and

welfare services to children listed on the CPNS. They told inspectors that the challenges and risks to the service included unmanageable case loads, high turnover of staff, violence and aggression towards staff by service users, increased demands for a service from the community, increase in the number children requiring care in the area, limited access to suitable placements for children requiring alternative care and challenges securing legal orders for children. Data provided by the area manager showed an increase in the number of children in the area being admitted to care since the COVID-19 pandemic in 2020, as well as a decrease in the number of children being discharged from care in the area. They said that this posed significant challenges in the provision of alternative care for children and these trends were escalated from the service director to Tusla's national management team in April 2021.

The child protection notification system comprises a confidential register of children in the area who have been identified as being at ongoing risk of significant harm. Inspectors found that while the register was secure and well maintained in line with Children First 2017: National guidelines on the protection and welfare of children, the category of abuse recorded for each child on the CPNS was limited to the primary type of abuse or harm posed to them. In line with Tusla policies and procedures, the entry of each child's name only occurred as a result of a decision made at a CPC that there was a risk of significant harm, leading to the need for a child protection plan. Harm was confined to physical, emotional, sexual abuse and neglect. This register is there to notify a small group of relevant professionals who make decisions about the safety of a child, and access is strictly confined to Tulsa social workers, members of An Garda Síochána, out-of-hours general practitioners and hospital medical, social work or nursing staff.

There were interim national guidelines on child protection case conferencing and the child protection notification systems but these had not been subject to review and required updating by the Child and Family Agency, as a means of assurance of quality and consistent practice. This also impacted on the consistency of the service delivered nationally. In this inspection, inspectors found that basic minimum requirements relating to the monitoring and implementation of child protection safety plans, such as frequency of visits and safety planning meetings, were not explicit and practice varied in the area. Feedback provided to inspectors following this inspection, described that a review of national guidelines scheduled for 2019 was postponed in order to further develop and embed the national approach to child protection social work practice in Tulsa, and to gain evidence and confidence of its effective use and implementation. However, several actions associated with this development were curtailed in 2020 and 2021 due the risks and restrictions associated with COVID-19, coupled with significant challenges to the service as a result of the recent cyber-

attack. Furthermore, Tusla's national management team provided feedback to inspectors that they were satisfied that the current guidelines were working well in 2019 and 2020. Actions outlined in the compliance plan with this report state that a full review of the guidelines is scheduled for 2022 which will include the participation of children and families.

There were governance systems in place in the area to support the management and oversight of service provided to children on the CPNS but not all of them were robust, such as risk managements systems and monitoring systems. This is discussed in the body of the report. The area manager had systems of oversight of the child protection conferencing service in place, such as governance meetings, strategic management meetings, complex case forums, staff supervision and informal communication, but some of these needed to strengthened.

The service area benefitted from having a stable and experienced management team who knew the area and needs of the community well. There were clearly defined roles and responsibilities in relation to the management of children listed on the CPNS. The area manager delegated oversight of the day to day implementation of child protection safety plans and monitoring of children listed on the CPNS to two principal social workers and their respective social work teams. They worked in two separate locations across the area and held a range of duties across all aspects of the child protection and welfare service.

The area manager delegated conferencing duties to a principal social worker who was a child protection chairperson and who also had responsibility for maintaining and updating the CPNS. She also managed requests for child protection conferencing from social workers and determined their suitability for conference. Inspectors found that there were good levels of consultation between the chairperson and social work staff and managers and cases reviewed by inspectors were appropriately referred for CPC. There was one vacant chairperson post which meant that there was reduced opportunity and scope for the chairperson to fully develop quality improvement systems within her remit and this was acknowledged by the area manager.

The organisational culture in the service encouraged open communication and team working. Inspectors found that there were good communication systems in the area and established working relationships between managers and staff. There was a good level of connectivity across all grades and this facilitated good information sharing. This was evidenced in management and governance meetings minutes, and from discussions by inspectors with the senior management team and social workers throughout the inspection. Inspectors found that the senior management team and social workers team leaders, had a high level of knowledge of individual cases of

children listed on the CPNS register and when clarification was sought on actions or decisions on individual children's files, this was provided to inspectors.

There were good strategies in place to support staff. The service area's leadership encouraged continuous professional development and managers supported and valued their workforce. There were opportunities for social workers to access additional supervision and support to manage the challenges associated with their role. There were coaching programmes in place to support newly promoted social work practitioners progress in their new posts. Inspectors found that social work managers undertook casework in conjunction with newly qualified social workers who were managing cases on the CPNS. Staff described a positive working culture within the area.

Strategic management systems were developed in the area. The area's service plan and improvement plans were appropriately aligned to Tusla's own cooperate plan objectives and national service development plan. There were monthly strategic management meetings in the area to review the progress of actions and targets set out to improve the quality of the service, including aspects of the service which were relevant to the theme of this inspection. For example, an integrated service map of therapeutic supports for children and families in the area was recently completed. A local initiative to enhance the level of contact between social work and An Gardaí Siochana in line with the Joint Protocol for interagency collaboration between Tusla and An Gardaí Siochana was also being implemented. However, ongoing and persistent risks to the service posed serious challenge in the area's capacity to implement all of Tusla's national business plan actions. This is set out in detail further on in the report.

The area manager convened monthly area management meetings and area governance meetings in order to communicate and manage issues relevant to all teams across the service, such the strategy for service recovery from the recent cyber-attack and the management of risks to service delivery associated with COVID-19. Inspectors reviewed minutes of meetings held in 2021 and 2020 and found standing agenda items associated to quality and risk management as well as the management of performance, HIQA inspections and relevant compliance plans. During these meetings, the child protection chairperson also provided analysis of data relevant to the oversight and management of cases on the CPNS to the area manager. There was evidence of actions taken to improve the quality of the service. For example, there was a reduction in delays for review child protection conferences for children on the CPNS from 30 overdue in July 2020 and to eight overdue at the time of this inspection.

Complex case forums were used in the area to facilitate objective review of cases listed on the CPNS and to provide scrutiny of the effectiveness of child protection

safety planning. Cases were referred into the forum for discussion by social worker managers where there were challenges and complexities which required review. Managers and social workers who spoke to inspectors said that these meetings were a strong mechanism for assurance and accountability in relation to practice and service delivery. Actions were agreed at the forum to ensure that appropriate measures were in place in response to risks posed to the safety and welfare of children on the CPNS. However, in one of the 20 cases reviewed by inspectors, actions identified in the complex case forum were delayed in their implementation. In a second case reviewed by inspectors, a referral was not made to the complex case forum despite this action being recorded on file. This was a missed opportunity to provide critical analysis and review of increased risks to a child and this case was subsequently escalated by inspectors for assurances from the area manager.

Monitoring and auditing systems to identify specific areas for service improvement in the management of children listed on the CPNS required improvement. In June 2020, Tusla's practice assurance and service monitoring team completed a monitoring audit of the service provided to children listed on the CPNS. This audit provided the area manager with assurances that there was a responsive and effective service was maintained during the COVID-19 pandemic. In addition, in January 2021, on foot of a national lockdown, the area manager convened a review of all cases listed on the CPNS in order to assure herself of appropriate safety planning for children and to prioritise and plan for visits/ contact with children and families during this time. This review identified immediate next steps in the management of cases. The CPNS chairperson also conducted some monitoring of the quality of the service through a formal feedback system offered to external professionals and families who attended CPCs. However, other planned audits such as a safety planning audit and an assessment of child centred practice in the service were delayed. Inspectors found that there was a lack of routine or systematic auditing to assure managers of the effectiveness of the service being provided.

The restrictions associated with COVID-19 had a significant impact on the delivery of the service in the area but these were managed well. Social workers endeavoured to engage with children and families in alternative ways and there was an Interim Child Protection Conference Guidance which set out measures to mitigate against challenges in the facilitation of conferencing due to COVID-19. The area also had access to appropriate technology to facilitate video conferencing where appropriate.

While there were risk management systems in place to ensure that all risks in the service were reported on and managed, this system was not effective in the reduction of prolonged and persistent risks to the service. Risks recorded on the area risks register, which affected the quality and safety of service provided to children listed on the CPNS, included insufficient placements for children requiring care, high levels of staff vacancies in the area and unmanageable caseloads. Actions were not effective in

reducing these risks, some of which were listed on the area risk register for 6 years. For example, inspectors found that the area had experienced a prolonged shortfall between the demand for child protection services, and the resources to meet that demand for a number of years. Prior to this inspection, these risks were escalated to the service director in June 2021, following further systemic increases in the demands to the service since March 2021, coupled with 14 staffing vacancies across the service at that time. Actions to address these risks at a regional and national level, such as recruitment campaigns, social work graduate programmes and approval for the use of agency staff, had not made a significant impact and, as a result, social work professionals had caseloads, including children on the CPNS, which they said were too high. Consequently, social work practitioners said it was difficult to sustain the level and quality of intervention required in cases of children listed on the CPNS.

Inspectors found that the lack of suitable placements for children requiring alternative care had been recorded on the risk register in the area since 2015. In response to this risk, the senior management team worked hard to increase the number of foster care placements available to the area. There was a comprehensive strategy for the recruitment and retention of foster cares in the region and the development of a regional fostering assessment team to explore the possibility of matching children to carers within the Dublin North East Tusla region. In addition, there were focused media campaigns, social media advertisements, online information sessions and designated personnel in the area to promote and maximise foster care recruitment opportunities. However, inspectors were also informed the impact of the COVID-19 pandemic posed real challenge to the success of these initiatives. At the time of this inspection, the risks associated with insufficient placements for children requiring care remained in the area.

The area also used a process called 'need to know', to escalate individual cases of children who required alternative care where there were no suitable placements identified but inspectors found that this system was not robust. Individual cases on the need to know register were closed on foot of children being placed in care and there was no evidence of additional actions taken to address the systematic nature of this risk. In addition, inspectors found that there was a failing in the use of need to know to escalate one case of a group of children requiring alternative care. This meant that both the individual and cumulative impact of these risks could not be effectively monitored and reviewed. Worryingly, the service could not perform its statutory functions for all children who required care and protection in the area.

This inspection found non-compliances in the service's ability to perform its functions in line with relevant legislation, national policies and standards. The lack of responsive pathways for children on the CPNS who required alternative care posed major risk to the quality and safety of the service. Inspectors found that admission to care, in circumstances when all alternative means of protecting children had been

exhausted, was delayed for 4 children listed on the CPNS. While one child had been placed in care at the time of this inspection, for 3 children, who were identified as requiring care placements in February 2021, Tusla had not initiated care proceedings to protect these children in line with legislative requirements. Inspectors were informed that this decision was taken due to the lack of suitable care placements available to the agency. Following the inspection, inspectors escalated this case for immediate assurances from the area manager in relation to safety of these children. HIOA received an appropriate response that indicated the children were in a place of safety.

This non-compliance was also escalated by HIOA to national senior management of Tusla, following this inspection and a response was received from Tusla which outlined actions to be taken to address the ongoing risks regarding the lack of suitable care placements for children.

The provision of formal supervision, as a method of providing assurance on the quality of service provided to children listed on the CPNS, required improvement. The quality of supervision records reviewed by inspectors varied. The areas of improvement for supervision identified by inspectors included the frequency of supervision in cases generally and the need to ensure that all aspects of supervision were completed. Actions arising from supervision were not always made explicit and subsequent supervision sessions did not always review their progress. There was also evidence of good supervision practice including good discussions of cases and clearly recorded managerial direction. Inspectors also found evidence of continued professional development on most records reviewed and supports provided to social workers as required.

As stated, Tusla had recently been the target of a major cyber-attack which had compromised their national child care information system (NCCIS) for several weeks prior to the inspection. Inspectors found that actions were taken to ensure the continued recording of CPC conferencing as well as other pertinent records in relation to the assessment of children's circumstances and safety. For example, there were hand written notes recorded during this time and uploaded on children's files.

Standard 3.1

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

There were governance structures in place at local, regional and national level to support the delivery of the CPNS service in line with the legislation and the standards but these were not all effective. The service could not perform its statutory functions for all children who required care and protection in the area and inspectors found that admission to care, in circumstances when all alternative means of protecting children had been exhausted, was delayed for 4 children listed on the CPNS. This posed major risk to the quality and safety of services provided to children on the CPNS.

There were interim national guidelines on child protection case conferencing and the child protection notification systems but these had not been subject to review and required updating by the Child and Family Agency. This impacted on the consistency of the service delivered nationally.

Judgment: Not 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.

Accountability for the service was clearly defined. The organisational culture encouraged open communication and team working. Governance arrangements were developed but some monitoring and oversight systems required improvement. The area had strategic and operational plans in place and these provided clear direction in the planning and delivery of the service. However, ongoing and persistent risks to the service posed serious challenge in the area's capacity to implement all of Tusla's national business plan actions. The governance structures at a regional and national level could not support the effective implementation of strategic and operational plans to ensure all aspects of service delivery was in line with relevant standards and legislation.

Judgment: Not Compliant.

Standard 3.3

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

There were risk management systems in place to ensure that all risks in the service were reported on and managed. Some risks were addressed such as risks associated with COVID-19 and the recent cyber-attack, but other risks persisted. Ongoing risks such as the lack of placements, high levels of staff vacancies and staff turnover, and high caseloads made it continuously difficult for practitioners to sustain the level and quality of intervention required in cases of children listed on the CPNS. The service did not have the necessary resources in place to meet the service's needs and this posed a risk to the quality and safety of the service provided.

Judgment: Not Compliant.

Quality and safety

The quality of the creation, implementation and monitoring of effective safety plans for children experiencing ongoing risk of significant harm was too variable. The service was not consistently in compliance with the national standards for the protection and welfare of children.

While the cases referred for a child protection conference (CPC) met the required threshold, initial CPC's did not take place in a timely manner in all the cases reviewed on inspection. Inspectors found that in 14 cases reviewed, there time frames ranging from zero to 15 weeks from when the social work team requested the conference to when the initial CPC took place. For eight out of 14 cases (57%), the timeframe was between five and 15 weeks. For example, in one of the eight cases, there was an 11 week period from when a decision was made to refer the case of a young infant to CPC to when the CPC occurred. In two of the eight cases delays were between 13 and 15 weeks. Inspectors found that risks had been recently escalated within the service in relation to delay in social workers completing preparatory work for conferences. This delay was attributed to unmanageable caseloads for social workers in the area and difficulties in ensuring a prompt handover of children's cases to the children in care team. Given that there was significant child protection concerns for these children, HIQA was of the view that these timeframes were too long.

The child protection conference (CPC) was comprehensively facilitated by an appropriately trained professional who was not directly involved in the assessment or management of the case. CPC records showed that the chair carefully facilitated conferences in order to maximise the involvement of parents, professionals and family members in determining the nature of the risk posed to children and the impact of harm to children. Inspectors found that CPCs were well attended by professionals from external services. Records showed that the chair summarised and clearly communicated risks to parents and family and clearly identified what needed to change to keep children safe with their families. The chair facilitated inclusive participation of all attendees in eliciting solutions to address harm to children and improve their safety. Inspectors observed an initial CPC and saw discussions that clearly outlined what the child protection risks were and what the impact of these risks were for the child. Multi-agency discussion was well facilitated and a clear and responsive decision was reached as to why the child would be placed on the CPNS register.

Social workers said that they consulted with children and parents on their views and to explain the initial case conference process, in advance of the initial case conference. Social workers said they routinely went through their assessment/case conference report and recommendations with parents in advance of the review case

conferences. This was important in order to facilitate buy in from families and to strengthen collaboration practice between social workers and children and families. Inspectors found that these consultations were not always recorded on file and this required improvement.

There was evidence of the representation of children's views found on most files reviewed by inspectors. In most cases, inspectors found the use of child friendly tools to help social workers engage and gather information in a child friendly way. There was evidence of direct work with children including observation of children over the course of multiple visits to elicit views of children less able to articulate their wishes. Inspectors found in some cases, that there were delays in the completion of direct work with children, and as a result, children's views were not always included in the minutes of CPCs reviewed by inspectors. This required improvement.

Information provided by social workers in CPC reports to the chair and external professionals and families, in preparation of the CPC, was mixed. Inspectors found that in some instances, the analysis of past harm was weak. For example, in one case the harm was described solely within context of the behaviours of parents and there were limited details of the impact of harm on the child and or the child's lived experience. In another case reviewed by inspectors, the analysis of past harm excluded a recent incident of physical abuse pertinent to the case; and in another case there was no acknowledgement of actual harm to the child detailed in a previous referral to the service. Weak analysis of risk and harm hindered decision making processes for children using the child protection and welfare service, and this meant that the service could not always ensure that children were responded to at the right threshold. This had been identified by the area manager at governance meetings in November 2020 but appropriate action had not been taken to improve upon this element of practice.

Following a CPC, a child protection plan was formulated by the social worker in conjunction with the family, the identified safety network and relevant professionals involved with the child. The purpose of the child protection safety plan is for the family and network to agree a set of rules, based on the concerns and bottom lines identified for children at CPC, which will show how everyone will keep the child safe.

Child protection safety plans were generally adequate. Positive findings included the use of standardised templates which provided a comprehensive record of each plan. The template prompted the social worker to reflect on key components of safety planning such as the identification of existing strengths and safety of the situation as well as the identification of short-term and long-term goals to be achieved to secure the protection and welfare of the child. In some cases, the development of comprehensive child protection safety plans was weak and improvement was required

to ensure reference to child centred outcomes so that the impact of safety planning for the child could be measured.

The implementation and monitoring of child protection safety plans for children listed on the CPNS varied. There was good practice found in nine out of 16 cases (56%) reviewed. In these cases, inspectors found that there was good multi-agency consultation between social workers and a vast range of services involved with children listed on the CPNS. This provided a level of assurance to social workers as to the safety and welfare of children utilising these services in the community. There were regular visits by social workers to monitor children and records showed that appropriate support and challenge was provided to families to ensure that safety plans were adhered to. There was timely response to rising risks in these cases and responsive actions were taken to protect and safeguard children. Managerial oversight was clearly recorded and there were evidence based decisions being made on the closure and or de-listing of cases from the CPNS.

In other cases, inspectors found that improvement was required in the implementation and monitoring of child protection safety plans. Inspectors found that improvements were required with regard to evidencing managerial oversight in line with practice guidance. In some cases, records of visits to children and families were descriptive but lacked analysis to gauge the impact of the visit on the ongoing assessment and review of children's safety. Furthermore, records were not always bespoke to each child in cases where there were siblings being visited. Social work case notes did not always account for the level of improvement discussed at review CPCs and this meant that it was difficult for inspectors to understand how and why some critical decisions were being made, and the area could not be assured that critical decisions had full consideration of all relevant information. In addition, inspectors found one record on a child's file which contained details of other children not relevant to the case and this was reported to the social worker who made immediate amendments to the record.

Where there were safety networks identified to support children and families, child protection safety planning meetings were used to monitor the implementation of child protection safety plans. Inspectors found that the recording and frequency of network meetings required improvement in some cases. In some cases, there were no natural network supporting children and families and safety plans consisted of only professional networks. In these cases, inspectors found that the systematic monitoring and review of actions involving other professionals was not always clear and this meant that there were periods of time of no multi-agency consultation in between child protection conferences.

Review CPCs were usually held within six months after the previous CPC. The area had improved the timeliness of review child protection conference in the 12 months prior to this inspection. There were good monitoring and oversight systems in place to track the timelines of reviews in line with Children First 2017. Review CPC records showed that the progress of actions to reduce risks to children was reviewed during the conference and decisions were taken in relation to next steps. However, inspectors found that managers' decisions to delay or postpone review conferencing for a small number of children listed on the CPNS was not in line with national guidance. This meant that child protection plans for these children were not afforded an appropriate level of verification and review in line with Children First 2017.

In three cases reviewed by inspectors, there was a slow response to rising risks to children. Inspectors found that details of the outcome or impact of previous interventions with families was not always given due weight, and there was a lack of use of chronologies to track ongoing risk of harm for cases with a history of involvement with the service. This meant that appropriate weight could not always be given to the cumulative harm experienced by children. Social workers told inspectors that some children listed on the CPNS, who experienced long term neglect, did not always receive the service they required. This meant that children were left in neglectful situations far too long before action was taken. In one case, there was delay in implementing a decision to seek a supervision order which had been decided as an appropriate course of action when bottom lines to safeguard children were not sustained. In two other cases, inspectors found that admissions to care, in circumstances when all alternative means of protecting children had been exhausted, were delayed for 2 cases comprising of 4 children listed on the CPNS.

Inspectors escalated two cases comprising of four of the 60 children on the CPNS at the time of the inspection to the area manager, due to the slow response to rising risks to children and for assurances on their immediate safety. In one case, inspectors found that safety planning was not robust. Certain risk factors for the child were not appropriately assessed as features of long term neglect and the safety of the child could not be ensured. In the second case, inspectors found that children who required admission to care in February 2021, remained at home at the time of the inspection. Senior managers in the area told inspectors that care proceedings had not been initiated due to the lack of suitable placements available to the area for these children. HIQA received satisfactory assurances in both cases and action was taken for children who required alternative care. As already outlined, the systemic risks for Tusla in relation to the lack of suitable placements for children requiring care was escalated by HIQA to national senior management of Tusla following this inspection.

Positively, this inspection found that there was a strategic approach towards partnership working and engagement between the service and external stakeholders

in the area. One principal social worker described to inspectors how an analysis of trends in referrals to the service identified an area for improvement. As a result, workshops were delivered by the social work department to local health care professionals to increase awareness of best practice principles of child protection and safeguarding for those in receipt of prenatal care, in line with national guidance.

The management of the service had systems in place to ensure that there was good information sharing and co-ordination of child protection cases amongst social workers, stakeholders and local services. Inspectors found mostly good levels of information sharing between social workers and a broad range of agencies and professionals involved with children. Good quality information was gathered from other professionals and this helped social workers to better understand the needs of children and parents.

Social workers worked hard to advocate for children and families' access to relevant community and statutory services in order to promote children's welfare and improve outcomes. Two parents interviewed by inspectors as part of this inspection said that their families had benefitted from access to a range of support services provided to them through their social worker, such as family support services and children's support programmes. Children's files reviewed by inspectors showed a commitment towards agency and partnership working. In addition, inspectors found that where challenges to partnership working were found, these were appropriately identified by the management team and actions were taken to address them.

Standard 2.6

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

Child protection conferences were managed and facilitated. The level of participation of families and other key professionals was strong but the timelines from when concerns of ongoing risk of significant harm were identified, to initial child protection conference needed to improve. Actions and bottom lines to keep children safe were clearly identified at child protection conferences but the implementation of child protection safety planning by social workers was variable. Decisions and judgements made to protect the safety and welfare of children listed on the CPNS were not always supported by strong analysis and assessment of potential harm and accumulative harm to children. Furthermore, responsive decision making was undermined by the lack of placements for children requiring alternative care in the area and for this reason the judgement is non-compliant.

Judgment: Not compliant.

Standard 2.7

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

The area had improved the timeliness of review child protection conference in the 12 months prior to this inspection. There were good monitoring and oversight systems in place to track the timelines of reviews in line with Children First. The service ensured that the delisting of cases from the CPNS was planned and agreed by social work managers. However, inspectors found that managers' decisions to delay or postpone review conferencing for a small number of children listed on the CPNS was not in line with national guidance. This meant that child protection plans for these children were not afforded an appropriate level of verification and review in line with Children's First 2017.

Judgment: Not compliant

Standard 2.9

Interagency and inter-professional cooperation supports and promotes the protection and welfare of children.

Inspectors found that the area had a strong working in partnership ethos with local agencies and commissioned services. There was a strategic approach towards partnership working and engagement between the service and external stakeholders in the area. Close inter-agency and intra-agency working was found on cases reviewed. The area had identified that some improvement was required to ensure that all interagency forums were effective and there were actions in place to address this. The service liaised with external agencies and professionals to promote their awareness of their responsibilities under the Children First Act 2015.

Judgment: Compliant.

Compliance Plan for Dublin North City Child Protection and Welfare Service OSV – 0004407

Inspection ID: MON-0033737

Date of inspection: 10 August 2021

Introduction and instruction

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

This document is divided into two sections:

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

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

A finding of:

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

Section 1

The provider is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when

making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

| Standard Heading | Judgment |
|---|----------------------|
| Standard 3.1 | Not Compliant |
| <p>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.</p> | |
| <p><u>Action:</u> Interim Guidelines on Child Protection Notification System to be reviewed by National office circa 2022. A Data Impact Assessment of the Child Protection Conference Interim Guidance is being finalised by Tusla's Data Protection Unit which will inform the review of the Interim Guidance on the Child Protection Conference Guidelines and any changes that are required to ensure that Tusla meets its data protection obligations under the General Data Protection Regulation (GDPR) 2018. <u>Responsible:</u> Head of Policy and Transformation <u>Completion by:</u> 2022</p> | |
| <p><u>Action:</u> Safety planning workshops, which were delayed as a result of Covid 19 and the Cyber-attack are being progressed in the remainder of 2021 and into 2022. <u>Responsible:</u> Signs of Safety Practice lead and Principal Social Worker. <u>Completion:</u> Q4 2021</p> | |
| <p><u>Action:</u> Review of all children on Child Protection Notification System by Area Manager & PSWs to ensure no other children identified as being in need of placement – completed on 28th September 2021 and to be reviewed quarterly at governance meetings. <u>Responsible:</u> Area Manager & Principal Social Worker <u>Completion:</u> 28th September 2021.</p> | |
| <p><u>Action:</u> A Staff Recruitment Strategy for Dublin North City to be developed to consider additional grades of staff that could be employed to support the statutory work by end of year. Plan to include how all vacancies will be filled. <u>Responsible:</u> Regional HR & Area Manager <u>Completion:</u> 31st December 2021</p> | |
| <p><u>Action:</u> Fortnightly meetings take place between area and Tusla recruit. <u>Responsible:</u> Tusla Recruit & Area Manager <u>Completion:</u> Ongoing</p> | |
| <p><u>Action:</u> New campaign for Senior Social Worker and Social Care Workers being planned for Dublin North City area. <u>Responsible:</u> Tusla Recruit</p> | |

Completion: 31st December 2021

Action: Active management of panels – exploring why posts aren't being taken up.

Responsible: Tusla Recruit

Completion: Ongoing

Action: Rolling campaigns for Professionally Qualified Social Workers in place and to continue.

Responsible: Tusla Recruit

Completion: Ongoing

Action: Ongoing and persistent risks regarding staffing and placement availability to be subject to Regional Oversight Group – monthly meeting with local senior managers and regional managers in HR, Quality. Risk and Service Improvement, Practice Assurance Service Monitoring. First meeting to take place on 8th November 2021. Standing Agenda Items:

- Staff Vacancies
- Caseload Management Data
- Staff Recruitment Strategy
- Children awaiting placements
- Foster Care Recruitment

Responsible: Service Director & Area Manager

Completion: 31st December 2022

Action: Principal Social Worker for Quality Improvement & Child Protection Conferences to be in post by 31st October 2021 – improve capacity to respond to requests for Child Protection Conferences and audit of supervision and cases on Child Protection Notification System.

Responsible: Area Manager

Completion: 31st October 2021

Action: Complex Case Forum – follow up by Principal Social Worker for Quality Improvement to track actions.

Responsible: Quality Assurance Principal Social Worker

Completion: 31st December 2021 & Ongoing

Action: Principal Social Worker & Area Manager to be notified of all children requiring care who do not have a placement via Need to Know.

Responsible: Principal Social Worker & Area Manager

Completion: Ongoing

Action: Review of agenda and Terms of Reference of Governance Meeting to take place.

Responsible: Child Protection and Welfare Governance Group

Completion: 30th November 2021

Action: Quarterly review of children on Child Protection Notification System to take place at governance meeting.

Responsible: Child Protection and Welfare Governance Group

Completion: Ongoing

Action: Escalation to Principal Social Worker if supervision between Social Worker & Team Leader identifies lack of progress on case on Child Protection Notification System.

Responsible: Team Leader, Child Protection & Welfare Principal Social Worker

Completion: Ongoing

Standard 3.2

Not 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.

Action: Governance at regional level will be enhanced by regional service director having oversight of the areas compliance plan

Responsible: Service Director & Area Manager

Completion: Ongoing

Action: Area to do a full review of it local risk register by 31st October to ensure that risks to the service are appropriately escalated to regional and national.

Responsible: Area Manager and local Quality, Risk & Service Improvement manager

Completion: 31st October 2021

Action: Tusla's National Operations Risk Management and Service Improvement Committee (NORMSIC) now in place to – Terms of Reference attached (appendix 5). Service Director is a member of NORMSIC and will highlight any ongoing issues in relation to Dublin North City from the Regional Oversight Group.

Responsible: Service Director

Completion: Ongoing

Action: Area's Risk Register is reviewed at bi monthly Strategic Management Meeting

Responsible: Strategic Management Meeting members

Completion: Ongoing

Action: Review of Terms of Reference and Agenda for governance meeting to take place.

Responsible: Child Protection & Welfare Governance Group

Completion: 30th November 2021

Action: At governance meeting, while discussing cases on Child Protection Notification System; cases on Child Protection Notification System are to be considered for complex case forum.

Responsible: Child Protection & Welfare Governance Group

Completion: Ongoing

| Standard 3.3 | Not Compliant |
|--|---------------|
| <p>Outline how you are going to come into compliance with Standard 3.3: The service has a system to review and assess the effectiveness and safety of child protection and welfare provision and delivery.</p> | |
| <p><u>Action</u>: Regional Oversight Group will monitor compliance with this plan. <u>Responsible</u>: Regional Oversight Members <u>Completion</u>: Ongoing</p> | |
| <p><u>Action</u>: Principal Social Worker for Quality Assurance to audit recommendations from Complex Case Forum. <u>Responsible</u>: Principal Social Worker for Quality Assurance <u>Completion</u>: Ongoing</p> | |
| <p><u>Action</u>: Audit plan to be discussed at Strategic Management Meeting and developed for team leaders. <u>Responsible</u>: Child Protection & Welfare Governance Group <u>Completion</u>: 30th November 2021</p> | |
| <p><u>Action</u>: Practice Assurance Monitoring Service to be requested to carry out an internal audit of the areas compliance plan and to review the effectiveness and safety of Child Protection service provision. <u>Responsible</u>: Area Manager & Local Quality, Risk and Service Improvement Lead <u>Completion</u>: Q1 2022</p> | |
| <p><u>Action</u>: Network meetings & home visits to be tracked and recorded at supervision by Team Leader and this will be fed back at quarterly meetings reviewing cases on Child Protection Notification System. <u>Responsible</u>: Team Leader <u>Completion</u>: Ongoing</p> | |
| <p><u>Action</u>: Principal Social Worker & Area Manager to be notified of all children requiring care who do not have a placement via Need to Know. <u>Responsible</u>: Principal Social Worker & Area Manager <u>Completion</u>: Ongoing</p> | |
| <p><u>Action</u>: As vacancies are filled and operational demand reduces, the area will establish a learning forum. <u>Responsible</u>: Area Manager & Local Quality, Risk and Service Improvement Lead <u>Completion</u>: Q1 2022.</p> | |

| Standard 2.6 | Not Compliant |
|--|---------------|
| <p>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.</p> | |
| <p><u>Action</u>: Additional part time Child Protection Case Conference chair in post by 31st October 2021</p> | |
| <p><u>Responsible</u>: Area Manager</p> | |
| <p><u>Completion</u>: 31st October 2021</p> | |
| <p><u>Action</u>: Work with Practice Leads for Signs of Safety re capacity building for new staff regarding analysis of harm.</p> | |
| <p><u>Responsible</u>: Principal Social Worker Child Protection & Welfare</p> | |
| <p><u>Completion</u>: Ongoing</p> | |
| <p><u>Action</u>: Network meetings & home visits to be tracked and recorded at supervision by Team Leader.</p> | |
| <p><u>Responsible</u>: Team Leader</p> | |
| <p><u>Completion</u>: Ongoing</p> | |
| <p><u>Action</u>: Chronologies to be developed on cases identified by Child Protection Case Conference Chair and Principal Social Worker by using student social workers to assist Social worker when available.</p> | |
| <p><u>Responsible</u>: Principal Social Worker Child Protection & Welfare</p> | |
| <p><u>Completion</u>: Ongoing</p> | |
| <p><u>Action</u>: Second Child Protection Case Conference chair will reduce time line for Child Protection Case Conference's.</p> | |
| <p><u>Responsible</u>: Child Protection Case Conference Chair</p> | |
| <p><u>Completion</u>: 31st October 2021</p> | |
| <p><u>Action</u>: Child Protection Case Conference Chair to track timelines from date Initial Assessment was completed to date Child Protection Case Conference took place.</p> | |
| <p><u>Responsible</u>: Child Protection Case Conference Chair</p> | |
| <p><u>Completion</u>: Ongoing</p> | |
| <p><u>Action</u>: Timeframes to be included and recorded for next steps at Child Protection Case Conference's.</p> | |
| <p><u>Responsible</u>: Child Protection Case Conference Chair</p> | |
| <p><u>Completion</u>: Ongoing</p> | |

| Standard 2.7 | Not Compliant |
|---|---------------|
| <p>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.</p> <p><u>Action</u>: Decision by the Chair to proceed with Review Child Protection Case Conference regardless of circumstances of the case. Unless child is actually in care, Review Child Protection Case Conference will take place.</p> <p><u>Responsible</u>: Child Protection Case Conference Chair</p> <p><u>Completion</u>: Ongoing</p> <p><u>Action</u>: Safety plans for children on Child Protection Notification System to be a standing agenda item and reviewed at supervision by Team Leader and Social Worker and escalated to Principal Social Worker if not progressing.</p> <p><u>Responsible</u>: Team Leader and Principal Social Worker</p> <p><u>Completion</u>: Ongoing</p> | |

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 | Major | Red | 30 September 2021 |

| | | | | |
|---------------------|---|----------|--------|--|
| | and promote their welfare. | | | |
| Standard 3.2 | Children receive a child protection and welfare service, which has effective leadership, governance and management arrangements with clear lines of accountability. | Moderate | Orange | |
| Standard 3.3 | The service has a system to review and assess the effectiveness and safety of child protection and welfare provision and delivery. | Moderate | Orange | |
| Standard 2.6 | Children's protection plans and interventions are reviewed in line with requirements in Children First. | Moderate | Orange | |
| Standard 2.7 | Children's protection plans and interventions are reviewed in line with requirements in Children First. | Moderate | Orange | |