Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of the investigation into the management of allegations of child sexual abuse against adults of concern by the Child and Family Agency (Tusla) upon the direction of the Minister for Children and Youth Affairs

Executive Summary

14 June 2018

Safer Better Care

Executive summary

Introduction and background to the investigation

On 9 February 2017, RTÉ television broadcast a Prime Time programme which revealed that the Child and Family Agency (Tusla) had sent a notification to An Garda Síochána (the Irish police force) containing a false allegation of child sexual abuse against a garda* whistle-blower, Sergeant Maurice McCabe. Tusla is the State's child protection and welfare agency, set up in 2014, with around 4,100 employees. In 2017, over 50,800 referrals were made to it.

In light of these circumstances and a concern about more systemic issues that may potentially require a response at a national level, the Minister for Children and Youth Affairs believed that the apparent poor handling by Tusla of information in this case indicated a possible 'serious risk to the health and welfare' of children who were the subject of child sexual abuse referrals to Tusla, including adults alleging abuse during their childhood where the alleged abuser may pose a risk to current children.

As a result, on 2 March 2017, the Minister of Children and Youth Affairs wrote to the Chairperson of the Health Information and Quality Authority (HIQA), formally instructing, in line with the Health Act 2007, [(1)] that HIQA carry out a statutory investigation under the Act. Furthermore, the Minister instructed HIQA to draw on its existing work in the monitoring of child protection and welfare services. On 8 March 2017, the HIQA Board approved the start of an investigation.

This report presents the findings of the HIQA investigation into the local, regional and corporate arrangements provided by Tusla to ensure the effective management of child sexual abuse referrals involving adults of concern, including allegations made by adults who allege they were abused when they were children (these are termed retrospective allegations). The report makes recommendations to improve the safety, quality and standards of services provided by Tusla in relation to referrals of allegations of child sexual abuse involving adults of concern.

HIQA's role in monitoring child protection and welfare services

Between 2014 and 2016, HIQA had conducted 12 inspections of Tusla child protection and welfare services, against the *National Standards for the Protection and Welfare of Children*, including child sexual abuse referrals.** These National Standards were approved by the Minister for Health and the Minister for Children and Youth Affairs in 2012.

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* Garda — the term for a police officer in Ireland.

** This investigation report refers to 12 inspections carried out by HIQA between 2014 and 2016, while HIQA's governance review in Appendix 10 reports on 14 inspections in a different time period during these years.

While there was evidence of good practice, particularly around responding to children who were at immediate risk of significant harm, HIQA inspectors found areas of significant concern which demonstrated inconsistencies in how Tusla ensured safe and effective child protection and welfare practice.

Examples of poor practice included high levels of unallocated referrals (where a named social worker has not been assigned to a case), unmanaged retrospective referrals, poor record-keeping, inconsistent risk management arrangements and difficulties with retention and recruitment. There were also inadequate quality assurance arrangements to effectively detect, manage and learn from deficiencies in practice identified during HIQA's monitoring and inspection programme.

Despite being brought to the attention of Tusla service areas during each inspection, these common shortfalls continued to emerge in inspections carried out throughout 2014 and 2015. Therefore, HIQA was not assured that the national governance arrangements within Tusla were adequately addressing these deficiencies in a systematic way. Because of this, in December 2015, in line with its powers under the Health Act 2007, HIQA started to review the governance arrangements in Tusla.

During the 2015–2017 review, there was evidence of a wide-ranging transformation programme within Tusla and abundant evidence of the considerable financial investment in terms of staff recruitment and training. Tusla had also indicated that it had significantly improved its governance structures. It also found the Child Protection Notification System, introduced in 2015, was accessible on a 24-hour basis across all service areas.

However, the 2015–2017 review also found a large number of child protection and welfare referrals that did not have a named social worker allocated to their case. There were inconsistencies in the identification, reporting and escalation of risk; inadequate managerial oversight at a local level, with poor practice and inconsistencies potentially not being actively addressed; and good practice was not being identified and shared.

The absence of an integrated information communications technology (ICT) system remained a significant risk to Tusla. There had been inconsistencies in the gathering and storage of data, and social worker recruitment challenges. It is in the context of the findings of HIQA's earlier governance review of Tusla that the Investigation Team looked at the governance and management structures during its 2017-2018 investigation.

Findings in relation to the management of referrals of child sexual abuse and referrals of retrospective child sexual abuse

In conducting this investigation, the HIQA Investigation Team was acutely mindful that the pathway that Tusla uses for managing child sexual abuse referrals is identical to its pathway for managing all child protection and welfare concerns. Therefore, these findings provide an insight into the governance and operational arrangements in place for all child protection and welfare concerns referrals and retrospective cases.

The Investigation Team found many examples of good practice by committed Tusla personnel in how they manage allegations of child sexual abuse and retrospective abuse. Similar to earlier inspection findings, Tusla appropriately responded to children who were judged to be at immediate and serious risk of harm. In these situations, there was good cooperation between Tusla and An Garda Síochána in taking protective action to ensure that children were safe. Furthermore, Tusla has strategically developed service-area-based dedicated teams and one regional-based team for retrospective cases and there was evidence to show that this approach is helping to increase the effectiveness of how retrospective child sexual abuse referrals are managed.

In line with the Terms of Reference of this investigation and in response to the Minister's concern as to systemic risk to children, the Investigation Team reviewed the systems in place in six of Tusla's geographical service areas and in one Sexual Abuse Regional Team (SART) in the Tusla Dublin North East Region to ensure Tusla effectively and safely manages all child sexual abuse referrals, including retrospective referrals. The investigation identified three defective points in Tusla's system of managing such referrals, which Tusla must now address as a matter of urgency:

a. screening and preliminary enquiry

b. safety planning

c. management of retrospective cases.

A. Screening and preliminary enquiry

This investigation found inconsistencies in practice around the screening of allegations and making preliminary enquiries, which meant that not all children at actual or potential risk were being assessed and where necessary, protected by Tusla, in a timely and effective manner.

B. Safety planning

Inconsistencies in safety-planning practice meant that while some children were adequately safeguarded, others at potential risk were not. Even for children who had a safety plan, these plans were not always reviewed to ensure the continued safety and wellbeing of the child.

C. Management of retrospective cases

While there was a policy on managing allegations made by adults of abuse during their childhood, it did not include a standardised approach to direct and guide staff in case management, leading to variation in practice and delays. Some people were not told that an allegation of abuse had been made against them and others were given only limited information.

The Investigation Team found that while Tusla focused on examining current risks to children, this often resulted in a lack of urgency in responding to retrospective allegations of abuse against adults of concern. This meant that children who are potentially at risk — from adults who are alleged to have abused children in the past, and or who were convicted of child sexual abuse in the past, and who now have access to other children — may be missed.

Omitting and or not fully completing any stage in the management of child sexual abuse referrals will invariably impact on the adequacy and or timeliness of any intervention put in place to mitigate risk to vulnerable children. This systemic risk is increased when the child protection and welfare staff who are operationally responsible are unclear about the steps they need to take or fail to adhere to them and or there is no formal guidance in place to begin with.

Keeping clear, contemporaneous and accurate records for each child ensures that there is a documented account of decisions taken to protect children. The child's or adult's record is an essential source of evidence for investigations and enquiries, and may also be required to be disclosed in court proceedings. Good quality records help with continuity of social work support whenever individual social workers are unavailable or when the named social worker on a case changes, and they provide an essential tool for managers to monitor work practices or for peer review.

The Investigation Team found that the quality of record-keeping varied widely in those service areas reviewed and, therefore, could not assure HIQA about the quality and effectiveness of Tusla's child protection and welfare service. For example, the Investigation Team reviewed 164 cases reported as closed in the six service areas and could not establish if some of the cases reviewed were actually closed. Furthermore, the Investigation Team found cases which were inappropriately closed as there were outstanding child protection concerns.

A central principle of the Child Care Act, 1991 is that the child's welfare and protection is paramount and is at the core of all child protection and welfare practice. Tusla staff frequently cited ongoing criminal investigations by the Gardaí for some of the delays in starting and completing assessments of child sexual abuse allegations, including retrospective allegations. It is imperative that Tusla ensures its own operational arrangements and cross-agency working practices do not allow criminal investigations to impede its statutory duty to safeguard children.*

Tusla has a duty from the outset to act fairly, proportionately and in line with the principles of natural and constitutional justice. The Investigation Team found that in the majority of cases, Tusla told persons subject of an abuse allegation whether or not the allegation against them was established or not at the end of the process. However, there were inconsistencies in the level of detail about the allegation communicated to these people, and delays to the start of the assessment, the assessment itself and the conclusion. Such delays could affect a person's ability to respond to their case adequately and this could present challenges for Tusla.

In October 2017, midway through this investigation, in line with the Terms of Reference and as a result of its findings, HIQA wrote and subsequently met with the Minister for Children and Youth Affairs, officials at her department, Tusla's senior management team and a Tusla board representative. These meetings were to highlight that the findings at that juncture concurred with the view that there were systemic risks to children which Tusla should address to ensure the effective management of allegations of child sexual abuse against adults of concern. In addition, HIQA highlighted evidence that this systemic risk may potentially extend across the wider child protection and welfare service, given the identical referral pathways involved.

* In May 2018, the Investigation Team received a copy of Tusla's Policy Submission to the Department of Children and Youth Affairs in respect of Section 3 of the Child Care Act, 1991, dated 9 October 2017.

Findings in relation to governance, leadership and management

The Investigation Team does not underestimate the amount of work that Tusla's board and executive have undertaken and achieved to embed the organisation during its four years in existence, particularly in the areas of corporate governance and management structures. There is now a clear strategic direction, and a long-term vision of what Tusla wants to achieve. The quality of its public and internal documentation, policy papers, information and communications is of a very high standard.

Tusla's governance structures are underpinned by a quality improvement framework, risk management policies, business planning processes, and many supporting policies and processes. However, they are not comprehensively and consistently embedded in front-line practice in the services areas visited by the Investigation Team. In those areas, there was evidence that staff neither fully understood Tusla's standardised processes or policies, or implemented or adhered to them. At the time of the investigation, potential poor performance was not being detected or corrected.

At a regional and corporate level within Tusla, there was evidence of insufficient oversight to assure its executive and board that staff are adhering to these corporate-wide procedures. Therefore, there is a system-wide risk in delivering a consistent and sustainable child protection and welfare service. While Tusla is moving towards a more responsive service to children and their families, this will only be achieved whenever the governance arrangements ensure clear accountability and effective managerial oversight.

Streamlined risk and quality assurance processes are also required. Nevertheless, those Tusla staff that the Investigation Team met with were openly committed to child protection and welfare. Indeed in some service areas visited, managers openly took on board the investigation's findings at that time and immediately addressed those risks identified.

The establishment of Tusla in 2014 brought approximately 4,000 staff together from a number of existing agencies, with a range of embedded cultures and long-established operational, performance and management practices. While efforts were being made to develop a culture of working together, the Investigation Team did not find strong evidence to suggest that opportunities to promote a culture of learning through the organisation have been maximised. Neither did the Investigation Team find strong evidence of effective staff training and development or detection of poor staff performance which could address the aforementioned risks.

The Investigation Team welcomes the development by Tusla of its Child Protection and Welfare Strategy. This includes adopting the 'Signs of Safety'* programme as its national approach to practice. Tusla is confident that its full implementation will address some of the risks identified in this HIQA investigation. However, Tusla must now ensure that in the interim, it addresses the systemic deficiencies identified by HIQA in Tusla's governance and support arrangements. This is necessary to ensure the effective and sustainable management of child sexual abuse referrals involving adults of concern, including allegations of retrospective child sexual abuse.

Findings in relation to workforce

The Minister for Children and Youth Affairs initially requested HIQA to include in this investigation an assessment of the number, skill-mix and adequacy of staffing levels. However, a comprehensive workforce assessment was outside the scope and competencies of this investigation. Notwithstanding, in line with the Terms of Reference, the Investigation Team examined how Tusla staff were adequately supported to confidently and effectively manage child sexual abuse referrals involving adults of concern, including allegations of retrospective child sexual abuse.

A shortage of qualified social work staff is undoubtedly contributing to delays in the appropriate management of referrals and the early assessment of children at risk. In response, Tusla had taken a number of steps to try to attract and retain social work staff. Despite this, Tusla only managed an increase of 12 whole-time equivalent social workers nationally between November 2016 and November 2017. The lack of available social work graduates is key to this poor return, but Ireland is not alone in experiencing such a shortage.

The Investigation Team believes the impact on Tusla from a shortage of qualified social workers in a number of jurisdictions are exacerbated by internal factors within Tusla, such as workforce allocation and staff training and development. Its supervision and caseload management systems, while appropriate in theory, were being inconsistently applied in practice in the service areas visited by the Investigation Team. In addition, the quality of personal development plans, a key element of staff supervision, varied widely and were not in place for all staff.

In addition, the Investigation Team believes Tusla's failure to consistently provide training to its front-line child protection and welfare staff on its national policy and procedures on managing allegations of abuse was a serious shortcoming. This was further compounded by the finding that some line managers providing social work practice supervision did not have the appropriate training in managing child

* Signs of Safety: national approach to practice within Tusla which provides a range of tools for assessment and planning, decision-making and engaging children and families.

sexual abuse referrals, including retrospective allegations.

It is evident that some staff feel they are spending too much time on administrative and on overly-bureaucratic tasks, rather than building relationships with people using the service. While HIQA recognises the need for good quality record-keeping for many valid reasons, Tusla needs to develop a workforce environment where social workers and social care workers can enjoy doing the core job they were trained for and are qualified to do. Such an approach should contribute to greater retention of staff and allow others to take on extra responsibilities.

And while Tusla undoubtedly believes it is currently under-resourced in terms of social work staff in particular, the Investigation Team did not find a comprehensive strategic approach to workforce planning within the organisation that was informed by the reality of the global jobs market. Little evidence was found of attempts to identify efficiencies and improvements in work flow or evidence of consideration of upskilling other social care disciplines or formal role enhancements, along with targeted educational strategies with third-level institutions.

Tusla in conjunction with the Department of Children and Youth Affairs has to manage the same workforce challenges faced by other jurisdictions and, as a relatively young organisation, avoid an organisational mind-set that sees such problems as insurmountable due to factors outside its control.*

Findings in relation to use of information

There is no doubt that Tusla was significantly restrained and challenged by the absence of and or poor deployment of information communication technology (ICT) systems. Tusla had made much progress in relation to addressing information communication technology (ICT) deficits previously identified by HIQA, by securing additional ICT funding, the establishment of an ICT directorate within the organisation and the development of an ICT strategy.

These measures should support Tusla to meet its business and strategic needs and will decrease its dependency on assistance from the Health Service Executive (HSE) for the ICT supports that the HSE currently provides to Tusla. At the time of this investigation, the National Child Care Information System (NCCIS) was developed and being rolled out across the service. When fully implemented (Tusla has set a target date of July 2018 for full implementation), the National Child Care Information System should provide an integrated child welfare and protection system that records each stage of referral from first contact through to case closure.

* Tusla reported in June 2018 that it has commissioned an external consultancy to conduct a workforce planning exercise.

The success of this system will be improved through providing essential equipment, such as computers and laptops, and associated training and support, to front-line social work departments without delay.*

Notwithstanding these achievements, Tusla continues to face significant challenges in relation to the quality of its record-keeping and the information that it gathers. The Investigation Team found a number of shortfalls in the management of information about child sexual abuse allegations, including those allegations made by adults about alleged abuse when they were children. Staff were not adhering to Tusla's guidance on maintaining records and there was a failure by Tusla to implement internal audit findings in relation to this.

Because Tusla will continue to use paper records for retrospective and adult cases, following the roll out of the National Child Care Information System, the risks and inefficiencies associated with paper-based records will remain a challenge for Tusla. While the new ICT system and its three-year ICT strategy should contribute to standardising data recording, they cannot alone assure the quality of the records themselves. Therefore, training will be required to ensure child protection and welfare practice is accurately recorded and maintained — a key requisite for effective and transparent decision-making about children's safety.

Findings in relation to bilateral engagement between Tusla and An Garda Síochána and external agencies

This investigation focused exclusively on Tusla's management of child sexual abuse referrals. However, in order to explore how well Tusla worked with An Garda Síochána and relevant external agencies, the Investigation Team held a number of focus group meetings with Tusla staff, members of the Gardaí and external agencies across the six service areas visited. Senior members of the Garda National Protective Services Bureau also met with members of the Investigation Team to discuss cooperation with Tusla.

Tusla has statutory responsibility for child protection and welfare services. In order to do this effectively, Tusla and An Garda Síochána need to work closely together in the best interest of those children who are the subject of child sexual abuse allegations and those adults who allege that they were sexually abused when they were children.

While there was a system in place for the notification of suspected child sexual abuse between An Garda Síochána and Tusla, there was no electronic data transfer interface between the ICT systems in both agencies. Instead, these notifications have to be sent by fax or posted.

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* Tusla reported in June 2018 that the majority of social workers had been provided with laptops, mobile phones and wireless Internet devices.

This is neither efficient, appropriate nor wholly secure given that these notifications relate to allegations or suspicions of child abuse. There are plans for electronic transfer of notifications to start in 2019.

Although there are a number of established forums for interagency working between both agencies, such as strategy meetings and liaison meetings, the Investigation Team found that many aspects of these forums need to improve. Record-keeping to clearly reflect their discussions was inconsistent across the six Tusla service areas visited by the HIQA Investigation Team. In addition, there was no agreed information-sharing protocol to facilitate good sharing of relevant information and which has the confidence of both agencies.

This resulted, in some cases, in difficulties in identifying risks to children in a timely manner. There were also evidence of lengthy delays in responding to requests by Tusla for additional information from An Garda Síochána, which led to delays in creating informed safety plans for children. Conversely, members of the Gardaí reported that requests to Tusla for written reports were often delayed, and when provided, lacked the information which had previously being relayed verbally and which was needed to support criminal proceedings.

Joint-specialist interviewing of children by the Gardaí and Tusla (where a child is jointly questioned at the same time by a social worker and a garda) was acknowledged at interview and group meetings as a key element in assessing an allegation of child sexual abuse. However, very few social workers are trained in specialist interviewing, training for which is coordinated and facilitated by the Gardaí. Joint-specialist interviewing should become standard practice, but can only happen with a significant increase in trained Tusla and Garda interviewers.

In spite of these challenges, it was reported that there are good informal working arrangements between members of the Gardaí and Tusla staff. In addition, it is anticipated that a new Tusla and An Garda Síochána Children First joint-protocol for liaison between both agencies, agreed in December 2017, should formalise these processes.

The Investigation Team found that the arrangements for providing allied support services such as specialist therapeutic and medical services to support the management of allegations of child sexual abuse were not equitable and largely depended on available resources within a particular area or county. Future provision and investment in child protection and welfare services would benefit from an analysis of the availability and capacity of resources accessible to Tusla service areas to support the management of child sexual abuse referrals. This would also highlight the likely impact of resource deficits wherever they may exist.

While the Investigation Team was informed of examples of effective interagency working at local level, it was also informed of concerns about delayed responses in one service area by Tusla to referrals of retrospective child sexual abuse made by external agencies working with children. In addition, the variation in practice with regard to formal service-level arrangements at local, national and or regional level between Tusla and external agencies working for Tusla represents a missed opportunity for enhanced interagency working in the best interests of children.

Conclusion

Concerns about the handling of information by Tusla in relation to a garda whistle-blower led the Minister for Children and Youth Affairs to direct HIQA in March 2017 to carry out a statutory investigation to assess whether there were systemic issues in Tusla that constituted a serious risk to the health and welfare of children. In informing its findings, the Minister expected HIQA to draw on its existing child welfare and protection inspections and its prior governance review of Tusla. The year-long HIQA investigation determined that these risks existed.

There is no doubt that the creation of Tusla as a national agency in 2014 for the protection of children and families at risk is a positive development. It would be remiss to underestimate the national investment, planning, negotiation and coordination required to set up Tusla. HIQA acknowledges that Tusla has had significant hurdles to overcome, none greater than its initial over-reliance on the HSE for information management support and the bringing together of approximately 4,000 staff, often with differing cultures, traditions and work practices.

It is evident that considerable strides have been made by Tusla to become established and to create a governance structure that should provide assurance to the public that children at risk are effectively assessed and protected in a timely and proportionate manner. Without question, this investigation found evidence that the shortage of qualified social work staff within Tusla is contributing to delays in the appropriate management of referrals and the early assessment of children at potential risk.

Notwithstanding evidence of positive strategic developments within Tusla, the evidence of good front-line practices seen in the service areas visited, and the committed Tusla staff that the Investigation Team met with, the shortcomings found in this investigation are a further reflection of HIQA's previous findings in its inspection and monitoring of child protection and welfare services, which includes child sexual abuse referrals, since Tusla was created in 2014.

Some children are being left at potential risk due to failures at operational level to consistently implement Tusla's national policies and business processes; to accurately record important decisions made and actions taken; to monitor the effectiveness of the steps taken to protect children; and to support staff members' personal development, day-to-day practice and skill set. These failings stem from a gap between national Tusla policies and business processes and what is actually happening on the ground.

Given that HIQA has repeatedly identified these risks in its previous inspection and monitoring activity, and given that it raised similar concerns in its previous review of the governance of Tusla, it is of the utmost concern to HIQA that Tusla's corporate governance systems have failed to effectively share learning across Tusla's 17 service areas from adverse findings by HIQA, whose statutory role is to promote quality and safety in these services.

In moving towards providing a more responsive service aimed at supporting and protecting children and families, Tusla must face a number of challenges. These challenges particularly relate to the planning and provision of a skilled and competent workforce to meet service demand, the use of validated information that informs future policy and strategic service planning and the provision of effective ICT systems. While the implementation of the Signs of Safety initiative is at the core of Tusla's strategic direction for child protection and welfare services over a five-year period from 2017, current challenges and systems risks require immediate attention as not all will be addressed by introducing Signs of Safety alone.

In the interim, the deficiencies in the current arrangements that have been identified in this investigation must be addressed to safely manage referrals of allegations of child sexual abuse and retrospective allegations against adults of concern. These referrals follow the same pathway as all child protection and welfare referrals, therefore raising the prospect of these deficiencies being replicated elsewhere in the child protection and welfare system. Concurrently, there was little evidence found that Tusla is systematically seeking out and sharing good practice across its 17 service areas.

In order to ensure that improvements are sustainable in the longer term, it is imperative that such improvements are supported by risk, quality and information management systems which are embedded in practice at all levels throughout the organisation. It is for this reason that the recommendations contained throughout the report relate to the need for Tusla to review, design and implement a nationally consistent approach to effectively managing waiting lists across all 17 service areas.

There must be a shared understanding of and consistent approach to safety planning, and there must be strengthened managerial oversight and accountability structures in place to ensure that Tusla staff adhere to good policy and processes.

The disparity between Tusla policy at national level and local practice on the ground, in addition to almost universal reports in risk registers across the country about inadequate staffing levels, represents a serious ongoing challenge to providing safe and sustainable management of child sexual abuse allegations.

Despite the measures introduced by Tusla to recruit more social workers, the organisation remains beset by insufficient numbers of social work staff. However, Tusla cannot rely on recurring staff shortages as a default reason for failing to deliver a more efficient and safer service to children and their families. In the absence of a strategic approach to workforce planning, such as using other staff disciplines to support the role of the social worker, staff shortages will continue to directly impact on the timely management of child protection and welfare referrals.

Tusla's new integrated information and communications system, while a key positive development, cannot assure the quality of the records inputted into the system. The Investigation Team also remains concerned that Tusla will continue to operate a paper-based system for retrospective and adult cases nationally. This makes it imperative to provide clear guidance and support for staff on the appropriate storage of sensitive information about persons who are the subject of allegation of abuse, in particular when such information is held on the complainant's file.

HIQA acknowledges efforts to improve working arrangements and information sharing between Tusla and An Garda Síochána, introduced in the latter part of 2017. HIQA welcomes the new Tusla and An Garda Síochána Children First joint-protocol for liaison between both agencies. This joint-protocol — along with an improved training scheme for joint-specialist interviewing — should, if fully implemented, address the deficiencies identified by this investigation in the bilateral interactions between Tusla and An Garda Síochána.

However, it must be accompanied by an agreed information-sharing protocol to facilitate the effective sharing of information which has the confidence of both agencies. Similarly, in order to ensure that joint-specialist interviewing of children by Tusla and the Gardaí becomes standard practice nationally, measures must be put in place to significantly increase the numbers of existing social workers trained to conduct joint-specialist interviewing with the Gardaí.

Finally, the impact of this investigation's findings depends on the recognition of those with responsibility at executive and board level in Tusla that management of all allegations of child sexual abuse follows the same referral pathway as child protection and welfare referrals. As such, there is a significant risk that the deficiencies identified during this investigation in the pathway for allegations of child sexual abuse in a sample of the services provided by Tusla may be replicated across the wider child protection and welfare services.

Moving forward

While HIQA acknowledges Tusla's work to date to merge child protection, early intervention and family support services, Tusla now has to address the risk and deficiencies identified within this report. This is necessary in order to improve how child sexual abuse referrals and retrospective cases are managed. Tusla must also ensure that it addresses as a matter of urgency similar risks and deficiencies which may exist in the broader management of all child protection and welfare referrals.

It is vital that Tusla's governance structures to support the implementation of the findings and recommendations of this investigation report are clear, and include a named accountable person within Tusla who has the overall delegated responsibility for implementing these recommendations. The associated implementation and or action plans should include clear timelines against each action and identified individuals in Tusla who are responsible for implementing those actions.

HIQA acknowledges the progress to date by Tusla in its efforts to improve the quality and safety of services. These include:

- the appointment of a director of ICT and chief social worker within Tusla and the roll-out of the National Child Care Information System (NCCIS) and its ICT Strategy
- the planned implementation of its Child Protection and Welfare Strategy
- the project management approach being taken by Tusla to the NCCIS and these strategies
- setting up of an additional three dedicated regional teams to manage retrospective allegations of abuse
- training initiatives with the specific purpose of improving governance and oversight activity at service director, area manager and principal social worker grades
- Tusla plans to improve performance information and reporting; quality assurance and monitoring; and risk and incident management.

HIQA — in consultation with Tusla, the relevant professional organisations and children's advocacy groups — will begin the design in 2018, based on the findings of this investigation, an inspection programme to promote improvement in child protection and welfare services. In addition, in 2019, HIQA will begin to develop revised National Standards for Children's Social Services. The standards should cover all support and protection services from the point of referral until discharge of the child or client from the service.

To inform the development of a regulatory framework for children's social services in Ireland, HIQA will assist the Department of Children and Youth Affairs in reviewing international best practice in the regulation of children's services. Given the significant system-wide recommendations outlined in this report, it will be vital that there is the necessary political commitment to their managed implementation in order to promote sustainable improvements in the quality and safety of all child protection and welfare services.

Therefore, HIQA recommends that the Minister for Children and Youth Affairs should set up without delay an oversight committee in the Department of Children and Youth affairs to ensure the recommendations contained in this HIQA investigation report are implemented. The roll out of this report's recommendations provides an opportunity to build upon the essential work being carried out by Tusla and to learn from adverse events in a meaningful way for the betterment of services to protect Ireland's most vulnerable children.

Recommendations

1. The Child and Family Agency (Tusla) should:

A. review all of the findings of this investigation, including the identified non-compliances with the *National Standards for the Protection and Welfare of Children* as set out in this investigation report

B. review these findings as they relate to all other child protection and welfare referrals, which follow the same referral pathway as all child sexual abuse referrals

C. review all of the recommendations made by the Investigation Team throughout this report

D. publish an action plan on its website outlining in clear language and with clear timelines the measures it proposes to take to implement the actions identified in the recommendations A to C above. This action plan should include a named person or persons with responsibility and accountability in Tusla for implementing these recommendations and actions.

E. ensure it continually reviews and updates this action plan and that updates on progress being made against these recommendations and actions are included in its annual report.

2. As a matter of urgency, Tusla and the Department of Children and Youth Affairs should seek the assistance of the higher education and training establishments to create formal career-path mechanisms for students and graduates to support current and future workforce needs in Tusla, with the aim of providing a sustainable child protection and welfare service.

In the interim, Tusla and the Department of Children and Youth Affairs should review the current operational arrangements in Tusla to identify efficiencies and improvements in workflow. This should include a review of the existing social worker, social care worker and support staff skill-mix, and the development of a workforce strategy.

3. The Department of Children and Youth Affairs, with the assistance of the Health Information and Quality Authority (HIQA), should undertake an international review of best practice in the regulation of children's social services in order to inform the development of a regulatory framework for these services in Ireland. This is with the view to providing independent assurance to the public that the State's child protection and welfare services are safe and effective.

4. The Department of Children and Youth Affairs should establish an expert quality assurance and oversight group to support and advise Tusla and the Department on the implementation of the recommendations of this investigation report and Tusla's Child Protection and Welfare Strategy and Corporate Plan. The Department of Children and Youth Affairs should provide regular updates on its website to inform the public of the progress being made.

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