Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

OVERVIEW REPORT

MONITORING AND REGULATION OF CHILDREN'S SERVICES IN 2021

June 2022

Safer Better Care

About the Health Information and Quality Authority

The Health Information and Quality Authority (HIQA) is an independent statutory authority established to promote safety and quality in the provision of health and social care services for the benefit of the health and welfare of the public.

HIQA's mandate to date extends across a wide range of public, private and voluntary sector services. Reporting to the Minister for Health and engaging with the Minister for Children, Equality, Disability, Integration and Youth, HIQA has responsibility for the following:

- **Setting standards for health and social care services** — Developing person-centred standards and guidance, based on evidence and international best practice, for health and social care services in Ireland.

- **Regulating social care services** — The Chief Inspector within HIQA is responsible for registering and inspecting residential services for older people and people with a disability, and children's special care units.

- **Regulating health services —** Regulating medical exposure to ionising radiation.

- **Monitoring services** — Monitoring the safety and quality of health services and children's social services, and investigating as necessary serious concerns about the health and welfare of people who use these services.

- **Health technology assessment** — Evaluating the clinical and cost-effectiveness of health programmes, policies, medicines, medical equipment, diagnostic and surgical techniques, health promotion and protection activities, and providing advice to enable the best use of resources and the best outcomes for people who use our health service.

- **Health information** — Advising on the efficient and secure collection and sharing of health information, setting standards, evaluating information resources and publishing information on the delivery and performance of Ireland's health and social care services.

- **National Care Experience Programme** — Carrying out national service-user experience surveys across a range of health services, in conjunction with the Department of Health and the HSE.

Table of contents

A message from the Chief Inspector of Social Services

Carol Grogan, Chief Inspector of Social Services, Health Information and Quality Authority

I am pleased to present this report on the inspection, monitoring and regulation of children's services in Ireland in 2021. This report focuses on the regulatory and monitoring work undertaken by the Health Information and Quality Authority (HIQA) and the Chief Inspector of Social Services within HIQA in relation to children's services. These services include foster care, child protection and welfare, Oberstown Children Detention Campus, special care units and statutory children's residential care. Importantly, it outlines what children have told us about their experiences of these services, and it also provides an overview of the factors which have influenced their quality and safety.

Overall, we found improved levels of compliance against national standards and regulations in children's services in 2021, and the majority of children spoke positively about their experience of services.

Governance of the Child and Family Agency's (Tusla's) statutory foster care services continued to be strengthened in the service areas inspected and, overall, the levels of compliance in non-statutory foster care agencies was good.

Child protection and welfare services also were found to have good levels of compliance, though challenges remained in relation to managing waiting lists. Some areas were subject to risk-based inspections due to ongoing challenges.

Oberstown Children Detention Campus introduced its new rights-based framework, and, therefore, we developed a new methodology for our inspections under this framework. All three special care units applied for and were granted a renewal of their registration following inspections in 2021. Our inspections of children's residential centres showed continued high levels of compliance with standards and regulations.

2021 was another exceptional year for children, their families and services. The impact of COVID-19 on children at home or in care, and their families, varied over the course of the year and reflected the changing public health restrictions in place at any given time. For example, alternative ways to maintain contact between children and their families were explored and used when visits were curtailed. They included remote contact using various technologies. While some children and their parents were satisfied with this approach, others were not and missed direct contact.

Children's services also experienced challenges throughout the year as a result of the COVID-19 pandmeic. Some services experienced high levels of staff absences, requiring areas to implement risk management strategies, and for residential services to put contingencies in place, such as reducing their bed capacity.

In May 2021, HIQA paused all routine inspections of Tusla's services due to the cyber-attack on the Health Service Executive's (HSE's) server, which Tusla's information system relies on. This severely impacted on the ability of Tusla staff to access key data on children. Our routine inspections of special care and residential services resumed quickly, followed by inspections of other services at the end of July 2021.

Over the past number of years, HIQA has routinely highlighted the importance of strategic planning and good governance in the planning and resourcing of services. It is without doubt that governance structures in Tusla have significantly improved, but some specific challenges remain. Tusla continued to experience challenges in adequately resourcing its community services. The importance of children having access to the ***right service at the right time*** is crucial in supporting their development and promoting their safety and rights. Through our inspections in 2021, we found that many children continue to experience delays in receiving a service or moving to a more appropriate service, and a small number of children were delayed in coming into care.

Insufficient resources in terms of staffing and suitable placements for children were an ongoing challenge to Tusla during 2021. Tusla put systems in place to manage growing waiting lists, and this was more effective in some service areas than others. Several other initiatives were considered by Tusla to mitigate the risks associated with reduced staffing levels which included, for example, employing other professional groups and using social care staff to complete tasks traditionally completed by social workers. However, staff vacancies impacted directly on service delivery for some children in care and children using child protection services. Many children did not have an allocated social worker or they experienced multiple changes in social workers over short periods of time. Towards the end of 2021 in particular, the numbers of children in care that did not have an allocated social

worker and the number of child protection cases on waiting lists increased in many service areas.

Our commitment to promoting the ongoing quality improvement of children's services continued with a range of quality improvement initiatives in 2021. We completed our thematic (quality improvement) child protection and welfare programme in early 2021 and published an overview report on our findings from this programme. In September 2021, we also published an overview report of the findings of HIQA's monitoring and inspecting of Tusla's foster care services during 2019 and 2020. A further quality improvement initiative was the thematic inspection programme of foster care inspections, which evaluated the adequacy of governance arrangements across foster care services and the impact that these arrangements have for children in receipt of foster care. In addition, focused inspections of child protection and welfare services provided to children listed on the Child Protection Notification System (CPNS)* commenced in 2021 with a view to completing these inspections in all 17 Tusla service areas by the end of 2022.

Ensuring children's voices are heard during inspections is a crucial part of our work. During 2021, we continued to seek the views of children. We consulted with children and young people and also with parents and foster parents. The majority of children who were consulted with spoke positively about the service that they were receiving and felt well cared for.

This overview report will provide a summary of the key findings from inspections conducted in 2021.

I want to acknowledge the ongoing participation and contribution of providers, foster carers and staff during our inspections. You continue to work in challenging circumstances with children and their families to provide safer and better services. I would like to thank the children, their families and advocates for their participation and their time which they gave to our inspectors when they contacted them.

Carol Grogan

Chief Inspector of Social Services

Health Information and Quality Authority

* The CPNS is a national electronic record of all children who are assessed by Tusla as being at ongoing risk of significant harm. Children placed on the CPNS have a child protection plan which is agreed at a child protection conference.

1. Introduction to regulation and monitoring

About this overview report

This report provides an overview of HIQA's and the Chief Inspector's inspection, monitoring and regulation of children's services in 2021. It also includes:

- how HIQA and the Chief Inspector inspect and regulate the services within their legal remit
- what children told inspectors during the course of the year
- engagement with stakeholders and informed and interested parties
- a concluding statement in relation to work undertaken in 2021 and focus for future inspections.

Introduction to the work of the Children's Team

HIQA and the Chief Inspector of Social Services within HIQA are responsible for regulating and monitoring the quality and safety of a range of adult and children's health and social care services across Ireland.

HIQA and the Chief Inspector fulfils its statutory obligations set out in the Health Act 2007 (as amended) under the stewardship of the Chief Inspector of Social Services, which oversees the monitoring, registration and regulation of following services:

- child protection and welfare services
- statutory and non-statutory foster care services
- statutory children's residential services
- special care units
- Oberstown Children Detention Campus.

This overview report also outlines how the Chief Inspector and HIQA met their business plan objectives[(2)] in 2021 in relation to children's services, including the:

- Receipt and assessment of all solicited and unsolicited information across children's centres and services and respond to risk in a proportionate and timely manner
- Conclusion of the thematic child protection programme reviewing cases from initial referral to the completion of initial assessment

- Publication of two overview reports on the findings of the Child Protection thematic inspection programme and Foster Care Phase 2 inspections carried out in 2019 – 2020
- completion of year one of phase 3 of a three-phase thematic programme of monitoring inspections of statutory foster care services to review the efficacy of governance arrangements across foster care services and the impact these arrangements have on children in receipt of foster care
- A programme of inspection of non-statutory foster care services
- An inspection of Oberstown Children Detention Campus
- A programme of focused inspections of child protection and welfare services to assess the quality of service provided to children deemed to be at ongoing risk of harm who are placed on the CPNS across all Tusla service areas
- A programme of inspection of statutory children's residential centres;
    - the focus for the first six months was to assess the leadership, governance and management, including statements of purpose and function, staffing resources and vetting
    - while the focus in the second half of the year was to assess compliance with staffing resources, statements of purpose and function, and standards related to planning for children in care and child protection
- A programme of regulation in special care units to include monitoring and inspection of all units and the processing of all registration applications received.

2. How we regulate services

2.1 The statutory framework — monitoring and regulating

HIQA and the Chief Inspector of Social Services carry out three different types of inspections:

- Inspections to assess compliance with statutory regulations, in the case of registered designated centres, such as special care units
- Inspections which monitor ongoing compliance with specified nationally mandated standards, and monitoring against the rights framework of the children's detention campus
- Thematic inspections which aim to promote quality improvement by focusing on national standards relevant to particular aspects of care and to improve the quality of life of people using services.

Each type of children's service has its own statutory framework that gives authority to HIQA and the Chief Inspector to inspect, monitor and or regulate the service using standards and regulations which set out what is expected from the service.

Table 1 on the following pages shows the statutory framework for each type of children's service monitored by HIQA or regulated by the Chief Inspector.

Table 1. Statutory basis for inspection and monitoring of children's services by HIQA and regulation by the Chief Inspector

Functions	Authority to inspect	Primary legislation	Regulations (where applicable)	National standards
Child protection and welfare services	Inspected under Section 8(1)c of the Health Act 2007 (as amended)	Health Act 2007 (as amended)		*National Standards for the Protection and Welfare of Children* (HIQA, 2012)
Foster care services	Inspected under Section 69 of the Child Care Act, 1991 as amended by Section 26 of the Child Care (Amendment) Act 2011	Child Care Act, 1991, as amended	Child Care (Placement of Children in Foster Care) Regulations, 1995 Child Care (Placement of Children with Relatives) Regulations, 1995	*National Standards for Foster Care* (Department of Health and Children, 2003)

Functions	Authority to inspect	Primary legislation	Regulations (where applicable)	National standards
Special care units for children and young people	Inspected under Section 41 of the Health Act 2007 (as amended)	Health Act, 2007 (as amended)	Health Act 2007 (Registration of Designated Centres) (Special Care Units) Regulations 2017 Health Act 2007 (Care and Welfare of Children in Special Care Units) Regulations 2017 Health Act 2007 (Care and Welfare of Children in Special Care Units) (Amendment) Regulations	*National Standards for Special Care Units: November 2014* (published 2015) (HIQA)
Children's detention campus	Inspected under Section 185 and Section 186 of the Children Act 2001, as amended by Criminal Justice Act, 2006	Children Act, 2001 as amended by Criminal Justice Act, 2006		*Oberstown Children's Rights Policy Framework (2020)*

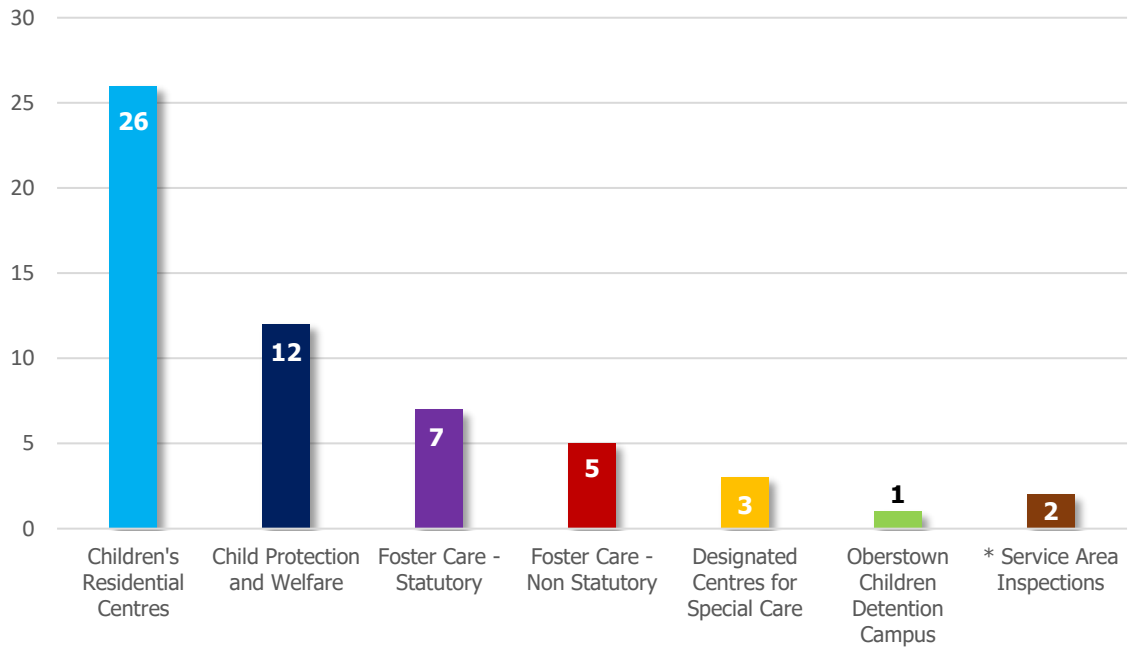
Functions	Authority to inspect	Primary legislation	Regulations (where applicable)	National standards
Children's residential centres	Inspected under Section 69 of the Child Care Act, 1991 as amended by Section 26 of the Child Care (Amendment) Act 2011	Child Care Act, 1991, as amended	Child Care (Placement of Children in Residential Care) Regulations, 1995	*National Standards for Children's Residential Centres* (HIQA, 2018)

2.2 Registration and inspection activity 2021

During 2021, HIQA and the Chief Inspector conducted 56 inspections of the various children's services under their remit (as illustrated in Figure 1).

This included inspections of statutory children's residential centres, statutory and non-statutory foster care services, child protection and welfare services, and Oberstown Children Detention Campus. Three of the 56 inspections were carried out in order to monitor ongoing regulatory compliance and to renew the registration of designated special care units.

Figure 1. Inspection activity 2021 by service and inspection type



* Service area inspections incorporate both child protection and foster care services.

2.3 Receipt of information

The Chief Inspector receives notifications from Tusla relating to designated centres for special care as well as non-regulated children's services. It also receives unsolicited information from people who have a concern about services provided to children.

2.3.1 Regulated children's services (special care units)

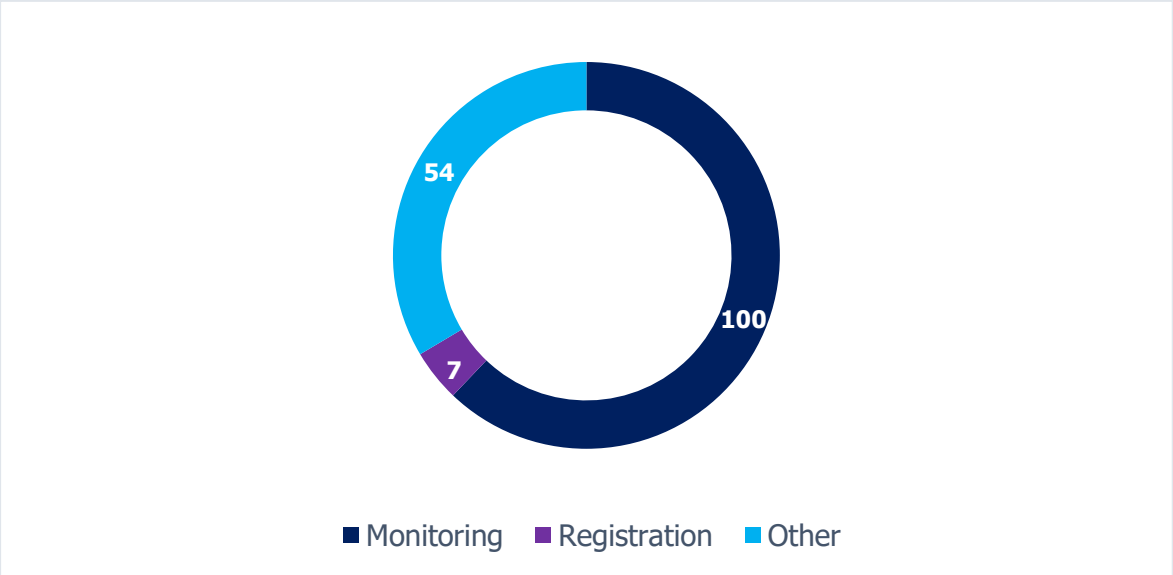
During 2021, 161 notifications were received from Tusla relating to designated special care units. These are notifications that special care units are required to submit to the Chief Inspector within specified time frames.

The majority of notifications received in 2021 were those prescribed in the care and welfare regulations for special care units and which are termed 'monitoring

notifications'. They primarily related to issues such as absconsions, allegations of abuse and times when children were injured and required medical attention. Figure 2 below provides a breakdown of these notifications.

Notifications categorised as 'other' relate to reports received from Tusla with regards to their monitoring of special care units, and quarterly notifications received.

Figure 2. Number of notifications received from designated special care units by type of notification



2.3.2 Non-regulated children's services

Notifications of serious incidents involving children who are known to Tusla's child protection and welfare services, including the deaths of children in care, are submitted to HIQA by Tusla within three working days of the death or serious incident happening.

In 2021, HIQA received 30 notifications: three related to serious incidents, and 27 related to the deaths of children in care or deaths of children known to the child protection and welfare service. Rapid or local reviews are carried out by Tusla following such incidents. These incidents are also referred to the National Review Panel[1] for a decision in relation to carrying out a further review.

As with all information received in 2021, reports of rapid or local provider-led reviews into these incidences and 11 reports completed by the National Report Panel were risk assessed by HIQA and informed HIQA's regulatory activity in regard to the specific service area concerned.

[1] This is an independent panel established in 2010 to review serious incidents, including the deaths of children in care and those known to the child protection system.

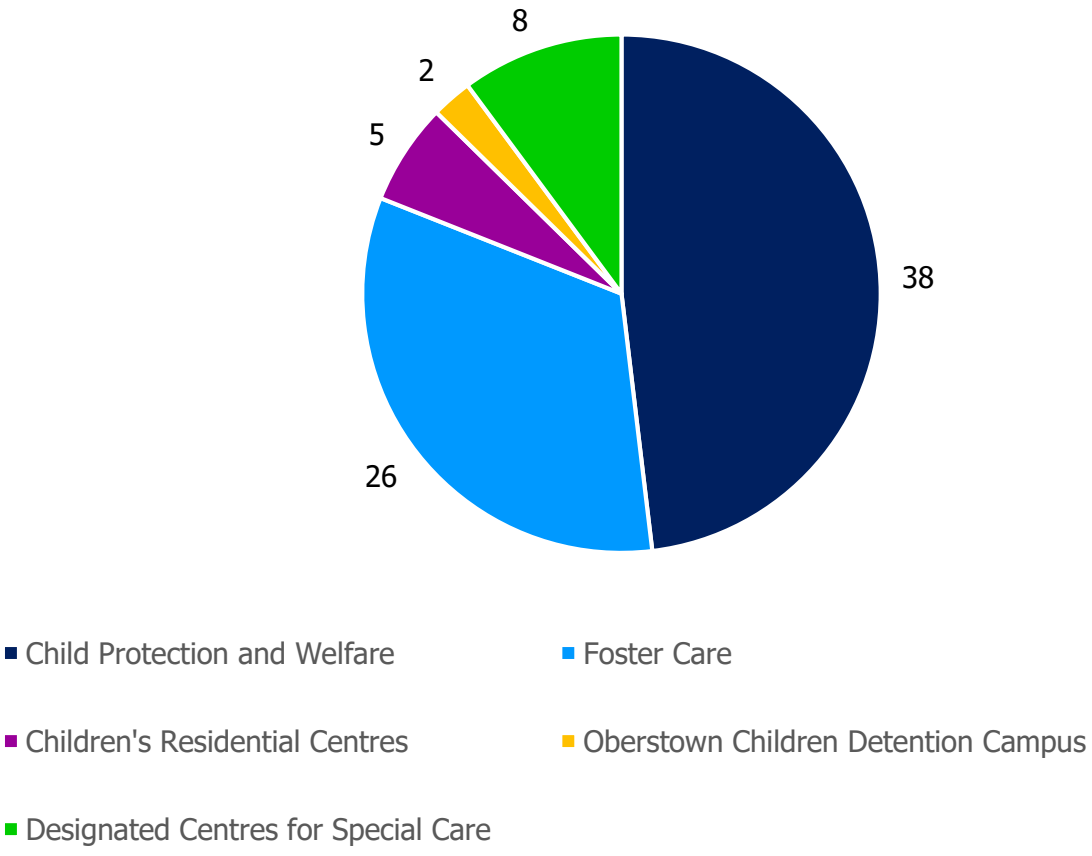
2.3.4 Unsolicited information

HIQA welcomes information about services. We call this type of information *unsolicited information*. It is information which is not requested by HIQA in relation to its statutory function. During 2021, HIQA received a total of 79 pieces of unsolicited information from members of the public who had a concern about services mainly provided by Tusla.

Of the 79 pieces of information received, 38 (48%) related to child protection and welfare services, 26 (33%) related to foster care services, five (6%) related to children's statutory residential centres, eight (10%) related to special care units, and 2 (3%) related to Oberstown Children Detention Campus. All information received informed our monitoring programme.

Figure 3 shows the number of pieces of unsolicited information received about the different functions we monitor, inspect and regulate.

Figure 3. Unsolicited information received by children's services



When HIQA receives unsolicited information in relation to services within its legal remit, or the legal remit of the Chief Inspector, it is reviewed by an inspector. The inspector assesses whether there are any trends or patterns that suggest something is happening in a service that falls outside of what is expected in the national standards or what is required under the regulations. In many cases, the inspector will seek additional information and assurance from the service provider about the issue of concern.

In responding to unsolicited information in 2021, inspectors:

- sought additional information on the issue
- requested plans from the service provider outlining how the issue would be investigated and addressed
- used the information to inform what areas of practice we would assess on inspection.

Where the information indicates that children's welfare may be at risk, HIQA reports the incident to Tusla, in line with *Children First: National Guidance for the Protection and Welfare of Children* (2017) requirements.[16]

HIQA also receives information about services that are not within its remit. Whenever this happens, the person is offered advice as to the organisation best placed to address their concern, for example the commissioner or provider of the service, the Office of the Ombudsman or the Ombudsman for Children's Office (OCO).

3. Listening to the voices of children and young people

The 'Voice of the Child' is at the centre of the services we monitor and regulate. Throughout 2021, HIQA continued to actively promote and reflect the voice of children and young people in its work. It is through this consultation process that we explored children's lived experience of their care and support.

Our ultimate aim is to speak directly with children and young people accessing a wide range of services, such as child protection and welfare, foster care, residential and

secure care. Since the onset of the COVID-19 pandemic, this has proven to be more difficult as it has not allowed inspectors to meet with many children and young people face-to-face to hear first-hand of their experiences. Where it was not possible to meet children and young people in 2021, conversations were mainly held through phone calls and online focus groups. However, this method did not suit all children and young people as they differed in age and ability. Additionally, only those children who agreed to speak to us were contacted, as all children had the right to choose whether to speak to us or not.

A variety of service-specific child-friendly questionnaires and other communication tools had been used in the past as a means to obtain the views of children and young people, and these have proved to be very successful in capturing children's experiences to date. During the latter part of 2021, two new surveys for children and young people in care, and children requiring a protection and welfare service, were developed and piloted by inspectors.

One survey was developed to cover all services accessed by children and young people, such as child protection and welfare, foster care and residential care. The other survey developed related to children and young people in Oberstown Detention Campus.

These surveys provide a child-friendly description of HIQA and explain the purpose of the survey. Contact information is provided throughout the survey for various services. Children and young people are advised on what they can do if they are unhappy with the care or service they are receiving. The surveys contain a checklist of questions that ask children and young people about their experience of the services that work with them, their families and the important people in their lives. Comment boxes are

provided at the end of each section so that they can share their own thoughts or concerns. The surveys also ask children and young people if there are any improvements they would suggest after completing the survey.

Of the 65 surveys that were piloted between October and December 2021 across child protection and welfare services, foster care services and a detention campus, 41 responses were received (63%). Of those who responded, children and young people were generally very positive in their responses.

Due to COVID-19 restrictions at the start of 2021, a number of inspections of statutory children's residential centres were undertaken remotely. While this did not allow for direct engagement and observation of children and young people, inspectors spoke with them primarily by phone so as to capture their experience of the quality of the service being provided. When public health guidelines allowed, inspections of these centres returned to a mix of on-site and remote inspection activity.

As part of the inspections completed in 2021, inspectors engaged with a total of 195 children, comprising 51 children in foster care, 63 in statutory children's residential centres, 11 in special care units, 34 in Oberstown Children Detention Campus, and 36 children receiving a Tusla child protection and welfare service. Children participated in inspections by talking directly with an inspector in the centre, by phone or in a focus group with an inspector (154), or by completing and returning a survey (41). The following section outlines the feedback we got from the children we spoke with and children who returned questionnaires.

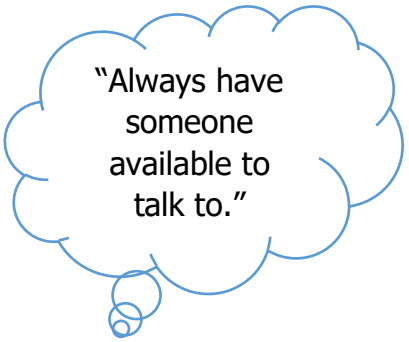
3.1 What children said about their experience of services

Experience of social work services

Children and young people were positive about their experience of the social work service they received, such as a child protection and welfare service or where they were placed in either residential, secure or foster care service. They reported that there had been positive changes in their lives because social workers and care staff were involved with them. Participation, consultation and inclusion were key elements of their care programme in residential care, and children and young people felt their individual needs were being met by staff and social workers involved in their care.

They understood why they were not living at home and or why social work services were involved with them and their families. For the majority of children and young people across the services, they liked and got on well with their social worker and made positive comments about their involvement in their lives. Others described different experiences and did not want any involvement from social workers.

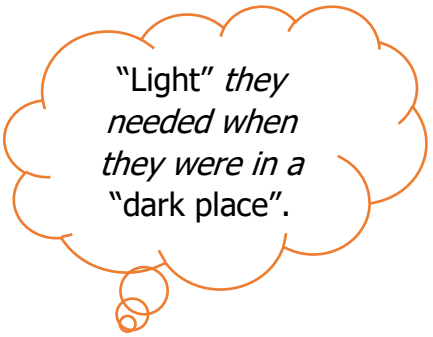
They talked about other key people who worked with them to support them. Having these people involved was positive for some children. Here is what a couple of them said:



Children and young people in residential care and secure care felt cared for and supported and had built good trusting relationships with staff members. Their individuality was respected and their rights were promoted and facilitated. They were helped to develop skills for independent living and to take responsibility for decisions about their future.

Respite breaks in a residential centre

A cohort of children and young people either at home with involvement from the child protection and welfare service or placed in foster care often availed of respite breaks in a residential centre. They were positive about going to the centre for respite and what it meant to them. Some of their comments included:



Contentment with placements

While children and young people were generally happy in their placements, some described mixed feelings about living with others. Some did not like their placement as it was not their own home and they did not like living with other children and young people. For example, they described times where they felt unsafe or were angry about incidents involving the behaviours of others living in the same house and the negative impact as a result.

Impact of COVID-19

COVID-19 continued to have some impact on children and young people's experiences of services but to a lesser extent in 2021 when compared to the year before, as public health measures began to be lifted. Those in foster care and children and young people in receipt of a child protection and welfare service said that they began to see their social worker on a more regular basis and, where appropriate, meetings in relation to their care and safety had returned to face-to-face meetings. In line with the lifting of some COVID-19 restrictions in 2021, some children and young people were pleased that they could attend school in person and see their friends again. Others spoke about the impact of restrictions on activities with staff during the earlier part of 2021 and how they adjusted to this and enjoyed newer and more creative activities as a result. Despite restrictions, children and young people said they were encouraged and facilitated to pursue their hobbies and interests and continued to have contact with family and friends.

3.2 Rights of children – information

The majority of children and young people were aware of and were given appropriate information on their rights. Some had knowledge of independent advocacy services and had contact with advocates. They could exercise their rights and were involved in decision-making processes about their care, depending on their age and ability. When asked about their knowledge of their rights, some were confident in making complaints or providing feedback regarding the service. Others spoke about how their rights were promoted in different ways such as a 'conversation café'[2] and one-to-one discussions with staff.

Many children were aware of their right to make a complaint and in some cases had exercised this right. Children and young people had a mixed experience of making complaints. Some were confident enough to bring their views to the staff team or their social worker to address and were happy with the outcome. They felt that any issues raised by them had been quickly sorted in a fair way. Others were unsure if anything had been done about their complaint. Some of the complaints made included those that related to house rules that children wanted changed as well as increased contact with family while in residential and secure care. While complaints were usually resolved quickly, and children were happy with the result, other complaints were more complex and took longer to resolve.

[2] Conversation café was another name given to young people's house meetings whereby they were provided with drinks and snacks to encourage engagement.

Some of their comments included:

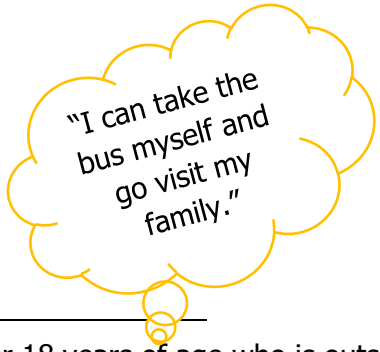
Children and young people's right to access information held about them was promoted in residential and secure care placements. While the majority said they could access, for example, their 'daily logs' and could request access to other records, such as their family history and information on why they were placed in care, many did not want to do this.

Rights of children – contact with family

For the children and young people who did not live at home, contact with family and friends was very important. Most children and young people were satisfied with the amount of contact they had. On the occasions where public health restrictions limited this contact, care staff or social workers facilitated contact via phone and video calls to keep in touch with the people who were important to them.

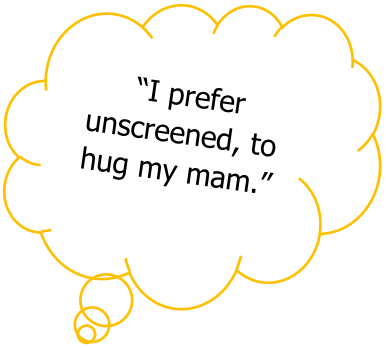
Where families could visit them in their placement, this was facilitated and children and young people could meet them in private, and they enjoyed spending time with them. Other children met their family in dedicated spaces for contact provided by Tusla, or in public areas such as parks and play zones. Some children were facilitated to visit their families at home. For those that lived in secure care settings, young people said they had good contact with their families and spoke about upcoming visits. A number of separated children seeking asylum[3] spoke about the things that were difficult for them, such as little or no contact with their immediate family and wider support networks.

Comments from these children included:



[3] A child under 18 years of age who is outside their country of origin and separated from both parents, and their previous legal and or customary primary caregiver. During 2021, this term changed and they are now referred to as children seeking international protection.

Others spoke about the impact of public health restrictions on some visits. Children in Oberstown Children Detention Campus explained that their visits with family took place in a room with a screen between them and that they missed the physical contact with parents and siblings.



The right to privacy was important for children and young people. As such, they considered their bedrooms to be their private space. All children and young people spoke about how they could personalise their bedrooms in ways that appealed to them.

Rights of children – personal space

Children spoken with described how they had decorated their rooms by changing the layout, choosing colours they liked and adding decorations and other items that they had chosen. They enjoyed having their own personal space and having time alone was something children and young people in care valued a lot. They felt that this was respected by staff and the others that lived in the centres. One child commented:

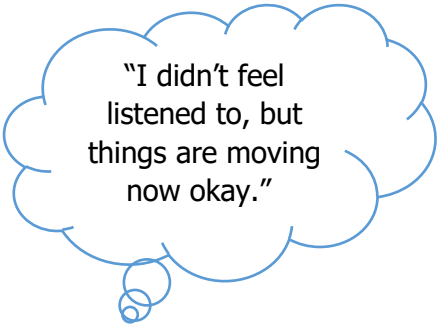
While those who lived in secure care also described how they could decorate their rooms, some felt the rules around items allowed or not in their rooms were strict and that they did not fully understand the reasons for this. The environment and very nature of secure care meant that some children and young people found aspects of it challenging. Some said they did not like that they could not access their bedrooms themselves and that they would prefer not to have to ask staff to unlock their doors for access to their bedrooms.

3.3 Participation by children in decision-making

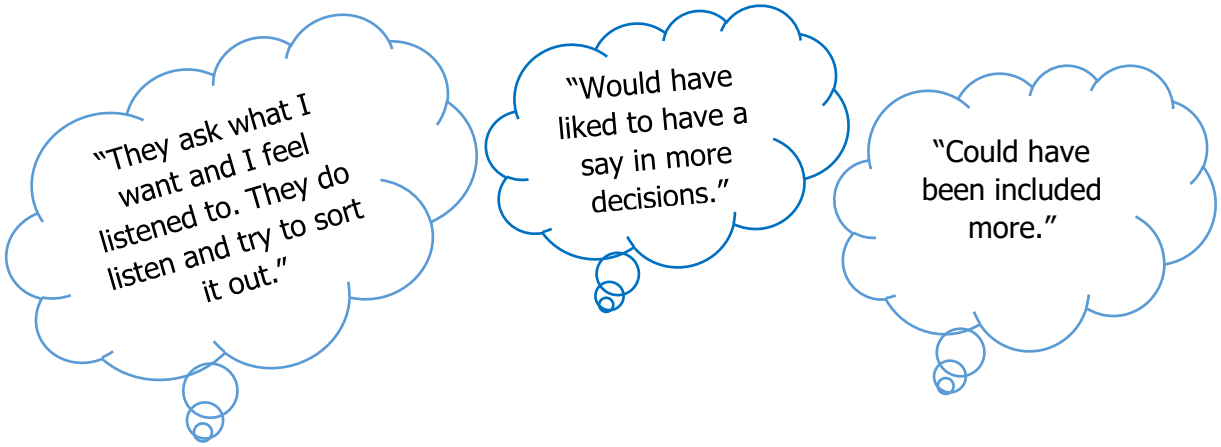
The right to be involved in decisions about issues that affected them and to participate in meetings that impact their lives was very important for children and young people. The majority told inspectors that they felt listened to, attended their planning meetings and contributed to decisions made about their care. Some children in foster care chose not to attend their care planning meetings. For example, one said "I didn't go but talked to the social worker" and another stated "I don't like going to meetings". They also spoke about filling in their review forms with the help of their foster carers and social workers. One child stated: "I fill in the form and speak my mind." When decisions were made that did not reflect their views or preferences, they said that staff or social workers usually explained the reasons for this to them.

Children and young people who were receiving a child protection and welfare service said that social workers asked for their opinion on what should happen next for them. While some were happy with how they were involved in decisions about their lives, others would have had liked to have had a say in more decisions.

Some children's comments about attending a child protection conference[4] were that it was "awkward" but "it was good". Children said they sometimes attended these meetings with their parents and social workers and felt they knew everyone was proud of them because of the progress they had made. Their comments included:

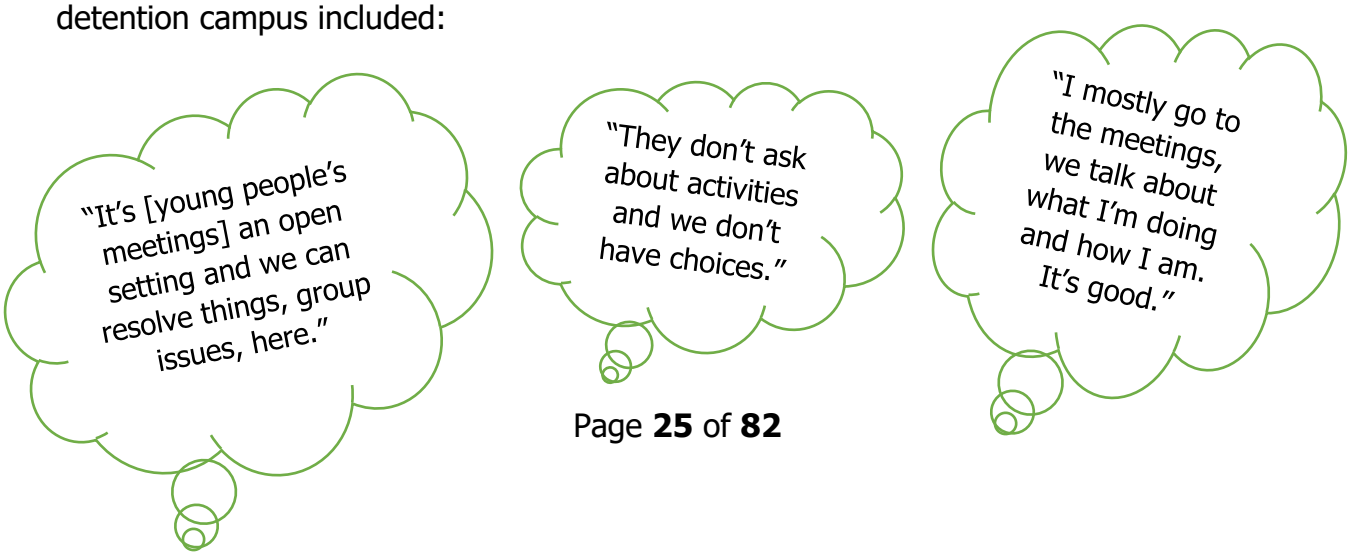


[4] The Child Protection Conference is an interagency and inter-professional meeting, its purpose is to share and evaluate information between professionals and parents, to determine if there is an ongoing risk of significant harm to the child and consequently to formulate a child protection plan.

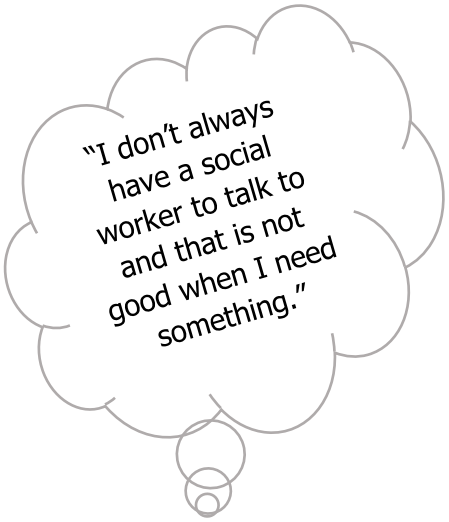


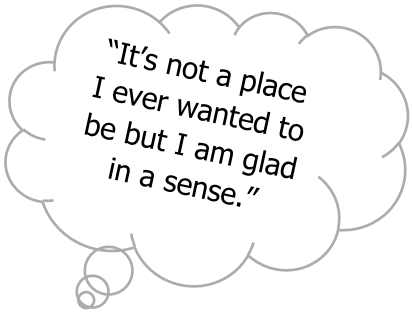
Those that lived in residential care or secure care described regular meetings with the managers, staff and others living in the centre. They said they were able to make suggestions about day-to-day life in the centre, and they felt their views and wishes were listened to. For example, comments included "I have a voice", "what comes up in the meeting goes to the staff meeting and they give us feedback" and "get to choose different 'themes' to work on during the meetings". For those that did not want to attend these meetings, they had the chance to speak to a staff member which gave them the opportunity to express their views and raise any issues they had. Most children and young people were satisfied that their suggestions at these meetings had led to improvements in the centre, while others were looking forward to responses to other suggestions, such as improved Internet access and planned outings. Some children's and young people's views were also obtained when placements had ended through exit interviews. Suggestions for improvement in these interviews had informed the plans for improved outdoor activity facilities in a secure setting.

Many of the children and young people in the detention campus said they had opportunities to participate in all aspects of the service and had meetings where they discussed what was going on in the units and to have their views heard. However, others felt they did not have as much of a say, as there were no meetings in their respective unit in the campus. They did not feel they had opportunities to have their views heard in a number of areas, predominantly relating to decisions about their care, their future and their day-to-day life. Comments from children and young people in the detention campus included:

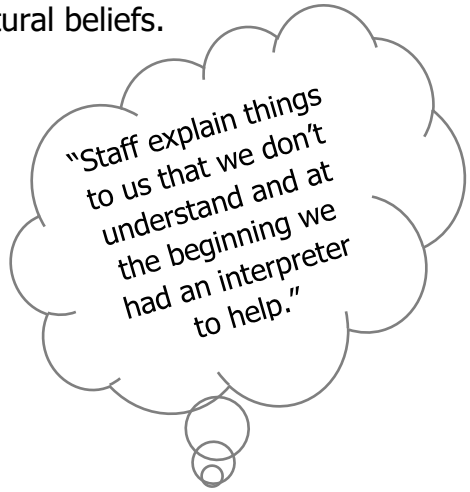


The majority of children and young people across the services felt safe, well cared for and supported by staff and social workers. They described the positive relationships they had with them and being able to talk to them if they were worried or had an issue. While children and young people generally felt safe, some gave examples of when they felt less safe or were angry about incidents involving the behaviours by others living with them. They felt that this was usually well managed by staff to ensure everyone's safety, but some commented that "there are not enough staff" at times.





Children and young people's cultural and ethnic backgrounds were respected across all services. Not all had English as a first language, and they explained that interpreters were in place to assist them to communicate effectively and to participate in decision-making processes. For some in residential and secure care, placement planning set out actions to promote their identity and beliefs. For example, children and young people spoke about the preparation of particular foods or access to information about their country of origin. The majority of young people in detention identified areas for improvements in relation to information and supports to practice their religious and cultural beliefs.



Most children and young people had an educational and or training placement, and this was explored with them during a number of inspections in 2021. They talked about their favourite subjects as well as the challenges they faced adjusting to school routines, particularly during COVID-19-related restrictions. Some children and young people were more actively involved in their education programme than others, while some had an individual education plan suited to their specific needs. Their particular interests and talents were encouraged and explored through discussions with care and education staff. Young people in the detention campus liked school and the overall range of classes and activities available to them there, such as cooking, drama and the gym.

3.4 Transitions to care, home or onward placements

Over the course of our inspections in 2021, children and young people told us about their experiences of coming into a care placement or moving between services. For some, this was a difficult and anxious time but for others it was less so. Some told us they "felt welcomed" but also felt a "little nervous" on moving into a placement. For most, they felt these times were well managed and they were given appropriate information to support them to understand and manage these transitions. For those in residential or secure care, their experiences of arriving and moving into their placements were generally good and they reported that staff were very welcoming and put them at ease. Planning around transitions was considered in conjunction with social workers and family where appropriate.

Children and young people described how they were encouraged and supported to develop their independent living skills, to participate in activities in the wider community and prepare for their future. Some felt well prepared and had plans in place to support this transition into young adulthood and felt they had a strong say in preparing for their future lives.

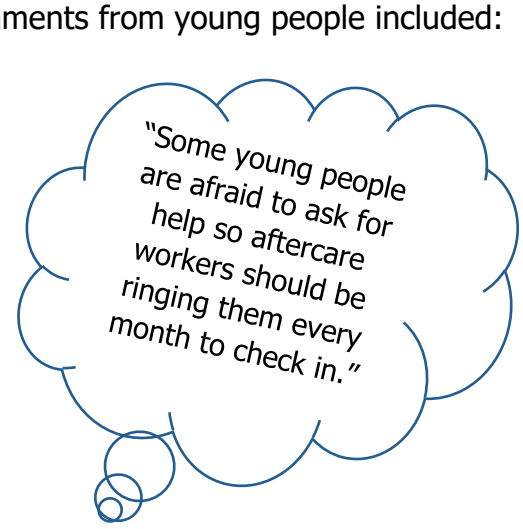
For those children who, following their period of detention were returning to the care of Tusla, this was challenging at times due to the lack of availability of onward residential placements. Delays in securing these placements impacted on the ability of the detention campus to make provision for other services and supports, such as education and training prior to a young person's release. Young people placed on remand or due for release from the campus felt that the plans around this were good and they felt confident about avoiding a return to the campus due to the supports put in place in the community on their release.

For children and young people who were seeking asylum in Ireland, they expressed concerns for their future and their uncertainty about where they would live when they reached 18 years of age, when they were no longer the responsibility of Tusla. As such, some found it difficult to focus on planning for their future and moving into young adulthood in a new country. They expressed concerns about experiencing delays in confirming their immigration status and the impact of this delay on their health and wellbeing. While these children and young people said they were happy living in the residential centres and were cared for and supported by staff, they also said they did not have any hopes and dreams, and this was an anxious time in their lives.

Some children and young people in secure care did not know the length of time they would continue to remain in their placement, and some felt they had done what was required of them to be discharged from there. This was reflected in the findings of the inspection of one secure care centre which found that onward placements for some children and young people had been difficult to find and had delayed their discharge from the centre. One young person spoke about the difficulty in finding a placement in the community because everyone "was looking at my past".

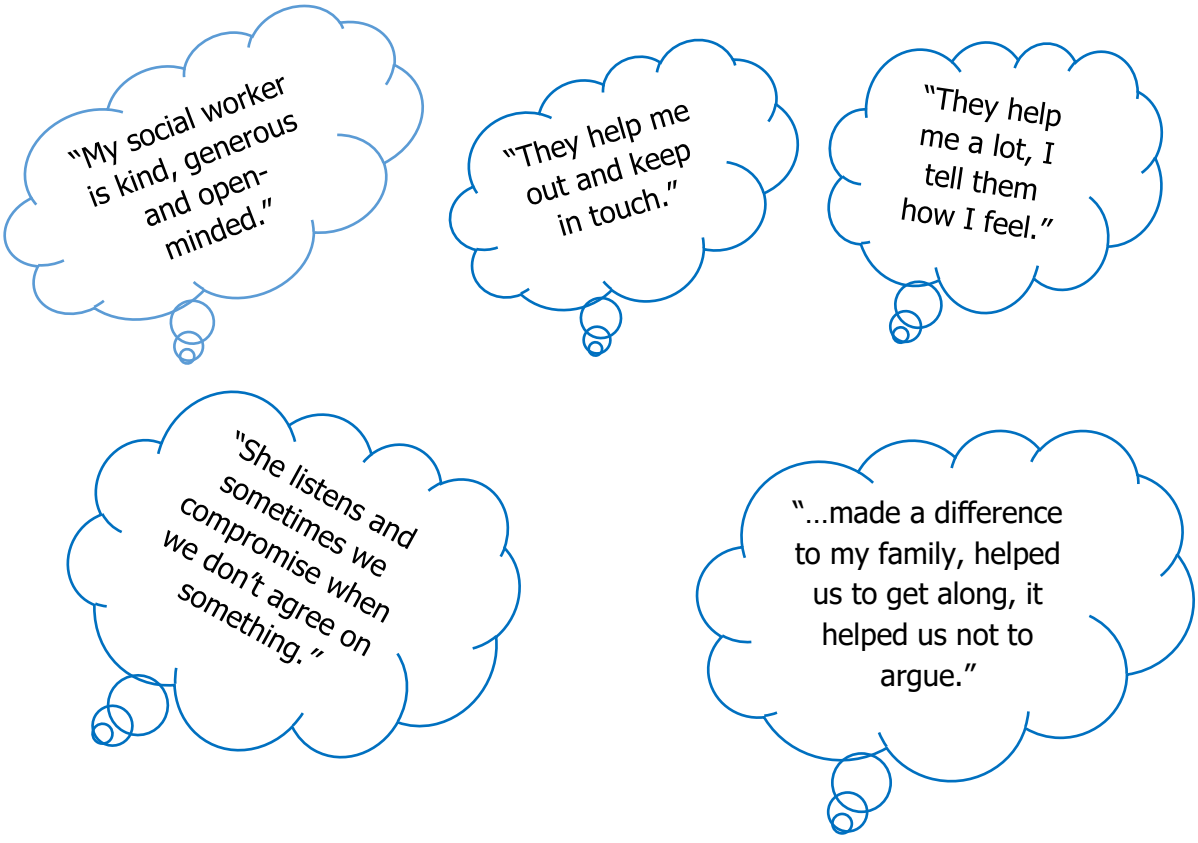
Young people who were availing of a leaving and aftercare service described how they were given information on important issues in preparation for reaching adulthood. While most were satisfied with the level of support from aftercare services, some had mixed views of their experiences. For example, one young person said "they listened to me" and that the aftercare worker "is very capable" and "did all the paperwork and just explained to me what I needed to know and who would give me support". Other young people felt they needed more support. Where they were unable to rely on their foster carers for support and local accommodation for young people leaving care was at capacity, they described their concerns about having no plan B. The particular vulnerability of young care leavers to become homeless was a concern expressed by young people.

Comments from young people included:



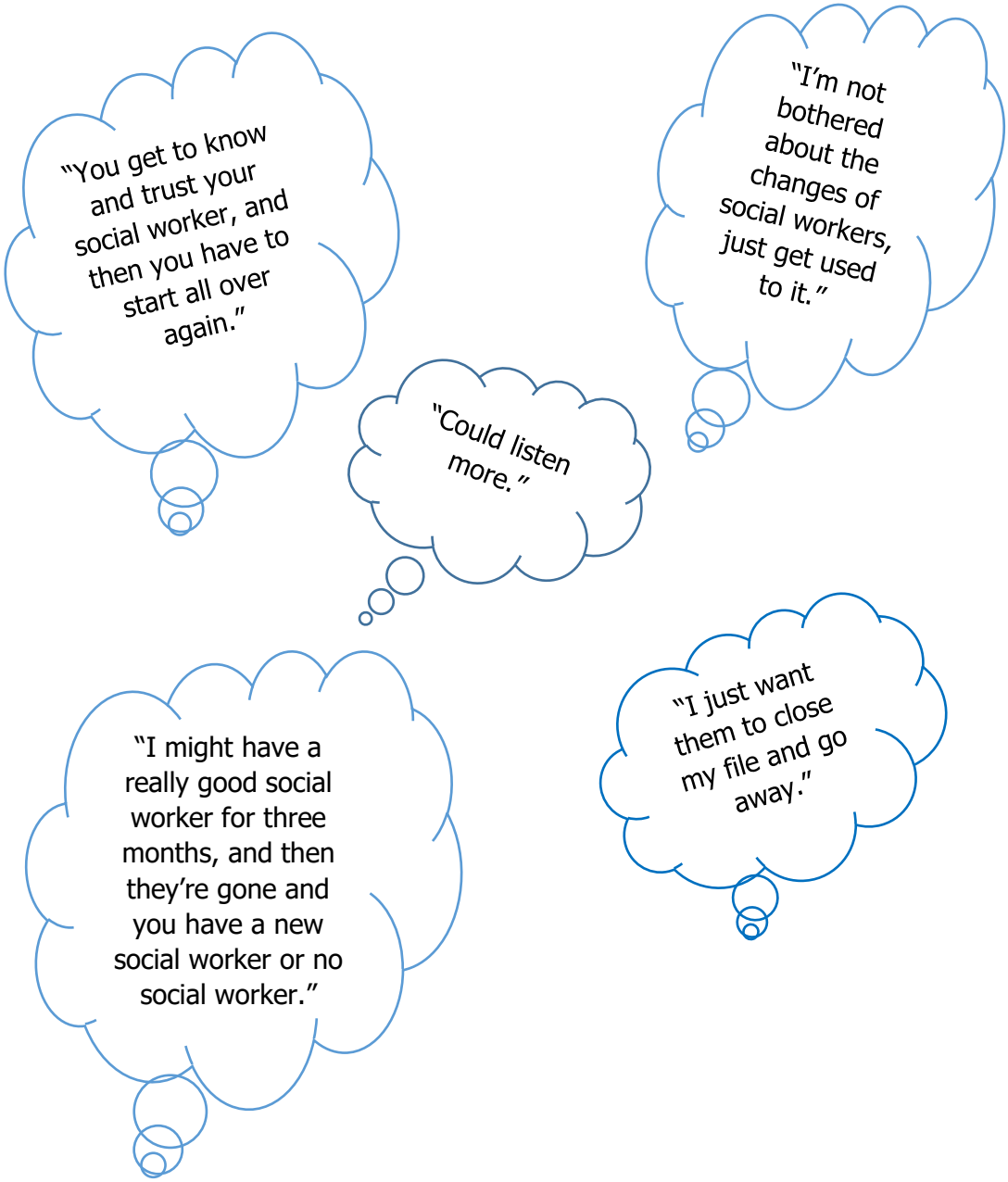
3.5 Children's views on access to social workers

Most children and young people who spoke with inspectors in 2021 said they had a social worker in place. They understood the role of their social worker and why they were in their lives. However, some children and young people had mixed experiences about their social workers. The majority of children and young people told us that they liked and got on well with their social worker and made positive comments about their involvement in their lives. For example, comments included: "great bond, always there"; "truly the best"; "feel like I have someone by my side"; and "amazing". Children and young people generally felt that they trusted their social worker and could confide in them about their worries and concerns. Other comments included:



Other children and young people were not as positive or did not have a social worker in place. Some felt they did not want a social worker involved with them, while others said that not having a social worker meant a lack of support. One commented "that was not good when I need something". Other comments included: "what happens when I am not okay and need to speak with somebody and there is no one there?" and that social workers "come and go, I don't get to know them". The frequent changeover of social workers for children and young people in foster care or at home with involvement from the child protection and welfare service was a significant concern for many. Some children and young people said they would like to have the same social worker so they were not repeatedly having to re-tell their story to a new social worker.

Comments included:



3.6 Children's views on areas of improvement

While the majority of children and young people told inspectors of their positive experiences during the course of inspections, they were also asked about what improvements they would like to see. A number of the improvements recommended by them reflected findings of non-compliance by HIQA and the Chief Inspector in those children's services inspected over the course of 2021. The improvements which were identified by children and young people as being required included:

- stability and consistency in social work allocation
- social worker to visit or be in contact more
- increased supports to help those with substance misuse issues
- increased supports to practise their cultural and religious beliefs
- improved planning for those leaving care and the provision of timely onward placements
- clearer explanations in relation to behaviour management
- consistent and fairer rules
- to listen more to the individual child or young person
- help in establishing immigration status.

3.7 Children's experiences of secure care

For some children and young people, secure care placements are required. The Chief Inspector inspects special care units where children are placed when it is determined that they need care and protection as their behaviour places them at risk. HIQA also inspects Oberstown Children Detention Campus, where care and education is provided to children who have been committed to custody following conviction for a criminal offence or who have been remanded in custody while awaiting trial or sentencing.

Children and young people placed in secure care spoke positively about their experiences of care and were well supported by staff. They told inspectors that they generally felt safe and included in decisions relating to their health, education activities and family contact. They could identify staff members they could speak to if they were unhappy or had any issues arising for them. They also said that they were provided with support and information to understand why they were placed in secure care, what to expect and how to access relevant supports if they needed to.

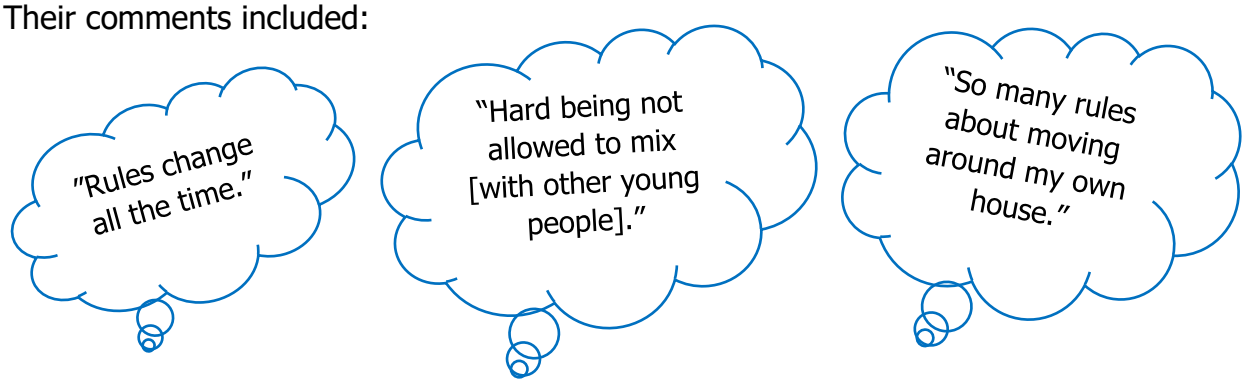
However, there were mixed views across the secure care settings due to some reported practice inconsistencies, such as young people's meetings. Most children and young

people said they were respected, consulted and encouraged to participate in decisions about their care. They said they felt listened to and cared for.

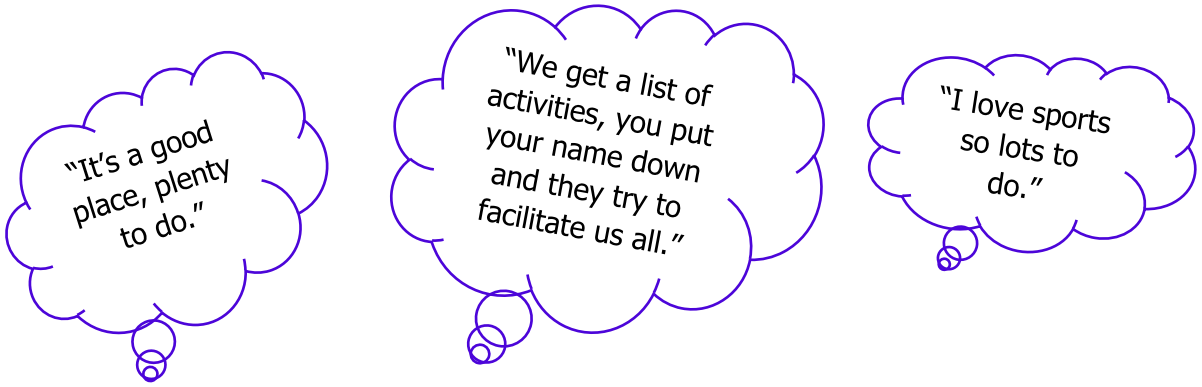
Some children and young people in detention spoke proudly about their positive behaviour and how they were supported by staff to problem-solve when issues arose, so as to avoid becoming agitated and the consequences that could follow as a result. They had the opportunity to participate in meetings where they discussed what was going on for them and said they liked these meetings. Others had different experiences, saying that it was not always clear to them what needed to improve in terms of their behaviour.

A minority of children and young people were unhappy as they felt that staff responses to challenging behaviour were not always fair. Children and young people who had experienced restrictive practices — such as physical restraint due to presenting risks or single separation (not being allowed to mix with their peers) — had mixed views. Some described it as "grand" or "alright" while others described it as "not nice", "depressing" and "not good for my mental health". Others struggled with understanding 'the rules' and being supervised so closely by staff. The secure environment and the nature of secure care meant that for some children, it was difficult to understand how they were being cared for. As such, some children and young people found this quite challenging.

Their comments included:



Overall, children and young people in secure care benefited from the approach taken to their care. They said they were kept active through sports, outdoor pursuits, indoor activities and school — which the majority liked to attend. Comments in relation to this included:



They also spoke about improvements needed. Those in detention wanted to see improvements in relation to increased supports for young people with substance misuse issues, supports to practise their cultural and religious beliefs and to be more involved in decisions about their care and their future. Improvements regarding the quality of some of the food in one of the special care units was a common theme for children and young people. Other improvements across the special care units included care planning and changes to some of the fixtures in the unit.

4. Listening to the parents and foster carers

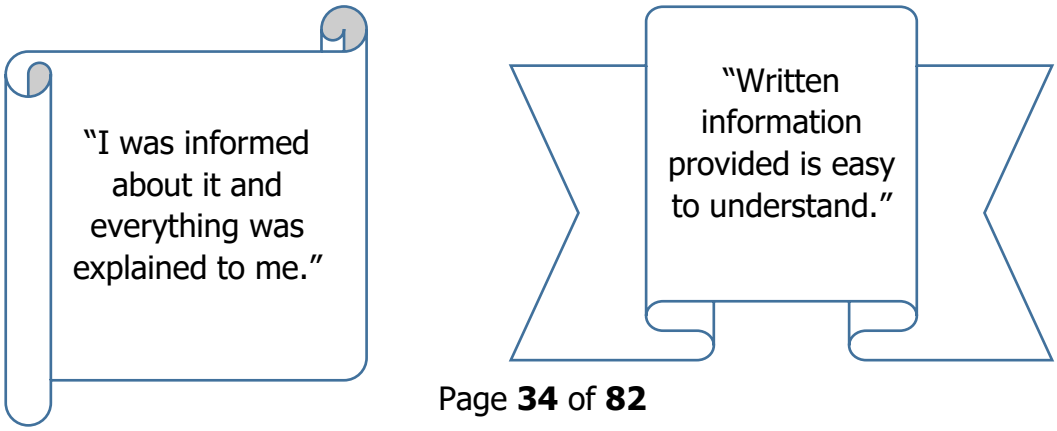
What parents told us

Parents were routinely asked about their experience of being involved in children's services in the community, such as child protection and welfare services or if their child was in the care of alternative care services such as foster care, special care or in detention.

Child protection case conference process

Inspectors talked to 26 parents and seven other family members who had experienced the child protection conference (CPC) process and whose children were, or had been, listed on the CPNS.

The majority were satisfied with the service they received. Most parents described good communication between themselves, the social work department and the child protection conference department. Parents agreed that they were given information about the child protection conference service in advance. 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. Their comments included:



Most said that they were well prepared for the child protection conference and felt actively involved in the process.

Some parents described the child protection conference process as challenging, and some parents or family members expressed dissatisfaction with the service they received; they felt they were not respected or listened to and that family support interventions were not timely. One parent felt that "we don't really have supports in CPCs. It says you can bring someone with you but that person can't say anything or contribute to the meeting and it can be intimidating". This parent also felt that "sometimes we are still going over the same plan and actions, because of funding. So we are still waiting for things to happen. Everyone's workload and COVID can delay things".

Participation by parents in the child protection conference

The majority of the parents spoken to felt that they were supported and encouraged to participate in the child protection conference. They felt that their voice was heard. One parent told inspectors that "I was able to share my views, but I didn't have much to say", while a second parent said that "if we had any issues, we'd bring them up. They would be discussed then".

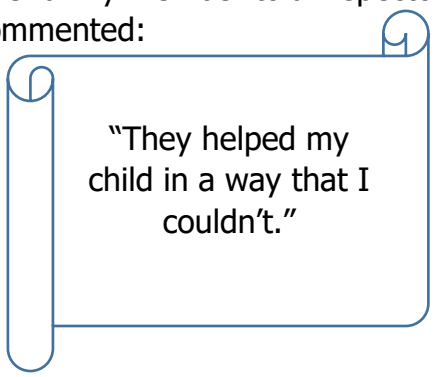
Most of the parents felt that the child protection conference was well managed to support their participation and they fully understood the outcomes and the child protection safety plan. The majority of the parents said that they were informed of the outcome of the child protection conference meeting, and some parents said that they were asked for feedback on the meeting process. One of the parents commented that "yes, the feedback can be given anonymously; however, the feedback form already has identifying information on it". They also described good communication between them, the social work department and the child protection conference department. As one family member put it, "I had a lot to say. There were no interruptions or disputes. Everyone was given time to speak."

Feedback to parents from the child protection conference

The majority of parents confirmed to inspectors that they received copies of the CPC minutes and the child protection safety plans. Some parents told inspectors that they were sent forms in the post by the conferencing service after they had attended a conference to provide feedback about it. Inspectors reviewed feedback forms completed by parents. While some parents had preferred the teleconferences held during COVID-19, others had preferred face-to-face meetings. Parents said they felt listened to and understood what needed to happen for their children.

Impact of the intervention on parents and their children

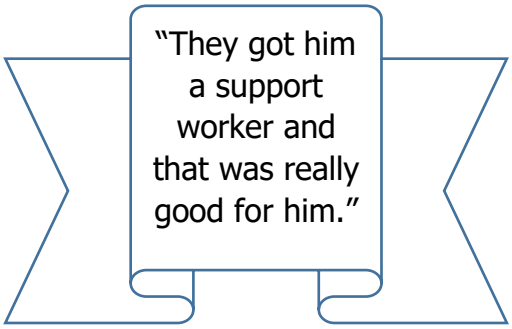
Parents and family members described a quality service which had a positive impact on them and their children. One family member told inspectors: "It saved my life and my daughter's life." Another commented:

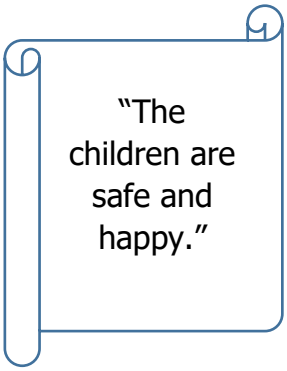


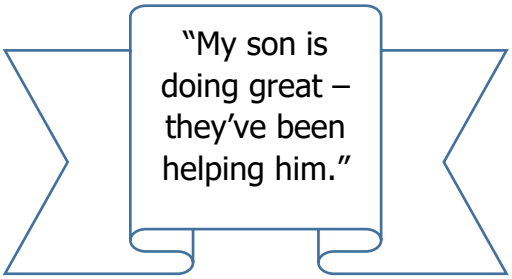
Another family member told inspectors, "I did find it helpful in getting supports for my family. This has worked really well. It's a helpful meeting. People who run it are fine and fair."

Following the child protection conference, parents said that social workers and other people involved in their safety network supported them. One parent told inspectors that they found it helpful and supportive of their family and that "the social worker would always check if there was anything we needed. If we needed to talk about anything. Safety network worked really well. Supports we needed we got, always there to step in".

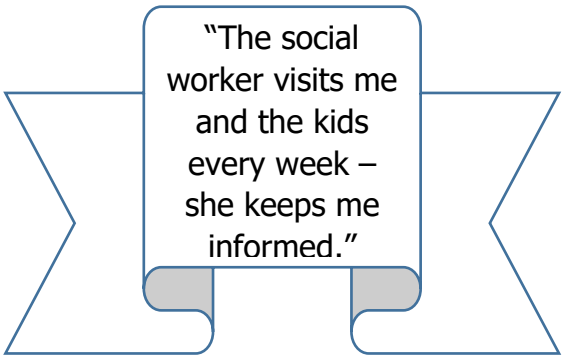
All parents who spoke with inspectors experienced some good outcomes in regard to the safety of their children. Some of their comments are as follows:

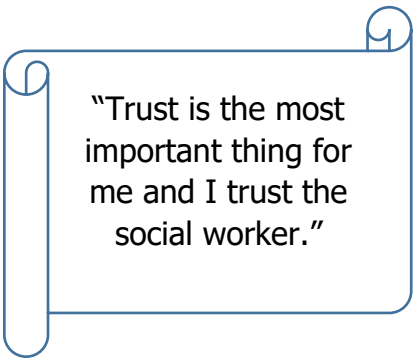


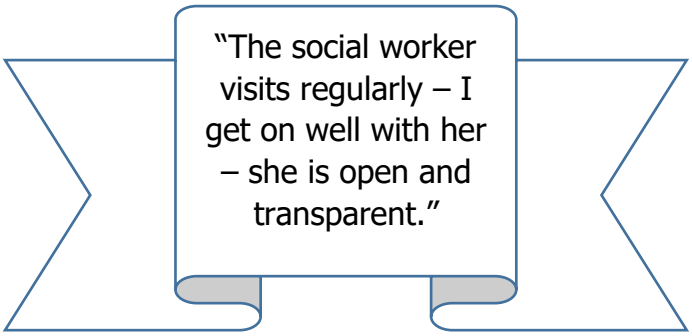




Almost all parents spoke very positively about the social workers they worked with. For example, some commented:







What parents told us about their experience of child protection and welfare services

Generally, parents spoke positively in relation to their experience of the child protection services in five areas where risk-based inspections of the child protection service took place. The majority of parents said they felt supported by their social worker and felt that the social work service had made a positive difference in their lives and those of their families. They described the communication process as good, whereby social workers explained their role and kept them informed of what was happening. They felt

that social workers listened to them and treated them with respect. Parents said contact was maintained during the COVID-19 pandemic through phone calls, video calls and meetings, where required. They said there was no delay or drift in scheduling meetings.

Parents gave positive feedback about the service they received and said their social worker:

"Was very helpful and gave good advice and support."

"They helped me become more involved in my children's care."

"Gave enough support, without being too intrusive."

"Very supportive and really believed in me."

"Their interest in the kids was massive… they wanted me to re-build my relationship with the kids."

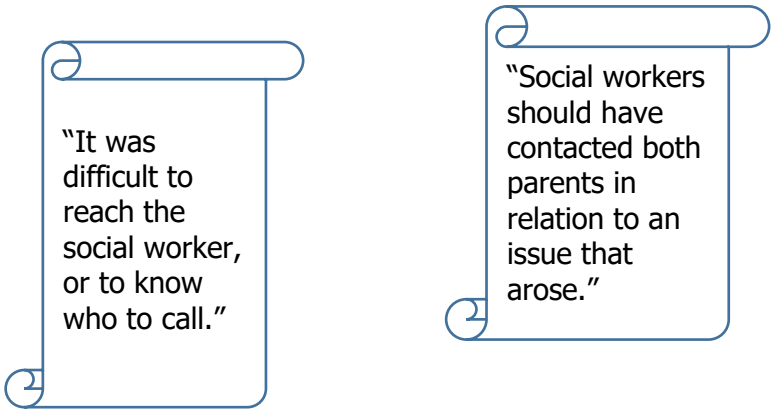
"We have a safety plan … it's very hard but there are plenty of people supporting us."

"They were very nice — they didn't judge — they never thought I was a bad mother."

"The social worker set me at ease — they were upfront and honest."

However, not all parents had positive experiences and some parents suggested improvements in communication from the social work department. One parent struggled without the availability of an interpreter during some interactions and suggested that this service be routinely available for all interactions where required. The remaining suggestions for improvement concerned timeliness of response to concerns and delays or waiting times for a service. Comments from parents included: "I don't think Tusla take action quick enough", "Tusla can be slow to take action sometimes" and that they wished Tusla had taken "urgent" action sooner. During the year, inspection reports noted other areas of dissatisfaction, for example, several parents told inspectors that there were not informed of Tusla's complaints process, that they did not know how to make a complaint and couldn't recall being given this information. One family said that the experience had not been positive, as their case had been placed on a waiting list following screening without any further contact or interaction. Another parent said they did not feel listened to or believed and only heard that they were a danger to their children, and a further parent said that they had had several different social workers and they found it confusing and inconsistent.

Areas of dissatisfaction described by some parents included:



What parents told us about foster care services

In the main, parents had mixed views of the foster care services. While most reported that their children were well cared for and were happy in their placements, others felt that improvements could be made. Some parents felt left out or not informed of decisions made about their children, while some parents who spoke with inspectors had positive views on the service. In addition, some parents said they felt listened to but some parents did not have the same view and reported their concerns about poor communication.

Some of the positive comments made by parents included:

"Social worker keeps a good check."

"The children's social worker is very fair, respectful and supportive."

"I have no complaints — we have a nice social worker — she is working well with us."

"She (social worker) treats me with respect all the time."

"My social worker is always transparent, good to give information and easy to deal with."

"I am kept informed about my children's care plans and reviews, and am able to give my views."

Some of the negative comments from parents included:

"Difficult to get information from the social worker."

Feels her voice is "ignored".

"No major issues but concerned about the big turnover of social workers."

What parents told us about special care services or the detention centre

Parents who spoke to inspectors were satisfied with the care their child was receiving. They talked about the arrangements in place for visiting with their children, and parents who had to travel long distances were facilitated by the centre and social worker to do so. Where appropriate, children were facilitated to attend family occasions and visit with siblings and extended family members. Two parents spoke positively of visits to the centre, where brothers and sisters had opportunities to relax, play games and be shown around the centre. Parents felt that this was of real value to both their child living in the centre and their siblings.

One parent expressed concerns about the choice, nutritional value and quality of some of the food provided in one centre. This concern was known to the person in charge, who at the time of the inspection was monitoring the quality and variety of food available to children.

What foster carers told us

Overall, foster carers were positive about the social work support they received from their link social workers. Inspectors met with or spoke with over 91 foster carers over the course on inspections carried out in 2021. Some of the comments made by foster carers included:

"Positive help in solving problems."

"Could not fault them in any way."

"Great support, never left waiting."

Foster carers said they were well supported. They described both good formal and informal support provided by their link social workers. There was a variety of good additional support services available to foster carers as a support to placements where children had complex needs, across several service areas. These supports included, for example, direct work with social care workers and leaders, external therapists, and access to respite care. A few foster carers highlighted gaps in the respite care provision, with one commenting:

"I have asked for respite, but it is not available."

Other foster carers did not share the same views. One of the areas foster carers identified for improvement were the frequent changes of children's social workers and the impact this had. They said that "this was very hard for the children" and "this shouldn't happen, it's very unfair". They outlined that social workers should be the first person that the children should trust, but one remarked that the changes meant that "they can't build that bond".

In addition, some foster carers told inspectors that they were not always asked for their views in relation to service planning and development. However, some foster carers said that they were able to provide constructive feedback in relation to the care and needs of children through the support and supervision process, the foster care review process, and through informal conversations with link social workers.

While foster carers overall were positive about the help and support they received, in one area a few foster carers reported that they had not seen their link social worker face-to-face over the previous 18 months, due to COVID-19 restrictions. Some comments from foster carers included:

"They apologise about staff turnover and delays."

"Lots of phone and email contact usually."

"Lots of support at the start of the placement."

Some foster carers did not have a link social worker for several months and told inspectors that there was "no communication" during that time.

Foster carers spoke positively about the social workers allocated to the children they were caring for. They said that "all supports are provided" and spoke about being "amazed how good the social worker is". They spoke about social workers being very supportive and they had great relationships with children.

Other foster carers, however, told inspectors that children they were caring for had no social worker at times and there had been "lots of changes" in social workers.

Foster carers told inspectors that they were regularly offered training. Much of the training and foster care support groups were being delivered online due to COVID-19.

5. Child protection and welfare services

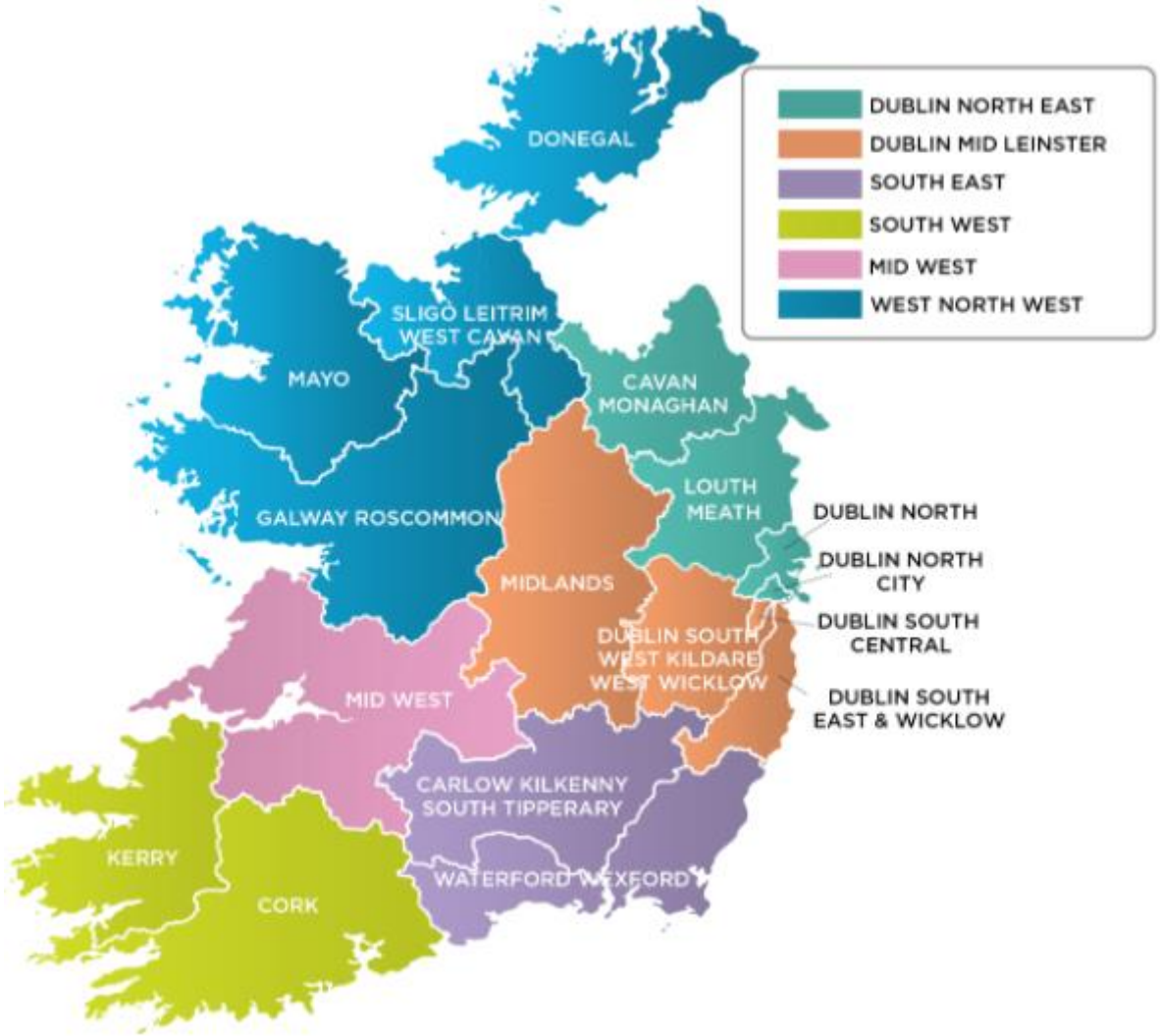
5.1 Introduction

HIQA monitors and inspects child protection and welfare services against the *National Standards for the Protection and Welfare of Children* (2012).

Role of Tusla

Tusla has statutory responsibility to protect children and promote their welfare under both the Child Care Act, 1991 and the Child and Family Act 2013. Child protection and welfare services are provided by Tusla in 17 service areas located within six regions across the country.

Figure 4. Tusla's service areas*



*Map source: Tusla website https://www.tusla.ie/.

Tusla received a total of 72,095 referrals to its child protection and welfare service throughout 2021.[5] At the end of 2021, the number of cases open to the child protection and welfare service was 21,248, which was an increase of 105 cases when compared to 2020. Open cases refers to the number of children about whom referrals were received by the service and which were identified as requiring a child protection social work assessment or intervention. In each of these open cases, children were receiving a social work service or were waiting for a service. Data available at the end of 2021 indicated that of all open cases, 16,441 (77%) had been allocated to a social worker with 4,807 (23%) awaiting allocation, 436 of which had been identified as high priority. These figures illustrate an increase of 568 in unallocated cases, including 60 additional high-priority unallocated cases, on the previous year. Data relating to children on the CPNS at the end of 2021 indicated that there were 983 children in total listed, all of whom had been allocated a social worker.[6] The number of children listed as 'active' on the CPNS in the final three months of 2021 represented an increase of 44 (5%) compared to the same period in 2020 (when there were 939 children listed).[7]

Child Protection and welfare - monitoring and inspection activity

In 2021, HIQA conducted 13 inspections of child protection and welfare services in Tusla service areas. These inspections included:

- one child protection and welfare thematic inspection
- five risk-based child protection and welfare inspections, and
- seven focused inspections of the CPNS.[8]

This chapter provides an overview of the findings of the above inspections.

HIQA completed one thematic inspection (to promote quality improvement) and seven focused inspections in 2021. The thematic inspection focused on a defined point along a child's pathway in child protection and welfare services, from the point of initial

[5] Tusla Child and Family agency, Monthly performance and activity report 2021.
[6] End of 2021 data provided by Tusla Quality Assurance Directorate February 2022.
[7] Active means that there is a Child Protection Plan in place because it has been decided that the child is currently at risk of significant harm and needs support to be safe and well. Inactive means that the child was at risk of significant harm before and had a Child Protection Plan in the past. A child's name is removed completely from the list as soon as they reach 18 years of age.
[8] A national record of all children who have reached the threshold of being at ongoing risk of significant harm and for whom there is an ongoing child protection concern, resulting in each child being the subject of a child protection plan (Children First, 2017).

contact or reporting of a concern, through to the completion of an initial assessment[9] by Tusla. This concluded a HIQA child protection and welfare programme of thematic inspections which began in October 2019 and ran until March 2021. An overview report was published in November 2021 which outlined its overall findings.

A programme of CPNS inspections started in August 2021 and were conducted in seven Tusla service areas throughout the remainder of the year. These inspections focused on the three national standards in relation to leadership, governance and management and three standards relating to the service provided to children who have been deemed to be at ongoing risk of significant harm, including interagency and inter-professional cooperation.

HIQA also completed five risk-based inspections of child protection and welfare services in 2021, where there were specific concerns in relation to the delivery of child protection services.

Overall, HIQA found generally good governance of Tusla child protection services, but the challenge of staff vacancies persists across the service. Specific risks in relation to the availability of suitable foster care and or residential placements for children who required care or transition has been identified across all Tusla services.

5.2 Thematic child protection and welfare programme

Overall, service areas participating in this inspection programme from 2019–2021 were found to have embraced the concept of quality improvements, and inspections illustrated that services were focused on achieving this through the implementation of quality improvement plans. The overall findings of the child protection and welfare thematic programme of inspections are contained in a report on the programme which was published in November 2021.

In line with the findings of previous thematic inspections in 2019 and 2020, the inspection of the final service area in 2021 also demonstrated a commitment to quality improvement. Overall, the leadership, management and governance of the duty and or intake and initial assessment service was strong and effective in driving continuous service improvement. The service area had appropriate arrangements in place for the identification, management and review of organisational risk, and there were good quality assurance mechanisms in place.

Staff vacancies were found to be have been a challenge in this area. These vacancies impacted service provision in that there had been some delays in the completion of preliminary enquiries, while initial assessment teams had not had sufficient capacity to

[9] An initial assessment is an assessment completed to identify the level of unmet need and or risk to a child. This assessment informs decisions relating to the supports or interventions required to ensure the safety and welfare of the child.

effectively carry out their duties, resulting in delays in completing these assessments. This meant that there were ongoing delays for some children and their families receiving the help they needed.

In relation to the quality and safety of services provided to children, initial assessments were of good quality, and good communication with families was evident. There was good oversight of notifications to An Garda Síochána (Ireland's National Police Service), and staff adapted well to the changing work environment resulting from the impact of COVID-19, ensuring that essential services were being provided safely within public health restrictions. The area had a strong improvement focus on safety planning to help protect and reduce harm to children. In addition, the area had strengthened its management oversight of waiting lists.

Focused inspections of the Child Protection Notification System (CPNS)

In 2021, HIQA commenced year one of a two year programme of focused inspections of the child protection and welfare service provided to children listed on the Child Protection Notification System (CPNS), and seven inspections were completed. Children on the CPNS in the remaining 10 service areas will be inspected by the end of 2022. The CPNS is a national secure database containing the names of all children who have been assessed by Tusla as being at ongoing risk of significant harm and for whom there are ongoing child protection concerns. The CPNS can be accessed by professionals with responsibility for making decisions about the safety of a child. These include members of An Garda Síochána, out-of-hours general practitioners (GPs), Tusla social workers and hospital staff. The decision to list a child on the CPNS is made as part of a child protection conference (CPC). Parents, professionals and the child, where appropriate, attend this meeting.

Every child who is listed on the CPNS is subject to a child protection plan which clearly sets out the steps to be taken to help reduce the risk of harm to the child, as well as identifying those responsible for each part of the plan. The family circumstances, safety and progress of children subject to a child protection plan and listed on the CPNS are closely monitored by social workers and other professionals. This plan is regularly reviewed for its effectiveness and, where progress is not evident or the child's safety and welfare cannot be maintained, social workers then take action to ensure their safety, up to and including receiving the child into the care of Tusla.

CPNS Findings

Overall, a high level of compliance with national standards relating to children listed on the CPNS was found. The majority of children on the CPNS had appropriate plans in place to safeguard them, which were reviewed regularly and monitored by their allocated social worker. Four of seven service areas inspected were found to be compliant or substantially compliant with all standards examined. Non-compliance with

one standard was identified in one service area and two non-compliances were identified in another. Major risks were identified in one service area with five of six standards inspected found to be non-compliant.

The governance of the CPNS service was effective in the majority of service areas inspected. These areas had effective:

- Service planning
- Quality assurance systems
- Systems for the transfer of learnings and implementation of action plans arising from audits
- Communication
- Good analysis of data
- Risk management
- Systems for monitoring of children's child protection safety plans including visiting children
- Service provision in line with Children First (2017).

Tusla had appropriately ensured that all children listed on the CPNS in all seven service areas had been allocated social workers and the majority of children were visited regularly by social workers. There was a strong emphasis placed on both children and their parents participation at case conferences. Children's attendance where appropriate was encouraged and children's views were sought and represented regardless of whether they were in attendance. Family participation was promoted and encouraged and they played a central role in child protection conferences. There was also evidence of good interagency work, where key professionals involved with the child attended and contributed to the case conference and the safety plan.

There was effective governance of the electronic CPNS record in the majority of services, and children were de-listed appropriately in line with the decisions made at the conference.

Improvements required

However, there were some areas that required improvement. These included the review and updating of Tusla's interim national guidelines on child protection case conferencing and the child protection notification systems which guided managers and staff on their work. These guidelines had not been subject to review since 2018 and required updating by Tusla. This had impacted on the consistency of the service delivered nationally, as local areas had developed local policies in order to bridge gaps

within the national policy. This meant, for example, that there was no national timeframe for the convening of a child protection conference, and led to national variation. Inspectors found that the convening of conferences varied from within three weeks to five weeks or longer. Despite this, inspectors found within a sample of files reviewed as part of inspections that appropriate safety plans were in place for children while arrangements were being made for child protection conferences. Tusla have assured HIQA that they are in the process of updating this interim guidance.

Risks Identified

Improvements were required in the effectiveness of risk managements systems in two service areas. Systemic risks relating to the lack of appropriate placements for children requiring care were identified as being on the risk register of two service areas since 2015 and 2018 respectively, without sufficient action having been taken to address this risk. While there was evidence that this risk was escalated to Tusla's regional and national offices, strategic actions to affect change were inadequate. Planning for children at ongoing significant risk within their homes and identified as requiring care placements was delayed at the time of inspection in one service area. This resulted in a small number of children remaining in unsafe situations for a considerable period of time. Appropriate assurances were provided by area managers in relation to these individual cases.

In August 2021, the Chief Inspector and the Director of Regulation in HIQA escalated the systematic risk associated with an absence of necessary care placements for children with complex needs across child protection services, foster care, special care and residential services to the Chief Executive Officer of Tusla. In response, Tusla outlined that they were managing each case individually, but highlighted that they were developing a national residential care strategy and more recently indicated a foster care strategy was also being created. At time of publication of this report, Tusla had submitted their residential care strategy to HIQA outlining their strategic approach to the provision of residential care until 2025. Their foster care strategy is expected imminently.

Overall, the majority of children on the CPNS were effectively monitored and were provided with a safe service in line with Children First (2017). The governance arrangements in place were effective in the majority of areas; however, as identified, there was ineffective risk management of the lack of suitable placements for children who required care in two service areas.

Tusla's national management team's attention was required in relation to the planning for and effective management of children's care placements. It is imperative that when a child needs the care of the state that a suitable foster care or residential care placement is available. Tusla have committed to implement their strategic plan for

residential care, develop a foster care strategic plan and also revise their current interim guidance for child protection conferences and the CPNS.

5.3 Key Findings of child protection and welfare risk-based inspections

Five risk-based inspections of child protection and welfare services were completed in 2021. Two of these inspections were service area inspections where risks in the child protection and welfare service and the foster care services were reviewed by inspectors. (Findings in relation to foster care risk inspections are outlined in section 6.3). The majority of these inspections reviewed progress in relation to Tulsa's management of new referrals, the assessment of children's needs and safety planning.

An overarching finding of child protection risk-based inspections was that there were incremental improvements in the delivery of services across four out of five service areas. However, vacant posts was a challenge in all five areas and this impacted on service provision. Further improvements were required in relation to the governance of all five service areas in order to achieve full compliance with the *National Standards for the Protection and Welfare of Children* (2012), as in four out of five areas inspected the majority of standards were non-compliant, and two of the four areas had two standards which were major non-compliances

Good governance and management is crucial to the effective delivery of a good quality and safe service. In 2019, Tusla's national office put in service improvement plans in three of the areas inspected, and the fourth area had an improvement plan in place since 2020. Therefore, Tusla has been aware that these areas required improvement in order to deliver a consistent and good quality service to children and their families. These plans had been effective in bringing about incremental improvements but more work was required in order to further improve service delivery to children and their families. The governance arrangements of the fifth areas was escalated to Tusla's Director of Services and Integration and, following the inspection, a service improvement plan was devised and implemented for this area.

The majority of service areas had prior to inspection made changes to the structures of their teams with the aim of achieving greater efficiencies in line with their service improvement plans — and these structural changes had made a positive impact in service provision to children. In addition, at the time of the inspections, two of the five areas had imminent plans to develop additional teams as they were awaiting new staff to commence.

Good practice was identified in relation to the following:

- Improvement in the timeliness of the screening of new referrals and the majority of referrrals in all areas were being screened by a social worker, appropriately categorised and prioritised within 24 hours of receipt.

- The quality of preliminary enquiries and initial assessments completed in relation to children's needs was good. Children were routinely consulted with as part of the initial assessment process in the majority of areas.
- The majority of service areas (three out of five areas) consulted with children and their families and put effective safety plans in place for the majority of children.
- An overall reduction in the number of children waiting for a child protection service as all areas had achieved reductions in the number of children waiting for a service.
- The majority of areas had put in effective plans to manage the impact of COVID-19 on the delivery of services; these plans were reviewed and amended regularly.
- The management of retrospective allegations was reviewed in one service area and there was substantial progress in effectively managing these cases since the previous inspection.
- Quality assurance systems effectively used audits to provide assurances in relation to the functioning of the service in three out of five areas. These areas shared the learnings from audits, but there were some delays in the implementation of actions plans from audits due to reasons such as the impact of COVID-19.

Despite this progress, improvements were required in relation to:

- Timeliness of response to referrals in relation to children. The majority of areas had made incremental improvements in relation to the timeliness of their response to new referrals, but none of the five areas were achieving compliance with Tusla's own standard business processes including the timelines for completion of screening and preliminary enquiries (five working days) and initial assessments (40 working days from receipt of referral).
- The timeliness of notifications of suspected abuse to An Garda Síochána by social workers had improved but more work was required to ensure that all notifications were made in a timely manner. Inspectors found a small number of notifications were not made to An Garda Síochána in three areas and assurances were provided that all notifications were subsequently made.
- The delivery of services to some children and families were impacted by staff vacancies in the majority of services. At the time of inspection, three areas were approved by Tusla's national office for additional posts and were awaiting for new staff to join their teams.

- The quality of recording of children's records on Tusla's National Childcare Information System (NCCIS). Good quality information is crucial for managers and staff to have in order to make good decisions in relation to the organisation and management of child protection services. The recording of information on the NCCIS was reviewed by HIQA in four service areas. All areas recorded their information on the NCCIS, however, some improvements were required in relation to the quality of recording in three out of the four service areas.
- Informing children and their families when cases were being closed as this varied widely throughout the service areas inspected. Some service areas routinely informed children and families of case closure, but others were found to be inconsistent with regard to informing children and families when their case was being closed
- Staff supervision required improvement in two out of four service areas where it was reviewed by inspectors. This system is the main way in which staff and managers are held to account. Therefore, regular supervision meetings, with accurate records of agreed actions, are essesntial in order to ensure both accountability of staff and the progression of work.

Specific risks

Risk management: many of the risks identified, such as vacant posts and the lack of alternative care placements during the CPNS inspections, were present in the majority of the five service areas. Other common risks among the five service areas were the risks associated with waiting lists and non-compliance with the *National Standards for Child Protection and Welfare* (2012). Many of these risks, such as vacant posts, were persistent. Despite escalation by the local service area to regional and or national senior management, these risks remained and plans to address them were dependent on the recruitment of additional staff, foster carers, residential placements or support services.

The governance of waiting lists: the majority of service areas needed to improve their governance of waiting lists as their systems at the time of inspection were either ineffective or not consistently implemented. Tusla had no national time frame in place for the review of children on waiting lists. As a result, local service areas had their own standard operating procedures with differing timelines for reviewing cases, but these were not adhered to by the majority of service areas. Four out of five service areas inspected needed to improve their governance of waiting lists. Despite the reduction in the number of children waiting for a service in all five service areas, the number of referrals of children waiting for a child protection and welfare service in the five areas at the time of inspection varied from 86 to 711. The majority of these referrals were of

medium and low priority. Regular reviews of waiting lists is essential in order to ensure that children receive a service as quickly as possible.

In three out of five service areas, governance arrangements were ineffective at providing assurances on the safety and quality of the service, and systems to ensure the accountability of senior managers were underdeveloped. Inspectors found two service areas were majorly non-compliant in standards relating to the leadership and management of their child protection and welfare service. Of these two, one service area did not sufficiently identify or manage cumulative harm to children where multiple referrals had been received. In the other area, the leadership, management and governance of the "front door" (the duty service where new referrals are received) service lacked clear direction. Appropriate assurances were provided to HIQA by Tusla and compliance plans were put in place to address these risks and to strengthen governance arrangements.

Conclusion

Overall, the findings of risk-based child protection and welfare inspections conducted in 2021 illustrated that the majority of services were making progress against their improvement plans, including focusing on reducing the number of children who were waiting for a service. Staff completed good quality assessments of the needs of children. Improvements in governance were required, particularly in relation to risk management and the management of waiting lists. However, further progress was impeded by the ongoing challenges in relation to staff resources. All of the service areas submitted a satisfactory compliance plan, following inspection, to HIQA. HIQA will continue to monitor these areas progress against their compliance plans in 2022.

6. Alternative care services

Alternative care refers to both residential care and foster care services provided by Tusla or the private and voluntary sector for children and young people who are unable to live with their own families. HIQA monitors and inspects the 37 statutory children's residential centres provided by Tusla, and both statutory and non-statutory foster care services.

6.1 Statutory children's residential centres

6.1.1 Inspection and monitoring findings

In 2021, HIQA completed 26 inspections of children's residential centres run by Tusla,[≠] one of which was risk based. Centres within each Tusla region were selected where an inspection was either due or there had been non-compliances in the previous year

[≠] The number of Tusla-provided children's residential centres fluctuated between 36 and 39 in 2021. It remained at 37 at the end of 2021.

which required further monitoring. Two centres closed in 2021 and one was re-opened to provide an emergency placement for a child. This centre was the subject of a risk-based inspection.

Inspections in the first half of the year focused on key standards related to leadership, governance and management, including statements of purpose and function, and staffing resources and vetting. The promotion of children's rights were also assessed during these inspections. In the second half of the year, the focus of inspections shifted somewhat, and while these inspections continued to assess compliance with staffing resources and statements of purpose and function, compliance with standards related to planning for children in care and child protection were also assessed. Furthermore, additional standards were included for specific centres, based on their history of non-compliance.

Key findings in the first half of the year were that children's rights, particularly their right to participation, consultation, choice and access to information were promoted. There were good examples of the inclusive nature of residential centres, where children had a voice and a say in their direct experience of living in care. The quality of information provided to children was good and although they had access to information held about them by the centre, some had chosen not to exercise this right. The right to choose is of particular importance to children in care, and residential centres promoted children's right to choose; for example, their leisure activities, their participation and attendance at meetings relevant to them, and the type of food available on a daily basis.

Similar to findings from the previous two years, inspections throughout the year found that the overwhelming majority of statutory residential centre were well managed.

There were good systems in place to hold managers to account for the operations of each centre, and for staff on their individual practice. Equally, adequate governance arrangements at regional and national level were in place and there was evidence of key data and information being reported to Tusla's senior managers. Similarly, risk management systems were working well and this was particularly important in light of the impact of COVID-19 on staffing resources and the continued safe operation of each centre.

Statements of purpose and function are critical documents for residential centres as they inform the facilities, staffing, key policies and capacity of each centre. It is against this document that centres are measured to ensure they are operating within their operational capacity and capabilities, and are resourced to do so. Overall, statements of purpose and function were found to be in line with national standards and had been approved at the appropriate managerial level. It was evident, however, that some centres amended their statements to facilitate the admission of specific children, or to allow young adults to remain in a children's centre. This was typically to allow time to transition these young adults to their next placement or for them to complete State exams. Some of the issues identified in relation to these young adults included the lack of preparedness by centres to amend their practices to reflect the rights of an adult as opposed to those of a child.

Inspections in the first part of the year assessed compliance with staff recruitment standards. Key findings were that safe recruitment practices were in place. However, the centralised system of storing staff records related to recruitment and Garda Síochána (police) vetting as part of the shared services agreement with the HSE was not working effectively, and as a result, practice had varied across residential centres. This meant that all records for all staff had not always been held in this central location and, as a result, were not easily accessed.

In keeping with previous years, findings of inspections showed that staffing resources had fluctuated across the residential centres inspected. Of the 12 centres inspected in the first half of the year, five had their full staffing complement, and the remaining seven did not. Several were operating with managerial vacancies being filled on an interim basis. However, children continued to experience consistent care from stable teams, and there was limited impact on the operations of these centres. Six of the 12 centres were operating at full bed capacity, while only one of the other six centres was not at full capacity as a direct result of staffing resource issues. The remaining five had reduced their beds temporarily for reasons such as providing care to children with complex needs or in response to COVID-19 outbreaks.

Planning by social workers for children in residential care continued at a satisfactory pace in 2021, and this was important given some of the impacts of restrictions placed on face-to-face meetings over the year as a result of the pandemic. The overwhelming majority of children's care was well planned and written care plans were in place and reviewed. There were a minority of cases where delays existed in convening meetings to review children's care plans or in providing updated written care plans to the residential centres. However, residential centres had systems in place to escalate these delays and to prompt a social work response.

Similar to previous inspection findings since 2019, in a minority of situations, the needs of some children could not be met in their placement. When alternative and

appropriate placements for these children had not been readily available, there had been a negative impact on other children placed with them. This lack of alternative placements for a minority of children with complex needs and behaviours continued to challenge Tusla in 2021. While HIQA was satisfied that placements were found for individual children identified during inspections, as mentioned earlier, this recurring systemic risk was escalated by HIQA to Tusla's national office.

In addition to inspections, HIQA monitored children's residential centres in 2021 through regular phone calls to centre managers. Until September 2021, these calls were primarily supportive in nature in relation to the impact of COVID-19. However, with agreement from Tusla, these calls have continued and they now contribute to the routine monitoring of these services and inform, where appropriate, HIQA's responses to identified risks.

There is a process in place for Tusla to inform HIQA of any new statutory children's residential centre that it opens. In 2021, one such centre was established by Tusla. This was an unplanned temporary arrangement in response to an emergency situation, where a placement was not available for a child with complex needs. In response, HIQA carried out a risk-based inspection of this centre. This inspection found that there were significant risks which required an urgent response from Tusla in relation to staffing, medication management and the ability of the centre to operate in line with national standards, policy and legislation. Tusla took immediate actions to rectify the risks and the centre closed within 12 days, when the child was moved to an alternative placement. The concerns relating to the potential for other similar unsatisfactory arrangements was escalated to Tusla in October 2021 as part of the wider systemic issue in relation to the lack of appropriate and timely placements for children with complex needs.

As mentioned in our 2020 overview report, children who present with complex needs may often be hard to place. Despite escalation of the lack of appropriate and timely placements for individual children to Tusla in 2020, this situation remained essentially unchanged in 2021. However, in October 2021, Tusla committed to developing a new residential strategy in early 2022 as part of its response to meet the needs of children who require out-of-home care. HIQA will continue to focus on this issue throughout 2022 as part of our ongoing monitoring.

6.2 Foster care — statutory

6.2.1 Introduction to inspection of statutory foster care services

In Ireland, statutory foster care services are provided directly by Tusla on behalf of the State. In 2017, HIQA commenced a three-phase focused programme of inspection of these services across all 17 Tusla service areas. HIQA began the third and final phase of its foster care programme in 2021.

Phase 1 was completed during 2017 and 2018 and focused on the recruitment, assessment, approval, supervision and review of foster carers, including the arrangements in place for safeguarding and child protection of children in foster care placements. Phase 2 was completed during 2019 and 2020 and focused on the arrangements in place for assessing children's needs, the care planning and review process, preparations for children leaving care, and safeguarding of children. In September 2021, we published an overview report on the findings from this inspection programme across all 17 service areas.

The third and final phase of the three-phased schedule of inspection programmes is a thematic programme. As this inspection programme is focusing on service quality improvement, only those service areas deemed to have previously had a high level of compliance with standards will be included in this inspection programme. All other service areas will continue to be monitored and inspected in line with our risk-based monitoring approach.

In 2021, six Tusla service areas were inspected under Phase 3 of this thematic programme. The remaining participating service area inspections will be completed in 2022. Phase 3 of the programme assesses the efficacy of governance arrangements across foster care services and the impact these arrangements have on children in receipt of foster care against the following eight national standards for foster care:

- effective policies
- management and monitoring of foster care services
- training and qualification
- recruitment and retention of an appropriate range of foster carers
- special foster care
- the foster care committee
- placement of children through non-statutory agencies
- representations and complaints.

Before the start of the thematic element of the programme, all service areas deemed eligible for the inspection programme were issued with self-assessment questionnaires, in order for them to self-assess their compliance with the above standards. These were submitted to HIQA and informed its scheduling of these inspections. Each area was required to develop a service improvement plan on foot of any deficiencies it identified in its self-assessments, in order to start its quality improvement initiatives.

Over the course of inspections in 2021, inspectors met or spoke with 43 children placed in foster care, and two young people who were over 18. Inspectors also met with or spoke with over 91 foster carers and 11 parents.

Due to COVID-19-related restrictions and risks, some changes were made to the methodology employed in Phase 3 inspections. Instead of visits to foster care households, inspectors spoke with children and their foster carers by phone. While some inspectors were on site in service area offices to review governance documents, children's case records and to interview individual managers, others worked remotely and conducted interviews and focus groups through electronic means.

6.2.2 Phase 3 inspection and monitoring findings

Good governance is essential to ensuring the delivery of a safe and effective foster care service.

Overall, HIQA inspections found that there had been a significant focus on strengthening and further improving governance arrangements for the delivery of services to children in foster care. All service areas had developed service improvement plans, they knew what their identified areas for improvement were and they had plans in place to address them. All service areas inspected demonstrated a real commitment to promoting quality improvement in their areas. While three of the service areas were found to have non-compliances, some service areas' inability to meet standards was due to staffing vacancies, or because the measures that they tried to put in place were ineffective; for example, approving vacant posts, yet being unable to then fill them. Recruitment of foster carers, despite the best efforts of many service areas, remained a challenge and was not reflective of poor governance, but rather was at times due to factors outside of their control. All service areas provided a good service to children with complex needs who required more specialist services. However, the provision of 'special foster care'[10] services was not supported by the required Tusla national policies and procedures, and therefore the practice varied between service areas in relation to the level of supports they provided to foster carers caring for children with complex needs.

Inspectors found that three out of six areas inspected in 2021 were compliant or substantially compliant with all of the standards assessed. The remaining three areas were compliant or substantially compliant with most standards but also had moderate non-compliances. One of these service areas was moderately non-compliant with one standard; another was moderately non-compliant with two standards; and the third service area was moderately non-compliant with three standards.

[10] Standard 22: Special Foster Care requires Tusla to have policies and procedures in place to support the care provided to children with serious behavioural difficulties.

Effective policies

Nationally implemented policies, procedures and guidance leads to consistent practice throughout all Tusla service areas and, for the most part, inspectors found that the implementation of policies, procedures and guidance were aligned to relevant legislation, regulations, policies and standards.

Throughout the first six thematic inspections, inspectors found that strong leadership and management systems ensured that policies, procedures and guidance were effective at guiding staff to implement a consistent practice with children and young people. Staff demonstrated a good understanding of national policies and in the main they were being consistently implemented.

However, inspectors found that two of the six service areas had implemented local guidance which had led to differing practices, with one having had a more significant impact. In this area, local guidance was being implemented to assist staff with managing allegations made by children against foster carers, but which was not in line with Children First (2017) or Tusla's standard business process for managing allegations made by children. The respective service director subsequently provided written confirmation to HIQA that this new guidance would not be implemented in the service area and that all allegations by children in care would be managed in line with Children First (2017).

Overall, in the inspected service areas, there was appropriate planning and good oversight of children in care who transferred between service areas. Working protocols between Tusla and relevant stakeholders, such as HSE Disability Services and An Garda Síochána, facilitated good practice for the management of specific cases, such as children with additional needs who were turning 18 years of age. Nonetheless, a consistent finding from the thematic programme related to gaps in the availability of specialist services, such as play therapy and occupational therapy for some children.

Management and monitoring of foster care services

All six service areas had clearly-defined governance arrangements and structures to ensure the delivery of a high-quality service. Leadership and culture within service areas facilitated a commitment to continuous improvement. Service areas with good governance ensured that the provision of services was being informed by the voice of children and their experiences in foster care and service plans had been effectively used to promote improvements in service delivery. Each service area had effective strategic planning in place that was aligned to the Tusla national service plan. Five of the six service areas had sufficient staffing to deliver services. Auditing and the use of Tusla's case management system — the National Child Care Information System (NCCIS) — was used to monitor service provision and identify learning. Where required, action plans had been developed to implement that learning. Examples of

actions included the provision of training to enable better use of the monitoring function on the NCCIS and enhancing audit templates to focus on the quality of service provision. These governance arrangements had ensured children received a timely and appropriate service.

Governance arrangements in two of the six service areas required further improvement. In one area, staffing vacancies had impacted on the quality and continuity of care and support for children and for foster carers. Some contingencies to limit the impact of staff vacancies were effective, such as the foster care principal social worker undertaking social work team leader duties. Other contingencies, such as approval for filling a vacant post on a temporary basis, had not been effective, as the area had been unable to find a suitable candidate. In addition, auditing in this area had not been used effectively to support continuous improvement in practice. In the other service area, while no children were found to be at risk during the inspection, improvements were required in the monitoring and oversight of allegations made by children in care. These were to ensure that they were in line with Children First (2017). Improvements were also required in relation to systems for oversight of the placement of children with relative foster carers.

Improvements were noted in relation to the use of data, NCCIS, auditing, and management reviews, to inform the service areas' service improvement plans and initiatives. The impact of the cyber-attack earlier in the year was particularly challenging, and the importance of ensuring that children's information is safe, up to date, and easily accessible became even more important. Some areas continued to struggle with ensuring information was recorded and documents were uploaded onto the system in a timely manner and in the right place. While significant improvements were noted in the use of standard names on NCCIS documents, such as visits with children and foster carers, and the use of templates — for example, for statutory visits — some variance in recording of case work was still evident.

Training and qualifications

Overall, the six service areas inspected ensured that staff employed to work with children, their families and foster carers were professionally qualified and suitably trained. Inspectors found that staff employed were experienced, competent and had the skills to deliver a child-centred service. Recruitment practices were safe and ensured staff had appropriate Garda vetting. The majority of staff files reviewed by inspectors were accurate and contemporaneous with the exception of one area where some minor improvements were required, such as ensuring staff files were updated with current job descriptors, evidence of a promotion and new job title.

Service areas had effective staff retention strategies in place with wellbeing initiatives, such as 'Mindfulness' support for staff. Service areas were proactive at identifying

training needs of staff, with individual training needs identified through personal developmental plans and organisational training needs identified through training needs analysis. Ongoing training was delivered through a mixture of e-learning and in-person sessions where possible. Induction programmes were provided to new staff with relevant training, such as 'Inspirational Leadership' for managers. There were also arrangements in place to support partnership working with other agencies to facilitate the management of specific cases as needed.

Recruitment and retention of an appropriate range of foster carers

All of the first six inspections of this thematic programme found improvements were required in how Tusla recruited and retained an appropriate range of foster carers. None of the areas inspected were fully compliant against the relevant standard, with three areas judged substantially compliant and three as non-compliant moderate. Despite all six service areas having a clear and well-developed strategy for the recruitment of foster carers that was aligned to Tusla's national recruitment campaigns, there was a lack of suitable foster care placements for children requiring an admission to care. All areas sought to assess suitable relatives as foster carers in the first instance, with the percentage totals of relative foster carers out of all foster carers varying between 16% in one service area to 33% in another.

All areas ran recruitment campaigns to find suitable candidates for assessment as general foster carers and had varying levels of success. Each area had ensured prompt responses to potential candidates for foster caring. In some of the areas, initial enquires from prospective foster carers had proceeded to assessment stage, while in other areas, recruitment campaigns had not been successful at recruiting new foster carers.

Two areas were dependent on a regional assessment and fostering team (RAFT) to recruit and assess foster carers for their service areas. This had proved to be a significant challenge, with this regional team only approving two foster carers for one area and none for the other area in the preceding 12 months. This is in contrast to another area that recruits and assesses its own foster carers and despite the challenges with COVID-19 and staffing had successfully recruited and assessed 15 foster carers in the preceding 12 months.

Where children were placed with general foster carers, there were robust matching processes that sought to place children in their own community. Inspectors found that only two of the six service areas had placed children outside of their area. Given the challenges with recruitment, this was a positive achievement.

Special foster care

Tusla does not have a national policy or guidance in relation to providing a special foster care service for children with complex needs as outlined in and required by the *National Standards for Foster Care* (2003). HIQA found that the lack of a clear national strategic direction in relation to the provision of 'special foster care' meant that supports for foster carers providing care to children with complex behavioural needs and difficulties were not delivered in a consistent manner and the level of service depended on decisions of local service areas.

None of the service areas inspected identified the carers on their foster care panel as 'special foster carers'. However, the thematic programme found that in five of the six service areas inspected, some children with complex needs were placed with foster carers who received additional supports. Examples of supports included enhanced payments and specialist training for foster carers. In addition to supports for foster carers, inspectors found that children in care who required multidisciplinary or additional supports received them. These supports included specialist assessments and interventions, respite placements and additional specialist support services to meet the child's needs. All areas implemented a multidisciplinary approach for children with complex needs. Formal joint working protocols were in place with HSE Disability Services, and some areas employed a clinical psychologist who provided therapeutic supports to children.

The foster care committee

Overall, the six inspections found that foster care committees were operating in line with Tusla's *Foster Care Committees, Policy, Procedures and Best Practice Guidance* (2017). Independent and suitably-qualified chairpersons ensured that leadership was strong and they were supported by committee members with a broad range of experience. Arrangements for the Garda vetting of foster care committee members was appropriate and, by and large, new committee members received an induction. Inspectors found that foster care committees carried out their responsibilities in line with the foster care standards. This ensured they had good oversight in relation to the activities related to their function; for example, foster care assessments, reviews and oversight of allegations against foster carers. Each of the areas had a transparent appeals process in place, in the event that any relevant parties did not agree with a decision made by the foster care committee.

Chairpersons of foster care committees in each of the six service areas reported directly to the respective area manager and, where necessary, escalated issues as they arose. In addition, several of these chairpersons participated in regional meetings with other foster care committee chairpersons or development group forums in order to promote consistency and share learning and practice issues. This was a welcome development which will assist in maintaining consistency and quality. Chairpersons of

foster care committees produced an annual report on the operation of the committee. While two out of six areas did not prepare an 'Annual Adequacy of the Child Care and Family Services' report as set out within the *National Standards for Foster Care* (2003) and Section 8 of the Child Care Act, 1991, those that did not had produced annual reports which reported on key areas to inform alternative care and strategic planning.

Placement of children through non-statutory agencies

Five of the six service areas inspected placed children in non-statutory placements provided by private foster care agencies. At the time of the inspections, Tusla had no service-level agreement in place for these arrangements. Tusla's National Office was in the process of agreeing contracts with all private foster care agencies, which was to include a service-level agreement. However, this had been delayed due to the cyber-attack earlier in the year. For this reason, all five service areas were judged to be substantially compliant.

Local service area foster care committees ensured the assessment, review and approval arrangements for foster carers assessed by non-statutory agencies complied with the standards set out in the foster care committee policy, procedure and practice guidelines. In addition, the allocated social workers for children placed in non-statutory placements had carried out statutory visits and child-in-care reviews as required. These measures ensured monitoring arrangements were effective and provided a level of assurance on the service that children and young people received while placed through non-statutory agencies. In addition, in June 2021, Tusla introduced a governance framework for oversight of foster care provided by non-statutory foster care agencies in Ireland. While this was a positive and welcome development, the absence of a service level-agreement as required by the foster care standards and the lack of clear guidance for local managers did not support them in the monitoring and benchmarking of the performance of private foster care agencies.

Representations and complaints

The thematic programme found that effective procedures were in place for relevant persons, including children, their families and foster carers to make representations, including complaints, about any aspect of the fostering service. These procedures were aligned to Tusla's national complaints policy. All areas had ensured that children had been informed of the complaints process in a child-centred and appropriate manner. Four of the six service areas had ensured foster carers had been aware of their right to make a complaint. In all service areas inspected, children and foster carers had access to independent advocacy services.

Five of the six service areas had ensured all complaints were managed in line with policies and procedures; however, one service area was closing some complaints without reaching a conclusion or resolution. In general, complaints were managed in a

timely manner, had oversight by a manager in the service and outcomes were communicated to the complainant. Inspectors also found that managers in the service had monitored and reviewed complaints to identify areas for service improvement.

Individual foster care inspection reports are routinely published by HIQA on its website. However, a national overview report on foster care services, which will set out key national findings and trends across Tusla service areas and regions identified during Phase 3 of this inspection programme, will also be published by HIQA when the full programme of thematic inspections is completed in 2023. It is envisaged that this report may inform planning for improvements to the overall governance of Tusla's foster care services, and may support and inform consistency of practice at both local, regional and national Tusla levels.

6.3 Foster Care – risk-based inspections

During 2021, HIQA conducted three risk-based inspections of foster care services in two service areas. All three inspections were follow-up inspections to measure progress made since their previous inspections. In one of the service areas we conducted two separate risk-based inspections in 2021, and in the other area we undertook one inspection.

Findings from the follow-up inspection in 2021 of one service area were generally positive, as the inspection found that significant progress had been achieved since the previous inspection in October 2020. The management of waiting lists for children who had not been allocated a social worker, statutory visits to children along with child-in-care reviews had all improved. However, a significant number of children continued to be without an allocated Tusla social worker, and some children experienced frequent changes in social workers or keyworkers.

The other service area risk-based inspection, conducted in January 2021, was aimed at assessing the progress within the service area on actions identified to address risks to children across both the child protection and foster care services in response to a previous foster care inspection in 2019. The service had recently been restructured and the impact of this had yet to be seen. Improvement in managerial oversight of statutory requirements was required. There were significant gaps in children's records and managers did not have oversight of the work being undertaken with children during reported visits. While the area had put a plan in place for increased monitoring and oversight of visits, the previous action plan following the last inspection had not adequately addressed this issue. Not all children had an allocated social worker, and staff leave and vacancies impacted on the service's capacity to address this. Although supervision was regular, the quality and recording of supervision was poor. Allegations, serious concerns and complaints were not always managed in line with the correct

process. There were delays in the management of allegations which impacted on the timeliness of outcomes for children and foster carers.

Due to these risks being identified within the foster care service, HIQA carried out a further follow-up risk-based inspection of the foster care service in August 2021. This inspection found that the area had put measures in place to address the risks found on the previous inspections. These measures included regular audits of cases, training regarding supervision practice, enhanced oversight of monitoring visits to children in care. In addition, a new independent chairperson for the foster care committee was in post. The area had reduced the risks, and while not achieving full compliance in all standards assessed, had moved to improved levels of compliance in all other standards. Despite this progress, the inspection identified a major non-compliance with regards to the support and supervision provided to foster carers. For this reason, an urgent compliance plan was issued by HIQA following the inspection. In response, the area submitted a satisfactory response and have provided adequate assurances that these issues would be addressed in an effective and timely manner. The area subsequently returned to routine monitoring having submitted this satisfactory compliance plan and as it no longer required an escalated regulatory response.

7. Foster care — non-statutory

Children's foster care services are also provided by non-statutory foster care agencies under agreements with Tusla. However, Tusla retains its statutory responsibilities to children placed with these services. Tusla also approves the foster carers recruited by these agencies through its foster care committees.[11] Non-statutory foster care agencies are required to adhere to the relevant national standards and regulations when providing a service on behalf of Tusla.

HIQA carried out five inspections of the six non-statutory foster care services operating in 2021, inspecting across nine standards. The standards which were included in all inspections were:

- Standard 10: Safeguarding and child protection
- Standard 14a: Assessment and approval of foster carers
- Standard 15: Supervision and support
- Standard 19: Management and monitoring of foster care services
- Standard 20: Training and qualifications.

[11] A prescribed group that meet to make recommendations regarding foster care applications and to approve long-term placements.

There were other specific standards covered in some inspections due to previous findings or the length of time since these were last inspected against, and these were:

- Standard 16: Training
- Standard 17: Review of foster carers
- Standard 18: Effective Policies
- Standard 21: Recruitment and retention of an appropriate range of foster carers.

The majority of private foster care services achieved high levels of compliance during this inspection programme. Three of the five private foster care agencies were judged to be either compliant or substantially compliant across all of the standards that they were inspected against. This meant that children and foster carers received a service which was adequately resourced and well managed, with good governance systems in place.

The other two services had improvements to make regarding systems for the identification and management of risks and strengthening of the monitoring and oversight of the services.

Satisfactory assurances and compliance plans were received from those agencies that required further improvements.

7.1. Safeguarding in non-statutory foster care agencies

Four of the five private foster care agencies were compliant or substantially compliant with this standard. They had appropriate policies and procedures in place to safeguard children in foster care. Child protection and welfare concerns as well as allegations and complaints about foster carers were managed in line with Children First (2017). The services had management oversight in relation to the progress of child protection and welfare referrals reported to Tusla. Significant events, incidents and accidents were appropriately reported and responded to. Foster carers had an allocated link worker and had received mandatory training in Children First (2017).

One service was assessed as being non-compliant with this standard. Several policies relating to safeguarding and child protection needed to be revised. Systems to ensure that all complaints against foster carers and or staff were recognised as complaints and responded to as such needed to be improved. Protocols had not been agreed with Tusla to ensure that the steps to be followed in the event of a serious concern or an allegation against a foster carer were clear.

7.2. Assessment and approval of foster carers in non-statutory foster care agencies

There was a high level of compliance with this standard in four of the five private foster care services. They had clear processes in place for the approval of foster carers and their placements on the relevant foster care panel. There were monitoring and oversight mechanisms in place for the completion of comprehensive assessments and their approval process. When foster care assessments had been completed, they had been sent to the relevant foster care committee for approval. When foster carers had been formally approved by foster care committees, there were contracts of care appropriately in place for each individual child.

One service was judged as being non-compliant with this standard. Policies and procedures relating to assessments required further review and updating. Assessment reports did not make clear how many home visits were undertaken during the assessment process or record the reasons for delays with assessments. The systems of oversight needed to be strengthened to identify issues such as that of poor quality references and to ensure that information relevant to the foster care committee is included in assessment reports.

7.3. Supervision and support in non-statutory foster care agencies

Four services were assessed as compliant or substantially compliant against this standard. They provided good quality support and supervision to foster carers. All foster carers had an allocated social worker. Foster carers received regular formal supervision and support. There were adequate supports in place for foster carers, including out-of-hours support, training and direct supports appropriate to the needs of the children they were caring for. Where there were issues identified, the service took immediate action to rectify these, such as obtaining documents from Tusla for foster carer files.

One service was judged as being non-compliant with this standard. Supervisory visits to foster carers had not always been timely and there had been a lack of consistency of link social worker. Foster carer files required improvement and policies required review.

7.4. Training in non-statutory foster care agencies

Three of the five foster care services inspected were compliant and two were non-compliant under this standard. Compliant services were committed to the provision of training for foster carers. Foster carers were provided with additional training to support them to care for children when required. Foster carers' files indicated when foster carers had requested or needed additional support, information or training, and this had been provided for them. During COVID-19 and the public health restrictions, training events had been provided through video conferencing and social media

platforms. The two services requiring improvements to come into compliance needed to address issues such as managing risks appropriately, securing information appropriately and supporting staff effectively.

7.5. Review of foster carers in non-statutory foster care agencies

Three of the four services inspected under this standard were compliant. Foster carers participated in regular reviews of their continuing capacity to provide high-quality care. Reviews completed were comprehensive and of good quality. There was a tracking system in place to oversee the scheduling of reviews and to ensure they were completed in line with regulations. One service was non-compliant with this standard. The system for monitoring of progress and timeliness of foster care reviews had not been effective which had resulted in significant delays in reviews being completed.

7.6. Effective policies in non-statutory foster care agencies

Three of the four services inspected under this standard had good compliance. There were operational policies and plans in place to promote the provision of high-quality foster care. These promoted safe and effective care for children and young people. There were governance structures in place to ensure policies were up to date and in line with national policy and relevant legislation. Three of the four services had a policy in place for the management of carers both in and out of the service. Services operated a partnership approach and sought feedback from foster carers and other agencies. Staff were aware of the policies and procedures.

One service was judged to be non-compliant with this standard. Several of the newly-developed and newly-revised policies required further revision. There was no overall service plan to guide the development of the service, including policies and procedures.

7.7. Management and monitoring in non-statutory foster care agencies

Three services were compliant or substantially compliant with this standard. There were effective structures in place for the management, monitoring and delivery of the service. There was effective leadership and clear lines of authority. There were good communication systems in place and staff were aware of their roles and responsibilities. There were systems in place to provide for oversight by the management team.

Two services were non-compliant with this standard. While one service provided children and foster carers with a good quality service, systems for the identification and management of risks as well as monitoring and oversight required improvement. While another service had made changes to its management structures in the months prior to the inspection, the systems of governance were not strong enough.

7.8. Training and qualifications in non-statutory foster care agencies

Four services were inspected under this standard, and three services were compliant or substantially compliant with this standard. These services had a qualified staff team with the necessary competencies and skills to deliver a good quality service. They had effective recruitment processes in place that ensured each member of the team had all documentation, qualifications and registration as required. There were training and development plans for staff and they were supported to develop their knowledge and skills. Training needs were being monitored and training was being provided where required to ensure the delivery of good quality, safe and effective care and support.

One service was judged as being non-complaint with this standard as its induction process was inadequate and recruitment processes as well as supervision were not in line with best practice.

7.9. Recruitment and retention of an appropriate range of foster carers in non-statutory foster care agencies

One service was inspected under this standard, as it provided emergency placement for Tusla nationally, and was found to have sufficient resources in place to recruit and retain foster carers. The service was continually recruiting an appropriate range of foster carers.

8. Regulation of special care units

8.1 Monitoring and inspection findings

There are three special care units in Ireland. These units are secure (locked) residential centres for children aged 11 to 17 years. Children and young people are placed in special care by a court when it has been determined that they require care and protection, as their behaviour places them at risk. Children and young people who are placed in special care receive therapeutic and educational supports in each unit.

Special care units are regulated by the Chief Inspector within HIQA. All three special care units were first registered by the Chief Inspector in November 2018 and their registration was renewed in 2021. Within each three-year registration cycle, special care units are regulated^ by the Chief Inspector to ensure ongoing compliance with the regulations and standards.

^ Where the Chief Inspector refers to 'regulating' in this section of this overview report, it includes inspection, review of information submitted by the special care unit, information held about the unit and ongoing review of information. This is all taken into account when the Chief Inspector is assessing compliance with regulations and standards.

Each of the three special care units was inspected in 2021. All three inspections were announced inspections to monitor ongoing compliance with the regulations and to gain further information in relation to their individual applications for renewal of registration.

Overall, inspections found that these units were well managed and that governance arrangements had been strengthened over the previous three years. Levels of accountability for practice were high, but although good quality staff supervision took place, it was not always provided within the required frequency. It was evident that a learning culture across all three units was being cultivated and promoted and this learning was being shared across staff teams.

In terms of continuous improvement, there were initiatives in place to ensure learning happened at a local and national level, and ongoing levels of compliance with regulations were constantly monitored and measured. There was evidence of effective auditing of practice which brought about improvements in areas such as medication management and records of fire safety checks.

The supports in place for staff and managers had improved in these services, and there was an increased emphasis placed on personal development of staff members.

All three special care units had staffing vacancies to varying degrees. The impact of this was that only one of the three units was operating in line with the number of beds it was registered to provide and the remaining two were not. Initiatives were in place by Tusla to try to attract and retain staff so that vacancies could be filled, and in turn to raise the number of placements that the two units could offer to the system. Where vacancies existed, agency staff were used. On a positive note, these inspections found that despite vacancies, each special care unit provided good quality care through stable staff teams to the children placed with them.

Children in all units received good quality care within the least restrictive environment possible. Restrictive practices were only implemented in response to risk, and children were afforded as much freedom of movement as was possible within a secure environment. Despite the challenges of changing restrictions related to COVID-19 in 2021, children continued to have contact with their families and other significant people in their lives.

It was evident that the rights of children, particularly in relation to consultation and participation in decisions about their lives, had been promoted. These children had contributed to plans for their care and to daily life in each centre. There was access to education on site in each special care unit and attendance was good. There were good supports within each school for children who needed them, and relationships between teachers and social care staff were child-centred.

Children placed in special care units typically present with complex behaviours which require specialist supports such as psychology and psychiatry. Two of the units had access to on-site specialist supports. While the third unit did not, it did have access to off-site mental health supports, and managers were exploring the potential to establish a psychiatric nurse post for the service.

At the time of inspection, one special care unit in particular was caring for several children with highly complex needs. While the relevant regulations were complied with in relation to the care of these children, meeting their needs had the potential to stretch the staff team, and it was likely that moving them to appropriate onward placements would prove a challenge. These concerns were raised with managers of the service at the time, and inspectors were assured that these matters were being addressed.

By late 2021, ongoing monitoring of this special care unit by the Chief Inspector showed these risks had emerged. In response to the escalation to Tusla mentioned earlier in this report, Tusla provided assurances that plans were at that time being put in place to address this concern but that it would take time. These plans included additional therapeutic supports for special care units and the approval for the establishment of a step down facility.

9. Oberstown Children Detention Campus

Oberstown Children Detention Campus is a national service that provides a safe and secure environment for young people remanded in custody or sentenced by the courts for a period of detention. These young people have been committed to custody after conviction for criminal offences or remanded to custody while awaiting trial or sentence. The principal objective of the campus is to provide appropriate care, education, training and other programmes to young people between 12 and 18 years, with a view to reintegrating them successfully back into their communities and society.

Oberstown is funded by the Department of Children, Equality, Disability, Integration and Youth. It operates under a single board of management, which is appointed by the Minister for Children, Equality, Disability, Integration and Youth. HIQA inspects Oberstown Children Detention Campus annually under Section 185 and Section 186 of the Children Act 2001 (as amended).

2021 was the first year that HIQA inspected this service against the *Oberstown Children's Rights Policy Framework.* The Framework consists of 12 rules, adopted by the Oberstown Board of Management in 2020 following the consent of the Minister for Children. They set out a high-level statement or standard by which the performance of the campus will be measured. They replaced the previous standards which HIQA inspected this service against.

This was an inspection against all 12 rules. Four of the rules assessed were compliant, six were substantially compliant and the remaining two rules were moderately non-compliant.

This inspection found that, overall, young people had positive experiences of their time in Oberstown and this was because they were well cared for, and a person-centred approach to care planning was taken. There were many examples of the promotion of young people's rights in Oberstown, and this was promoted at board level through the development of a children's rights policy framework for the campus. However, there was a need to ensure operational procedures and day-to-day practice created equal opportunities for all young people, particularly in relation to their levels of participation and consultation. By way of an example, not all young people had the opportunity to meet regularly with staff and managers in their respective residential units and express their views or have their voice heard in relation to life in that unit. In addition, there were limited resources in place to support young people to practise their religion. Given the diverse backgrounds of young people placed in Oberstown, this required improvement.

The most significant areas of improvement identified in this inspection were related to managerial oversight and monitoring of everyday practice and risk management. Importantly, the service had shown an inability to bring about incremental

improvements in relation to record-keeping which have been identified in previous inspections stretching back as far as 2019.

Some improvement had been found in the earlier 2020 inspection in relation to the provision of supervision, but this had deteriorated in the intervening year. This is the second inspection report in a three-year period which has highlighted staff supervision as requiring significant improvement.

The service was provided by experienced and qualified managers and staff members, and although many of the managerial systems in place worked effectively, some needed strengthening. For example, the systems in place to authorise, record and maintain consistent oversight of the use of all restrictive practices were not strong enough, and this meant that the rationale for their use and their authorisation for implementation by a manager were not always evident. Although there were risk management systems in place, risks in the service were not reviewed regularly enough. There has been little progress year-on-year for the past three years in relation to areas such as record-keeping, and interim measures to address gaps in the service created as a result of vacant posts were inadequate.

The quality of healthcare provided to young people remained high at the time of inspection, and their recreational and educational needs were well met. Young people's access to programmes and supports to help them break cycles of offending behaviour showed sustained improvement, and there was a consistent model of assessment of need relating to offending behaviour in use. This was a positive improvement since the last inspection.

A cross-campus approach was taken to safeguarding and protecting young people, and staff were vigilant in their supervision of young people and keeping the campus safe. The systems in place to report and liaise with Tusla in relation to child protection and welfare concerns operated well, but there was a need to ensure concerns were being reported to the social work department of the service area within which the campus was located.

Although there were positive findings in this inspection, this was the third inspection which identified the need to significantly improve staff supervision and record-keeping, and specifically to ensure that young people's records reflected their stay in the campus.

In summary, the 2021 inspection found that the rights of young people were central to the delivery of this service, but while their rights were actively promoted, this was not consistent across the campus. Young people's healthcare, educational and recreational needs were well met, but additional supports for some young people in relation to the use of substances were needed. While overall governance of the campus was strong, managerial oversight and monitoring of practice required improvement, particularly in

relation to the authorisation and use of all restrictive practices. Recurring findings of sub-standard record-keeping and the inadequate provision of staff supervision had yet to be addressed. A timely, significant and well-informed programme of improvement is needed in these areas. The findings of this report will inform the inspection of this service in 2022.

10. Stakeholder engagement

Engaging with people who have experience of using social care services, the general public and staff who work in or manage services is central to our work. We do this through focus groups, forming advisory groups, consultation and as part of our inspection process. Listening to their views and feedback helps to inform our work and our decision making.

Throughout 2021 the Children's team continued to engage with various stakeholders and interested parties. Examples of these engagements are described below.

10.1. Children and their families

Over the course of 2021, inspectors consulted with 195 children in a variety of settings. Of the 195 children, 63 were children in residential care, 51 were children in foster care, 36 were children involved with child protection services, 34 were children in detention and 11 were children in special care units. Due to COVID-19 restrictions and public health guidance, consultation with children was mainly conducted by phone and through the use of questionnaires. In addition, a small number of children were spoken with in person.

HIQA is committed to listening to the voices of children, and doing so during inspections enables us to capture children's experience of their care and understand better the impact of the governance of these services on these experiences. A particular focus of participation of children and young people in our work is to capture how they are involved in decision-making on issues that affect them.

Inspectors also routinely consulted with parents, foster carers and advocates as part of our inspection activity. Inspectors spoke to 65 parents or family members involved in the child protection services, and an additional 11 involved with the foster care services.

10.2. Department of Children, Equality, Disability, Integration and Youth

During the year, the Chief Inspector and HIQA's Head of Programme (Children's Service) met with the Assistant Secretary of the Child Policy and Tusla Governance Division of the Department of Children, Equality, Disability, Integration and Youth. These meetings were to exchange relevant updates and exchange information on actual or potential risk across the sector, and to discuss progress on regulatory developments.

HIQA also participated in the Department's public consultation on the next Government Policy Framework for Children and Young People in Ireland.

10.3. Child and Family Agency (Tusla)

Throughout 2021, we held regular meetings with the CEO of Tusla and members of Tusla's senior management team to share information on HIQA's annual business objectives, inspection methodology and to provide feedback on inspection findings. Tusla presented information on their ongoing developments and discussion took place in relation to ongoing risks and practice issues.

HIQA was also represented on Tusla's Research Advisory Group.

10.4. Oberstown Children Detention Campus

The Head of Programme (Children's Service) met with the Director of Oberstown Children Detention Campus and the Chairperson of Oberstown's Board of Management to share relevant information and to learn of ongoing organisational developments. The Chairperson and Director of Oberstown attended a meeting of the Children's Team and presented on the *Children's Rights Policy Framework (2020)* for the campus. In turn, HIQA presented its methodology for inspection under the new framework to them.

HIQA also attended Oberstown's annual stakeholder event which was held virtually. At this event, the Director and Chairperson of the Board updated key interested parties and stakeholders on progress made by the campus over the previous year.

10.5. Department of Education

In line with HIQA's Memorandum of Understanding with the Department of Education, contact is ongoing with this Department in regard to inspection findings of special care units and Oberstown Children Detention Campus and to formalise meeting arrangements for 2022.

10.6. Other stakeholders

The insights and experiences of other stakeholders are very much valued by HIQA. HIQA met with the Empowering People in Care (EPIC) organisation, the Irish Foster Care Association (IFCA) and the Ombudsman for Children's Office (OCO).

11. Concluding statement

2021 was another challenging year for children's services in Ireland. The annual programme of work for HIQA's Children's Team is influenced by several factors, such as meeting legislative requirements, building on the previous year's work and responding to risk. HIQA and the Chief Inspector are committed to promoting quality improvement initiatives in order to improve the quality and safety of services that are experienced by children. This commitment continued into 2021 from 2020 through the completion of our thematic child protection and welfare programme and the start of our thematic programme of foster care governance inspections.

During 2021, our regulatory approach in the main highlighted that:

- strong leadership and effective governance is central to providing good quality and safe services to children
- effective strategic planning is at the core of the delivery of safe services to children
- resource deficits impacts on the timely delivery of services to children
- services have the capacity to use and build on the learnings identified by their own self-assessments and or learnings arising from HIQA and Chief Inspector inspection findings and they have in the main embraced these learnings
- risk occurs for different reasons, but they usually arise from poor governance which impacts on outcomes for children, such as:
    - poorly-developed systems for the monitoring of day-to-day practice, which can lead to unidentified or unmanaged risk
    - failure to regularly review and consistently implement the organisation's policy, procedures and processes which have been developed to guide staff's work with children and their families.

11.1 Improvements

Inspection reports published in 2021 in relation to the wide range of children's services inspected by HIQA have continued to highlight the incremental improvements found in children's services in 2020. The ongoing commitment at national, regional and local

levels to delivering good quality and safe services to children continues to be noted, despite the challenges faced by services due to COVID-19 and due to the cyber-attack on information systems used by Tusla.

Tusla has had continued success in embedding its national approach to practice and to fully implementing a national model of care in its residential centres. Notwithstanding the challenges that the cyber-attack brought with it for part of 2021, the operation of Tulsa's NCCIS across its social work and care functions has continued to be progressed by Tusla. The benefits of a centralised recording system across Tusla services, independent of the HSE's information systems which Tusla has relied on since the transfer of children's service functions to Tusla from the HSE in 2014, is now even more critical. Tusla has begun working on this.

There was a noted increase in the number of unallocated cases (children awaiting the allocation of a social worker), and the number of high-, medium- and low-priority cases on the waiting list remained at a significant level. However, it was clear that staff in service areas endeavoured to allocate children who were prioritised as high priority. 2021 brought with it significant challenges for Tusla in relation to successfully implementing its strategy to reduce the number of cases waiting for allocation and or assessment.

Oberstown Children Detention Campus implemented the newly-approved *Oberstown Children's Rights Policy Framework*, and our methodology for inspection was updated to reflect this new framework.

11.2 Challenges

Some service areas continued to present with risks to varying degrees. In particular, failure to provide the right placement at the right time has been a consistent finding throughout many of our inspections in 2021. As a result of these identified risks, inevitably, the safety and wellbeing of children can be compromised. Poorly governed and managed services have more prevalent high levels of risk, consistent with our findings from previous regulatory activity.

Some initiatives taken by Tusla to increase its workforce in 2020 had begun to make a difference in some service areas in 2021; however, many vacancies in social work posts remained and these vacancies had a direct impact on service areas' capacity to meet their demands.

Those areas that had previously demonstrated good governance and management arrangements continued to incrementally improve their systems of oversight, monitoring and quality assurance. However, in poorly governed service areas, these systems of oversight were not as effective.

The impact of these challenges on some children and their families was considerable. Increasing waiting lists were for child protection and welfare services, and increases in the time frames that families were waiting for a service, were noted.

Throughout 2021, HIQA continued to highlight cases whereby children were not provided with the right placement at the right time, or where there were delays in providing the appropriate placements for them. This was a feature in:

- special care units, whereby step-down placements were not identified and secured in a timely manner
- foster care inspections, where children remained at home or in short-term placements longer than necessary due to the absence of the appropriate foster care placement for them, and
- Child Protection Notification System (CPNS) inspections, whereby a small number of children were left in potentially unsafe situations, due to the lack of available placements for them.

While it has always been a challenge to find placements for children with complex needs, the lack of placement options for all children is now also becoming an increasing challenge. As outlined earlier in this report, HIQA escalated this ongoing issue to Tusla's CEO and has received their Residential Care Strategy. HIQA looks forward to receiving their Foster Care Strategy, which Tusla is currently working on.

Many service areas provided HIQA with appropriate responses to poor inspection findings and outlined the measures they intended to put in place to manage the risks identified. However, improvements are required to ensure that service areas actively identify these issues themselves thought their own governance structures, and put measures in place through their own service improvement plans, without waiting for such findings to come to light as part of HIQA inspections. As previously outlined in our 2020 report, HIQA is not and should not be the first line of defence in ensuring the delivery of consistently safe, good quality services to children and their families.

HIQA's programme of inspection activity should support the service areas in promoting their ongoing service improvement plans, and in improving their levels of compliance.

11.3 Moving forward

HIQA will continue its focus on the regulations, standards and framework around leadership, governance and management of services, to promote ongoing improvements in children's services. In 2022, we will continue to augment the work completed in 2021, through the continuation of its programme of thematic inspections of statutory foster care services.

The leadership, governance and management of children's residential services will continue to be a focus in our 2022 inspection programme and we hope to see the learnings identified during the inspection in 2021 being further embedded throughout all children's residential services across the country.

Our quality improvement inspections continue, with the ongoing programme of inspections of the management of cases placed on Tusla's Child Protection Notification System, and our thematic programme of inspections of the governance of foster care services. HIQA will also continue to respond to risk in services as required.

It has been proposed now for some time that the remit of the Chief Inspector be expanded to include the regulation of all children's residential centres, statutory and non-statutory. This proposal has not progressed and is still awaited. It is crucial that this be progressed in a timely manner, as this will help to provide assurances about the quality and safety of services being provided to children living in these residential services. In relation to non-statutory children's residential centres, HIQA and the Chief Inspector will continue to liaise with the Department of Children, Equality, Disability, Integration and Youth to relation to the proposal to transfer the registration and inspection functions for these centres from Tusla to the Chief Inspector.

Finally, HIQA wishes to acknowledge the participation and cooperation of children, young people and their families and advocates, providers, foster carers and staff during our inspections. HIQA is committed to continuing to hear the views of parents, children and young people accessing the services we inspect and to consult with them to improve what we do. Their views and first-hand experiences are of utmost importance to us in order to be able to further improve the services that are provided to them.

12. References

1. Health Act 2007 (as amended*). Dublin: The Stationery Office; 2007. Available online from: http://www.irishstatutebook.ie/eli/2007/act/23/enacted/en/pdf.

2. Health Information and Quality Authority (HIQA). *Business Plan 2020.* Dublin: HIQA; 2019. Available online from: https://www.hiqa.ie/sites/default/files/2021-04/HIQA-Business-Plan-2021.pdf

3. Health Information and Quality Authority (HIQA). *National Standards for the protection and Welfare of Children.* Dublin: HIQA; 2012. Available online from: https://www.hiqa.ie/reports-and-publications/standard/national-standards-protection-and-welfare-children.

4. Child Care Act, 1991 (as amended). Dublin: The Stationery Office. 1991.

5. Child and Family Act 2013. Dublin.

6. S.I. No. 260/1995 - Child Care (Placement of Children in Foster Care) Regulations, 1995.

7. S.I. No. 261/1995 - Child Care (Placement of Children with Relatives) Regulations, 1995.

8. Department of Health and Children. *National Standards for Foster Care.* Dublin: The Stationery Office; 2003. Available online from: https://www.hiqa.ie/sites/default/files/2017-02/Standards_children_fostercare_DOHC.pdf

9. S.I. No. 635/2017 - Health Act 2007 (Registration of Designated Centres) (Special Care Units) Regulations 2017.

10. S.I. No. 634/2017 - Health Act 2007 (Care and Welfare of Children in Special Care Units) Regulations 2017.

11. S.I. No. 108/2018 - Health Act 2007 (Care and Welfare of Children in Special Care Units) (Amendment) Regulations 2018.

12. Health Information and Quality Authority (HIQA). *National Standards for Special Care Units.* Dublin: HIQA; 2015. Available online from: Health Information and Quality Authority (HIQA). *National Standards for Special Care Units.* Dublin: HIQA; 2015. Available online from: https://www.hiqa.ie/reports-and-publications/standard/national-standards-special-care-units

13. Children Act, 2001. Dublin: The Stationery Office; 2001.

14. Department of Justice, Equality and Law Reform. *Standards and Criteria for Children Detention Schools.* Dublin: Department of Justice, Equality and Law Reform; 2008. Available online from: https://www.hiqa.ie/sites/default/files/2017-02/Standards_and_Criteria_for_Children_Detention_Schools_2008.pdf.

15. S.I. No. 259/1995 - Child Care (Placement of Children in Residential Care) Regulations, 1995.

16. Health Information and Quality Authority (HIQA). *National Standards for Children's Residential Centres.* Dublin: HIQA; 2018. Available online from: https://www.hiqa.ie/sites/default/files/2018-11/national-standards-for-childrens-residential-centres.pdf.

17. Department of Children and Youth Affairs. *Children First National Guidance for the Protection and Welfare of Children*. Dublin: Department of Children and Youth Affairs. 2017. https://www.gov.ie/en/publication/114c50-children-first-national-guidelines-for-the-protection-and-welfare-of/

18. United Nations. *Convention on the Rights of the Child*. Geneva: United Nations; 1989.

19. Child and Family Act, 2015. Dublin: The Stationery Office; 2015.

20. Health Information and Quality Authority (HIQA). *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.* Dublin: HIQA; 2018. Available online from: https://www.hiqa.ie/sites/default/files/2018-06/HIQA-Investigation-Report.pdf.

21. Health Information and Quality Authority (HIQA). *Guidance and assessment-judgment framework for Child Protection and Welfare Thematic Programme (CPW).* Dublin: HIQA; 2019. Available online from: https://www.hiqa.ie/sites/default/files/2019-08/CPW-Thematic-Guidance-Assessment-Judgment-Framework.pdf

22. Health Information and Quality Authority (HIQA). *Guidance and assessment-judgment framework for Child Protection and Welfare Thematic Programme (CPW Child Protection Notification System)*. Dublin: HIQA; 2020

23. Health Information and Quality Authority (HIQA). *Guidance and assessment-judgment framework for Foster Care Thematic Programme Phase Three*. Dublin: HIQA; 2020

24. Health Information and Quality Authority (HIQA). *Overview Report Monitoring and Regulation of Children's Services*. Dublin: HIQA; 2021

25. Health Information and Quality Authority (HIQA). *Overview report on the inspections of statutory foster care services 2017 to 2018.* Dublin: HIQA; 2019. Available online from: https://www.hiqa.ie/sites/default/files/2019-03/Foster-Care-Overview-Report_2017-2018.pdf.

26. Child Care (Special Care) Regulations, 2004. The Stationery Office; 2004.

27. Health Information and Quality Authority (HIQA). *Overview report on thematic inspections of child protection and welfare services 2019-2021.* Available online from: https://www.hiqa.ie/reports-and-publications/key-reports-investigations/overview-report-thematic-inspections-child

Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Published by the Health Information and Quality Authority (HIQA).

For further information please contact:

Health Information and Quality Authority
Dublin Regional Office
George's Court
George's Lane
Smithfield
Dublin 7
D07 E98Y

Phone: +353 (0) 1 814 7400
info@hiqa.ie
www.hiqa.ie