Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Child Protection and Welfare Service

Name of service area:	Dublin South East/Wicklow
Name of provider:	Tusla
Type of inspection:	Focused CPNS
Date of inspection:	31 August -2 September 2021
Lead inspector:	Caroline Browne
Support inspector(s):	Grace Lynam, Niamh Greevy, Sharron Austin
Fieldwork ID	MON-0033785

About monitoring of child protection and welfare services

The Health Information and Quality Authority (the Authority) monitors services used by some of the most vulnerable children in the state. Monitoring provides assurance to the public that children are receiving a service that meets the requirements of quality standards. This process also seeks to ensure that the wellbeing, welfare and safety of children is promoted and protected. Monitoring also has an important role in driving continuous improvement so that children have better, safer services.

The Authority is authorised by the Minister for Children, Equality, Disability, Integration and Youth under section 8(1)(c) of the Health Act 2007, to monitor the quality of service provided by the Child and Family Agency to protect children and to promote the welfare of children.

The Authority monitors the performance of the Child and Family Agency against the *National Standards for the Protection and Welfare of Children* and advises the Minister for Children and Youth Affairs and the Child and Family Agency.

In order to promote quality and improve safety in the provision of child protection and welfare services, the Authority carries out inspections to:

- **assess** if the Child and Family Agency (the service provider) has all the elements in place to safeguard children and young people
- **seek assurances** from service providers that they are **safeguarding children** by reducing serious risks
- **provide** service providers with the **findings** of inspections so that service providers develop action plans to implement safety and quality improvements
- **inform** the public and **promote confidence** through the publication of the Authority's findings.

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

Theme 1: Child-centred Services	☐
Theme 2: Safe and Effective Services	☒
Theme 3: Leadership, Governance and Management	☒
Theme 4: Use of Resources	☐
Theme 5: Workforce	☐
Theme 6: Use of Information	☐

How we inspect

As part of this inspection, inspectors met with social work managers and staff. Inspectors observed practices and reviewed documentation such as children's files, policies and procedures and administrative records.

The key activities of this inspection involved:

- the analysis of data
- interview with the area manager, focus group with two principal social worker
- interview with chairperson of the Child Protection Conferences (CPC)
- focus groups with social work team leaders
- focus group with social workers
- the review of local policies and procedures, minutes of various meetings, staff supervision files, audits and service plans
- observation of a child protection conference
- the review of 15 children's case files
- phone conversations with four parents, one relative and one child.
- phone conversations with one child

The aim of the inspection was to assess compliance with national standards the service delivered to children who are subject to a child protection case conference and whose names are entered onto the CPNS.

Acknowledgements
The Authority wishes to thank children and families that spoke with inspectors during the course of this inspection in addition to staff and managers of the service for their cooperation.

Profile of the child protection and welfare service

The Child and Family Agency

Child and family services in Ireland are delivered by a single dedicated State agency called the Child and Family Agency (Tusla), which is overseen by the Department of Children, Equality, Disability, Integration and Youth. The Child and Family Agency Act 2013 (Number 40 of 2013) established the Child and Family Agency with effect from 1 January 2014.

The Child and Family Agency has responsibility for a range of services, including:

- child welfare and protection services, including family support services
- existing Family Support Agency responsibilities
- existing National Educational Welfare Board responsibilities
- pre-school inspection services
- domestic, sexual and gender-based violence services.

Child and family services are organised into 17 service areas and are managed by area managers. The areas are grouped into four regions, each with a regional manager known as a service director. The service directors report to the chief operations officer, who is a member of the national management team.

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

Service area

Dublin South East/Wicklow is the fourth largest of the 17 service areas of Tusla, The Child and Family Agency. The area is the 4th largest of 17 Integrated Service Areas (ISA's) The ISA is an amalgamation of 3 previous Local Health Offices / former health board areas 1, 2 and 10. The former Dublin South East LHO includes the areas of Dundrum, Rathfarnam, Nutgrove, Ballinteer and Churchtown. The former Dublin South LHO includes the areas of Dunlaoghaire, Mounttown, Hillview, Loughlinstown, Monkstown and Blackrock. Wicklow includes the majority of County of Wicklow, excluding West Wicklow, and it borders the counties of Carlow and Wexford. The service area comprises of both urban and rural areas with some parts of the area having high deprivation rates among its population. Based on the 2016 census, the area had a population of 362,425 of which 86,810 are children.

The area is under the direction of the service director for the Child and Family Agency Dublin Mid Leinster Region and is managed by an area manager. The child protection conferencing service was delivered by one principal social worker and administration staff were employed to assist in the delivery of service. A second principal social worker had been recently been identified to assist in the chairing of child protection conferences as required.

There were 55 children listed on the CPNS at the time of the inspection and these cases were allocated across four social work teams with the exception of one child who was allocated to a child in care team. Two duty teams were responsible for the screening, preliminary enquiries and initial assessment of new referrals and reported to a principal social worker. They made requests for CPC's and cases were transferred to child protection

and welfare teams once requests for CPC's had been made. The social work service for children on the CPNS was delivered by four child protection and welfare social work teams. This teams reported to two principal social workers for child protection and welfare. All children on the CPNS were allocated to a social worker at the time of the inspection.

At the time of the inspection, there were six whole time equivalent social work vacancies in the child protection service. There were three vacancies on the duty teams and three vacancies across the child protection and welfare teams. At the time of the inspection, the area were in the final stages of the recruitment of eight social work graduates to fill vacant posts in the service.

Compliance classifications

HIQA judges the service to be **compliant, substantially compliant or non-compliant** with the standards. These are defined as follows:

- **Compliant**: A judgment of compliant means the service is meeting or exceeding the standard and is delivering a high-quality service which is responsive to the needs of children.
- **Substantially compliant**: A judgment of substantially compliant means the service is mostly compliant with the standard but some additional action is required to be fully compliant. However, the service is one that protects children.
- **Not compliant:** a judgment of not compliant means the service has not complied with a standard and that considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of children using the service will be risk-rated red (high risk) and the inspector will identify the date by which the provider must comply. Where the non-compliance does not pose a significant risk to the safety, health and welfare of children using the service, it is risk-rated orange (moderate risk) and the provider must take action within a reasonable time frame to come into compliance.

In order to summarise inspection findings and to describe how well a service is doing, standards are grouped and reported under two dimensions:

1. Capacity and capability of the service:

This dimension describes standards related to the leadership and management of the service and how effective they are in ensuring that a good quality and safe service is being provided to children and families. It considers how people who work in the service are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

The quality and safety dimension relates to standards that govern how services should interact with children and ensure their safety. The standards include consideration of communication, safeguarding and responsiveness and look to ensure that children are safe and supported throughout their engagement with the service.

This inspection was carried out during the following times:

Date	Times of inspection	Inspector	Role
31st August 2021	09.30 to 17.00	Caroline Browne Grace Lynam Niamh Greevy Sharron Austin (remote)	Inspector Inspector Inspector Inspector
1st September	09.00 to 17.20	Caroline Browne Grace Lynam Niamh Greevy Sharron Austin (remote)	Inspector Inspector Inspector Inspector
2nd September	09.00 to 17.00	Caroline Browne Grace Lynam Niamh Greevy Sharron Austin (remote)	Inspector Inspector Inspector Inspector

Views of people who use the service

As part of this inspection, inspectors in conjunction with the service area sought to seek the views of people who use the service. As a result of this request, inspectors spoke to four parents, one relative and one child who had experience of accessing the CPNS service.

All people spoken to shared positive experiences of the service provided to children on the CPNS. Parents and relatives spoke highly of the social workers and the work they had completed with their families. Parents, relatives and children said they had good relationships with the social workers and they said were always accessible and helped them and their children. One parent said that social workers were '*doing the best they can and I am very grateful'*. Another parent said that things were a lot better now for her and her children. A parent stated that the social worker '*works with me through the plan*'. A child identified that the social worker '*made me understand what was going on'* through '*words and pictures'*.

All parents spoken to had attended the child protection conference (CPC) and said they were given time to outline their views and felt their views were heard and respected. One person said that during the conference, the CPC chairperson went through things step and step and they felt that their '*feelings were respected'.* One parent said that the discussion at the CPC made '*me understand what was happening'*. All five parents and relatives said that they received the CPC records following the CPC, however, one parent said they did not receive them in a timely manner. Parents said they felt things were progressing for the children while on the child protection notification system (CPNS). One parent felt that while things were improving, progression was slow.

Some parents spoke about being part of a network group which reviewed how the safety plan was being implemented. They also spoke about other supports service involved and that the social worker often advocates for supports for families.

Capacity and capability

Overall there was a good level of service provided to children on the Child Protection Notification System (CPNS) who had been identified as being at risk of significant harm or neglect. Staff spoken to were experienced, demonstrated their knowledge of their role in the protection and welfare of children and were aware of their responsibilities and who they were accountable to. There were management systems in place to support the delivery of service in line with legislation, policy and standards. However, some management systems required development in order to support effective oversight, to ensure a consistent service was provided to children and to promote continuous evaluation and improvement in the service.

The focus of this inspection was on children placed on the CPNS register who were subject to a child protection safety plan and aligned governance arrangements in place to ensure effective and timely service delivery to these children. In line with Children First (2017), when concerns of ongoing risk of significant harm are identified during the assessment and intervention with children and families, Tusla are required to organise a Child Protection Conference (CPC). A CPC is a multidisciplinary, interagency meeting which is held to determine whether a child is at ongoing risk of significant harm. Once it is determined that a child is at ongoing risk of significant harm the child's name is placed on the Child Protection Notification System (CPNS) register and a child protection safety plan is developed. Reviews of children listed on the CPNS must occur at intervals of not more than six months to establish whether the child remains at ongoing significant risk of harm.

This inspection took place following a challenging period since March 2020 for social work professionals, children, and their families engaging in the services due to both the risks and public health restrictions associated with the COVID-19 pandemic. Further to the difficulties encountered due to the COVID-19 pandemic, a cyber-attack affecting Tusla's ICT systems occurred in May 2021. Consequently Tusla's national child care information system (NCCIS) was inaccessible for between 14 May 2021 and 31 July 2021. In light of these challenges, HIQA acknowledges that the service had to adopt their service delivery in order to ensure continuity of service to children and families. In addition, that there was a month for children's case documents to be uploaded onto NCCIS before the inspection fieldwork took place.

The child protection notification system comprises of a confidential database of children in the area who have been identified as being at ongoing risk of significant harm. The child protection conference and notification system is a key component to safeguarding children identified at heightened risk of harm and provides for rigorous oversight for the management for these children through interagency, interdisciplinary assessment and intervention. Inspectors reviewed the CPNS register and found that the register was secure and well maintained in line with Children First: National Guidance for the protection and Welfare of Children (2017). Children's names were updated on the register following a decision made at the Child Protection Conference. Access to the CPNS is strictly confined to Tusla social workers, members of An Garda Síochána, out-of-hours general practitioners and hospital medical social work and nursing staff. Where an enquiry to Tusla's out-of-hours service by an authorised professional, they will be will be informed of whether the child is listed on the CPNS and relevant details such as the child's name and address, allocated social worker and primary reason for being listed on the CPNS are available in order to assist professionals make decisions about the safety of a child.

Interim national guidelines on Child Protection Conference and the Child Protection Notification System had been developed in 2018. However, these guidelines had not been subject to review and required updating by the Child and Family Agency in order to review its impact on practice, to address gaps in compliance and to ensure a consistent quality of service delivery. For example, inspectors found that some aspects of the guidelines required further clarity to ensure consistent implementation and monitoring of child protection safety plans, such as the basic minimum guidelines for the frequency of network meetings and visiting for children on the CPNS. Furthermore, as stated while the CPNS was maintained in line with Children First (2017), the child could not be listed to reflect more than one category of abuse as it was limited to listing of children under one primary category of abuse. For example, in one case reviewed, records of CPC conference discussions reflected concerns about risks of both physical and emotional abuse to children, yet the children were listed on the CPNS register under the category emotional abuse.

There were governance and leadership structures in place to support the delivery of service at local, regional and national level. The overall accountability for the delivery of the service was clearly defined and there were clear lines of accountability at individual, team and service levels. There was a stable and experienced management team with clearly defined roles with respect to management of children listed on the CPNS. There were systems in place to ensure staff were made aware of relevant legislation and national policy and staff were provided with the opportunity to provide feedback to management with respect to how policy impacts on practice. Staff spoken to demonstrated a knowledge of legislation, policies and standards for the protection and welfare of children.

Oversight of the day to day implementation and monitoring of children on the CPNS was delegated to two principal social workers and their social work teams. The area manager delegated the management of the CPNS to an independent chairperson who was also responsible for maintaining and updating the CPNS register. The chairperson was a principal social worker who started this post in January 2020. She was independent in her role and did not have direct management oversight of cases. She also managed requests for CPC conferencing from social workers and determined their suitability for conference. The CPNS chairperson delegated some duties to an administrator who sent out CPC invites and the subsequent CPC records to relevant professionals. They also updated the CPNS following a conference. The quality assurance mechanisms in place to ensure the child protection notification process and procedures were in line with national policy required improvement. The CPNS chairperson identified that she reviewed the CPNS register on a weekly basis to ensure all information was updated. Subsequent to the inspection, the area manager told inspectors that a log was used to track the issuing of CPC reports to attendees after the conference.

Strategic objectives and operational plans required further development and implementation in order to set out clear direction for the delivery of a quality child protection service. The area manager identified that the area were employing the regional service plan in order to inform consistent services in the region. While the area manager was aware of and spoke about some of the regional objectives which focussed on the wellbeing and safety of children, the specific service plan for the area had not been finalised at the time of the inspection. The area manager identified that the recent cyber-attack in May 2021 had resulted in the delay in the finalisation of the regional service plan.

There were systems in place to review and assess the effectiveness and safety of service delivery. Learning from reviews and serious incidents was shared with staff to inform the development of best practice and service improvements. One rapid review was undertaken by the principal social worker which related to children on the CPNS and was in draft format at the time of the inspection. Inspectors found that this review was discussed with the area manager and learning for Tulsa as a service was identified. The principal social worker and the area manager identified that steps had been taken to enhance learning in the service area with respect to issues identified in this review. Systems were also in place to ensure learning from the review of adverse events, complaints and concerns. Complaints were discussed in supervision with principal social workers. Complaints were also a standing item on the agenda of management team meetings which were routinely reviewed to ensure best practice and improved services for children and families.

Management systems were in place to provide assurances that the service was protecting children, however some required development in order to provide greater oversight of the service delivered to children on the CPNS. The area manager told inspectors that she assured herself on the service delivered primarily through supervision with principal social workers, including the CPC chairperson. Additional methods of providing assurances to the area manager were governance meetings, risk management, meetings between the CPC chair and the child protection social work teams, national and local auditing and the complex case forum which the area manager chaired. However, some assurance mechanisms did not report on key indicators such as visits to children on the CPNS, implementation of safety plans, oversight of the CPNS system and implementation of the CPNS policy. While the service delivered to children on the CPNS ensured children were safe, some assurance systems required further development in order to identify gaps in the service, implement necessary service improvements and to ensure consistency in service delivery.

Monthly area management meetings and area governance meetings were in place in order to communicate and to oversee management of the child protection service delivered. Management meetings were attended by principal social workers including the CPC chairperson. The area manager identified that these forums were used as a mechanism of oversight and assurance on the service delivered to children on the CPNS service. Inspectors found that these meetings provided assurances to management with respect to some aspects of the service. Issues discussed at these meetings included COVID-19 updates from regional meetings, complaints, NCCIS recording, risk register and audits. However, inspectors found that while some procedural matters with respect to CPNS process were discussed, there was limited discussion relating to practice and quality of service provided to children on the CPNS,

for example, the timeliness of RCPC and ICPCs. This meant that areas for improvement were not identified to promote the delivery of a consistent service.

A complex case forum was also used in the area to provide support, advice and governance to the social work teams regarding complex cases that were open to the service. These meetings took place monthly and the criteria for discussion at this forum included cases on CPNS over 12 months where there had been little change and cases subject to care order applications or cases involving complex legal issues. This forum allowed senior management oversight and assisted in identifying solutions to generate better outcomes for children. Inspectors reviewed two meetings where children on the CPNS had been discussed and found that these meeting were a good mechanism for social work staff to discuss complex cases and provided some objectivity on case management. In particular, meetings explored the child's background, interventions to date, what were the blockages to better outcomes for the child and what was required to move the case forward.

National quality assurance mechanisms were in place, however subsequent service improvement plans had not been developed to improve service delivery. An audit had been completed in July 2020 by the national practice assurance and monitoring team of children on the CPNS during the COVID 19 crisis period. This audit identified gaps in implementation of the relevant policy and procedure such as the lack of evidence to verify that CPC records had been sent out to all participants. In addition, the audit also found there was lack of evidence of liaison between the principal social workers, team leaders and CPC chairperson regarding the review of the safety plans in place for the child where there reviews were deferred. One recommendation arising from the audit had been fully implemented to ensure that identified gaps in practice were addressed.

Local monitoring and auditing systems in place to identify gaps in service provision and ensure compliance with policy and procedures also required improvement. Two principal social workers who managed social work teams told inspectors that they had completed auditing of files of children on the CPNS, however, they acknowledged that further auditing was required. Audits reviewed areas such as safe and effective services, child centred services and record keeping. However, inspectors found that the level of auditing on files was limited and that these systems required further development in order to assure managers of the service being provided to children on the CPNS.

Risk management systems were in place to ensure risks in the service were reported managed. This system ensured that the service was effectively identifying assessing and managing the majority of identified risk related to the service delivered to

children on the CPNS. The service had a risk register which detailed risks to service provision in the service area. Examples of such risks, included the lack of appropriate placements for children requiring admission to both residential care and foster care, staff vacancies and COVID-19 operational risks. Staff were aware of their responsibility to manage risk and they were aware that there was a system in place to escalate risk to management at local regional and national level. One systemic risk relating to the lack of appropriate placements for children requiring care was identified on the risk register since 2018. However, actions taken to date did not address the systemic nature of the risk and had not made an impact of addressing the risk. Records showed that a recent review of the risk register by the area manager in August 2021, identified that this risk has been escalated to the Tusla Chief Executive Officer and the Department of Children, Equality, Disability, Integration and Youth.

There was also a process in place to escalate individual risks within the service through 'Need to Knows' which were reported to the area manager. There were five 'Need to Knows' relating to children on the CPNS. Inspectors reviewed one child on the CPNS where it was established that the child required a placement, however there were difficulties in sourcing a suitable placement and as a result this case was escalated to the regional service manager. In response to this case escalation, the regional service director contacted the service and approved funding for the private placement of the child should alternative placements not become available. At the time of the inspection, this child was placed in an interim placement while awaiting a suitable long term placement.

There was a good response to risks associated with the COVID-19 pandemic. The restrictions associated with COVID-19 had significant impact on the delivery of service in the area. In response to the pandemic, some interim measures were developed and adopted by social work staff in order to assess, monitor and support children and families in light of COVID-19 public health restrictions. For example, social work services adapted their means of communication with children and families to ensure they were safeguarded. Interim guidance for special measures regarding Child Protection Conferences was also disseminated in April 2020 which focussed on measures in place during the COVID 19 pandemic. These interim guidelines provided for the delay on convening review CPC's in circumstances where based on discussion with the social work team leader, the principal social worker and the CPC chairperson, the safety plan was evaluated and they were satisfied that a review CPCS could be deferred for up to three months. The chair of the CPNS identified that this interim COVID-19 guidance was still in operation in the service at the time of the inspection.

Staff supervision was also identified as an assurance mechanism however, improvements in supervision were required in order assure management on the quality of the CPNS service. Principal social workers identified supervision and in particular, case management was an assurance mechanism in relation to the safety of children on the CPNS. Inspectors found that through the case management of social workers cases, there was a good level of discussion and oversight of decision making and guidance provided to staff teams on individual cases, however, this was not evident on some cases reviewed where there was a lack of records of follow up of agreed actions. In addition, inspectors found that supervision did not act as an effective means of ensuring the consistent implementation and monitoring of children's child protection safety plans, use of network meetings and visits to children on the CPNS.

The area manager also identified that staff supervision was used as a means of providing assurances in relation to service provision in the area. Inspectors reviewed supervision provided by the area manager and found that regular supervision was provided. Issues discussed included, staffing, risks to the service, reflective learning following a review and training required. Inspectors found that the discussions relating to the CPC process mainly related to procedural issues. While some cases which were more complex on the CPC register were discussed and general guidance on the direction of the social work involvement was provided, this mechanism required further development at all levels of authority in order to provide assurance of the service and safety measures in place for all children on the CPNS.

There were clear lines of communication in place from management to staff which facilitated information sharing across the service. There was culture of learning and support and staff identified various communication methods such as group supervision, team meetings and the complex case forum. A principal social worker told inspectors that the service had good relationships with local universities and a local forum had been established to focus on practice matters emerging for the staff. Staff also identified that there was good working relationships with staff teams and informal communications with team members which also promoted information sharing learning and support. There was a regional child protection forum established to standardise practice across the region and to enhance learning for teams for child protection and welfare. In addition, there were regional CPC chairpersons meetings which also facilitated information sharing, shared learning and promoted a consistent service to children on the CPNS.

There was no system in place to ensure the consistent recording on children's files on the NCCIS. Inspectors found that there was no consistent naming convention used within the service to record interventions, monitoring and review of safety plans for

children. This meant that it was difficult for management to oversee and ensure implementation of safety plans and ensure practice was in line with relevant policies and procedures. Inspectors also found that data on children's files were not accurate and as a result this would impair the quality of oversight completed on case files. For example, in some cases there were inaccurate dates of CPC conferences and while the inspectors were cognisant of the recent cyber-attack and its impact on social work teams, mechanisms were not in place to ensure this information was correct once uploaded to NCCIS. Furthermore, some information relevant to siblings groups were not uploaded to each sibling case files.

Standard 3.1 The service performs its functions in accordance with relevant legislation, regulations, national policies and standards to protect children and promote their welfare.
Governance structures in place supported the delivery of the service to children and families. Staff teams were experienced and demonstrated a good knowledge of legislation policies and standards and were aware of their roles and responsibilities. While staff were aware of new and existing legislation and policies and they were consulted in relation to how policies and guidance documents impact on service delivery, the Interim national guidelines on Child Protection Conference and the Child Protection Notification System developed in 2018, had not been subject to review and update. As a result, the requirements relating to monitoring and implementation of child protection safety plans, such as, frequency of home visits and safety planning meetings were not clear which gives rise to inconsistency within this area and services nationally with respect to children on the CPNS. Furthermore, while the CPNS was maintained in line with Children First, it was limited to listing of children under one primary category of abuse.
Judgment: Not compliant
Standard 3.2 Children receive a child protection and welfare service, which has effective leadership, governance, and management arrangements with clear lines of accountability.
Governance and leadership structures were in place to assure management that the service was protecting children and promoting their welfare. There were clear lines of accountability in the service at individual, team and service levels. Management systems were in place to support the delivery of the service in line with relevant legislation and standards, however some management systems, such as supervision, management meetings, record management and auditing systems required development in order to provide stronger assurances that the service delivered to children on the CPNS was in line with relevant policy and standards. Strategic management systems required development as plans were not finalised at the time of the inspection. Case supervision was not evident on all cases reviewed and there was a lack of records of follow up of agreed actions.
Judgment: Substantially compliant

Standard 3.3 The service has a system to review and assess the effectiveness and safety of child protection and welfare service provision and delivery.
There were some systems in place to review and assess effectiveness and safety of the service. There was a culture of learning across the service and communication systems were in place to promote shared learning. A rapid review was completed and lessons learnt were taken on board by the management team and shared with the staff team. Systems were also in place to ensure learning from the review of adverse events, complaints and concerns. However, some systems such as internal and external quality assurance mechanisms required development. Both internal and external quality assurance mechanisms were in place, however internal quality assurance systems such as auditing were not embedded in the service and required further development in order to provide adequate levels of assurances to management teams in relation to compliance with policy and legislation. Service improvement plans had not been developed in a timely manner to address gaps identified by Tusla's quality assurance team.
Judgment : Substantially compliant

Quality and safety

Overall, there was a good quality service provided to children on the CPNS, however there were gaps identified in the level of consistency of service provided to all children. In particular, gaps identified related to timeliness of initial child protection conferences, recording of specific monitoring and review arrangements for child protection plans and the monitoring and the implementation of child protection plans.

All cases referred for a child protection conference (CPC) met the required threshold, however there were delays in convening conferences for some children. Once children had been identified as being at risk of harm or neglect, child protection conferences were held in order to determine whether the child's name should be placed on the CPNS register. Inspectors reviewed 15 files for timeliness of the child initial CPC and found that there was variance in timelines for holding initial CPC's. Inspectors found that some initial CPC's did not take place in a timely manner and timelines varied from 2 to 15 weeks. 53% or eight out of 15 of CPC records reviewed were over a five week timeline from request CPC to CPC occurring. In six cases of these eight cases reviewed by inspectors, there were delays of between five weeks and nine weeks. In the remaining two of the eight cases reviewed, there was a 15 week and 14 week delay from the request for CPC to the CPC occurring. One of those cases related to a young infant identified at risk of significant harm. While both of these cases had safety planning in place, they were nonetheless identified as being at ongoing risk of significant harm and were waiting long periods for an interagency meeting to take place. As a result, there was delay in the formation of a robust interagency child protection safety plan for these children. Given that there was significant child protection concerns for these children, HIQA was of the view that these timeframes were too long.

The child protection conference (CPC) was comprehensively facilitated by a professional who was not directly involved in the assessment or management of the child or family's needs. Records showed that the chair facilitated productive discussions with all participants to identify the strengths, concerns and risks relating to the case. All relevant assessment/information and reports were also presented at the conference. Inspectors observed a CPC conference and noted that the chair elicited information from all professionals to identify the strengths and concerns relating to children. Inspectors found that parents and family member's views were heard and the chairperson reflected on what was discussed to family members to ensure they understood. It was also evident from a review of records that the chair explained the purpose of the CPC conference to all participants and was cognisant of the difficult nature of the conference for parents and families. Inspectors found that in the majority of CPC meeting records reviewed, quorum was met in line with policy.

In some instances, CPC conference were changed or delayed in order to ensure that there was multidisciplinary discussion to support the assessment and planning of interventions for children.

There was a good level of consultation with parents prior to the CPC by the social worker allocated to the case. In line with good practice, the social worker consulted with children and their parents to explain the CPC process and to ascertain their views in advance of the initial CPC conference. Inspectors found that in the majority of files reviewed there was a good level of communication with parents about the CPC process. Inspectors found that there was a good level of attendance by parents at CPC's and records reflected that parent's views were represented at the conference.

There was also a good level of consultation with children about the CPC process in the majority of cases reviewed. In line with interim policy, the underlying principal of a CPC must be that a child should participate in the CPC and should do so in a manner appropriate to their age, ability and developmental capacity whilst also taking into account the best interests of the child. In particular, the policy outlines that children's views should be sought prior to the CPC whenever possible. Social workers identified that they completed direct work with children prior to and following the CPC in order to elicit their views. In 92% or 13 out of 14 files reviewed there was a good level of consultation or observation with children in relation to the initial CPC. Inspectors found evidence of social workers use of child friendly tools assisted them to communication with children to ascertain their views about the CPC process and to explain what decisions were made at the CPC conference. For example, in one case, children were met prior to the conference and it was evident that children were involved in the safety planning process and assisted in the identification of safety networks. However, in one case, there were no records of consultation with the child prior to the CPC and direct work was completed five months after the CPC.

At the CPC conference, once a child was listed on the CPC register, clear minimum requirements are identified that have to be in place in order for the child to continue in the care of their parents along with specific actions such as a safety plan. Following the CPC, a child protection safety plan is developed by the social worker at a series of meetings with parents, family and key professionals. The child protection safety plan should identify the social worker with lead responsibility for implementing the plan and should outline each specific action, for the safety network to ensure children are kept safe including monitoring arrangements should be clearly recorded.

Inspectors reviewed 13 child protection safety plans and found that the while all child protection plans identified key areas that ensured children's safety, aspects of some

child protection plans required improvement. Social workers told inspectors that it was critical to have an informed network of people in order to have a successful child protection plan in place. A specific child protection safety plan template was used which guided the social worker to reflect and record what was working for the family what were the concerns, consideration of information from professionals and the minimum requirements for the child to remain in the care of their parents.

However, there was some a variance in the recording of specific actions on some child protection safety plans. Inspectors found that in 54% or 7 out of 13 child protection safety plans reviewed, specific actions and detailed arrangements of how the service, along with parents and identified safety network persons, ensured children were safeguarded and their needs were met. A review of these records showed that these child protection safety plans clearly set out the monitoring and review arrangements, including the frequency of social work visits. For example, in one case, the child protection safety plan specified that a child required weekly home visits by the allocated social worker. However, in 46% or 6 out of 13 cases, records for specific actions outlined in the child protection safety plan required improvement. For example, monitoring arrangements such as the frequency of visits and safety planning meetings were not specified.

The monitoring of children listed on the CPNS and the relevant child protection safety plans through social work visits was not consistent and required improvement. All children listed as active on the CPNS had an allocated social worker. In focus groups with inspectors, social workers said that children on the CPNS were to be visited every two weeks. However, there were no local policies to guide staff in this regard. Inspectors found that social work visits were not consistent as while the majority of children were being visited by their social worker, there were gaps in visits to some children on the CPNS.

Inspectors reviewed 13 cases for monitoring of children on the CPNS through visits. Inspectors found that records of home visits were evident in 62% or 8 out of 13 files reviewed. It was evident that social workers were involved and monitoring child protection plans and in some cases, team leaders accompanied social workers on these visits. However, in 38% or 5 out of 13 files reviewed, inspectors found that there were gaps in social work visits to the child. In one case, while it was evident that a social care worker was seeing the child, there were no records of visits to the child by their allocated social worker. In another case, there was only two visits recorded over a four month period. In a third file, while there was evidence of the social worker monitoring the child protection safety plan through telephone calls to family members and the social work team leader was assured that the social worker was seeing this child at family access, there were no records of the social worker

completing home visits to this child. In another case, there were gaps in the recording of visits to children on the CPNS where the social worker identified that while regular visits had taken place, not all visits were recorded on the child's files.

The service reviewed the progress of interventions and information from professionals involved with the family. According to Tusla's guidelines for CPC's and the CPNS, regular safety planning meetings were to be convened following the CPC, to create a more detailed child protection safety plan, review the safety for the child and monitor the progress with the case. Where there was a network identified for children on the CPNS, safety plan network meetings were used to monitor the implementation of child protection safety plans. In 81% of child protection plans reviewed where a safety network had been identified, inspectors found that network meetings had occurred and there was evidence of good communication with identified network. For example, in one case, regular network meetings were occurring in response to identified risks in the case. However, in some cases, network meetings were not held at regular intervals and it was not always clearly specified how frequently these meetings should be held. In two cases, network meetings were not occurring as regularly as the child protection safety plan specified. However, it was evident that the safety plans were monitored by social work staff. For example, in one case there was regular phone contact with identified persons within the network about the implementation of the current safety plan.

Review CPC's for children identified at on-going risk of significant harm were not always held at regular intervals in line with Children First (2017). Children who are identified as at ongoing significant risk should have their child protection plan reviewed at regular intervals at a minimum of every six months. At the time of this inspection, the CPNS register identified that there were 18 children overdue a review, 10 of which were overdue by 30 days. Inspectors found that there were valid reasons for these delays such as parent's hospitalisation, treatment programmes and the need to await for school to resume to have their input in the review child protection conference.

Inspectors reviewed eight review child protection conferences and found that 50% reviews were timely. While there were delays in the remaining 50% review child protection conferences this was due to the circumstances of the cases and valid reasons were provided. One review was overdue by six months due to ongoing long term supports and interventions being provided to the family which required time to reflect on the success of interventions and progression of agreed actions. Three reviews CPC's were delayed due to lack of quorum, for example, one was delayed in order for school to resume and to include educational professionals in the review.

Review CPC's were of good quality, and there was a focus on ensuring that all key professionals were in attendance. Inspectors found that attendees reviewed what has worked well since the last conference, the views of the child and parents since the last conference, the updates on progress since the last CPC, information from key professionals and there was clear discussions on whether the child needed to remain on the CPNS. Clear minimum requirements required to be in place in order for the child to continue to remain in the care of their parents along with other actions such as a safety plan. However, in three cases reviewed, the monitoring and review arrangements were not clearly outlined in the child protection safety plan.

Systems to ensure children, families and relevant professionals routinely received a record of the CPC records and child protection plans required improvement. While it is a requirement outlined in the Interim Guidance for Child Protection Conferences that all those who participate in the conference, receive the records of the case conference and the recommendations from the meeting including the safety arrangements, there was limited evidence of this requirement being met on children's case files. While the CPC chairperson was confident that this was occurring, she acknowledged that there was no assurance systems in place to assure her that this action had been taken.

There was a good level of consultation with interagency professionals in the implementation and delivery of child protection safety plans. The service was proactive in promoting interagency liaison and had provided training to some external agencies with respect to Tulsa's national approach to practice and principal social workers identified that they were in the process of rolling this training to other external agencies. This level of consultation with a range of professionals promoted good safeguarding practices for children identified as at risk of significant harm. Inspectors found that in the majority of cases reviewed for implementation of child protection safety plans, there was evidence of liaison and joint working with interagency professionals such as medical staff, An Garda Síochána and various other support services. Inspectors identified 23% of cases in which there were strategy meetings held with interagency professionals. In the absence of strategy meetings on children's files, there was evidence of good communication with various professionals. For example, in social work staff frequent telephone calls to relevant professionals, requests for welfare checks, and joint visits with interagency professionals were evident on files.

Standard 2.6 Children who are at risk of harm or neglect have child protection plans in place to protect and promote their welfare.
Children who were at risk of harm or neglect had child protection plans in place to protect and promote their welfare. Child protection conferences were well facilitated and there was evidence of consultation with parents and families and children. However, timelines from the initial request for CPC to the child protection conference occurring required improvement. Child protection safety plans were developed and actions were identified to keep children safe and ensure their needs were met. However, some actions identified did not record specific timelines to enable effective monitoring. The monitoring of children listed on the CPNS and the relevant child protection safety plans through social work visits was not consistent and required improvement. In addition, the oversight and recording of social work intervention required improvement, in order to demonstrate the support and interventions provided and the effectiveness of child protection safety plans.
Judgment : Not compliant
Standard 2.7 Children's protection plans and interventions are reviewed in line with requirements in Children First.
Child Protection plans and interventions were not reviewed in line with requirement of Children First (2017), however there were clear rationales recorded for the delays in convening review child protection conferences.
Judgment: Compliant

Standard 2.9 Interagency and inter-professional cooperation supports and promotes the protection and welfare of children.
There was a good level of interagency and inter-professional cooperation and supports within the service. Interagency and inter professional attendance was good at CPC conferences. Strategy meetings were occurring for cases where this was required and there was a good level of communication and consultation evident within the service. Management had also taken a strategic approach to interagency involvement with the service and steps had been taken to provide training to other agencies with respect to the national approach to practice to increase awareness and understanding of practice at CPC conferences.
Judgment: Compliant

Compliance Plan for Dublin South East and Wicklow Child Protection and Welfare Service OSV – 0004380

Inspection ID: MON-0033785

Date of inspection: 31st- August – 2nd September 2021

Introduction and instruction

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Standard Heading	**Judgment**
Standard 3.1	Not Compliant
Outline how you are going to come into compliance with Standard 3.1: The service performs its functions in accordance with relevant legislation, regulations, national policies and standards to protect children and promote their welfare. Action: Interim Guidelines on Child Protection Notification System to be reviewed by National office circa 2022. A Data Impact Assessment of the Child Protection Conference Interim Guidance is being finalised by Tusla's Data Protection Unit which will inform the review of the Interim Guidance on the Child Protection Conference Guidelines and any changes that are required to ensure that Tusla meets its data protection obligations under the General Data Protection Regulation (GDPR) 2018. Responsible: Head of Policy and Transformation Completion by: 2022	
Standard 3.2	Substantially Compliant
Outline how you are going to come into compliance with Standard 3.2: Children receive a child protection and welfare service, which has effective leadership, governance and management arrangements with clear lines of accountability. Action: Auditing of children on the Child Protection Notification System has commenced in area by all Principal Social Workers and Principal Social Worker for Child Protection Case Conference. This will provide oversight of quality of work and ensure Supervision records	

are on system, visits recorded, minutes issued, safety plans specific regarding visits and meetings consistently recorded. Area Manager will ensure monthly audits are routinely completed and log kept of audits findings and actions followed through with Teams via Service Improvement plans.
Action: Service Plan was completed at Area Management Meeting in September 21. Monthly file audits in place since 29/10/21 overseen by Area Manager.

Standard 3.3	Substantially Compliant

Outline how you are going to come into compliance with Standard 3.3: The service has a system to review and assess the effectiveness and safety of child protection and welfare provision and delivery.

Action: Auditing of work by Principal Social Workers and Child Protection Case Conference Chair needs to be consistent and oversight by Area Manger to ensure this is happening and Service Improvement Plans are developed and tracked. Additional resources to support PSW capacity will be looked for in estimates for 2022/new business support posts 2022. Audits commenced in area as of 30/10/21 and service improvement plans tracked by Area Manager every quarter.

Standard 2.6	Not Compliant

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

Actions: lack of consistency re safety plans details will be improved. Meeting to review safety plans with Principle Social Worker/Team Leaders will take place to consider improvements required and Service improvement Plan developed to agree actions and track progress by PSWs by 30/11/21.
Audits will ensure improvements are made and sustained. Oversight of adherence to timelines and supports to address same have been put in place by Area Manager and timelines overseen every 4-6 weeks in Supervision with PSW for CPCC.

Section 2:

Standards to be complied with

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

The provider has failed to comply with the following standards(s).

Standard	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Standard 3.1	The service performs its functions in accordance with relevant legislation, regulations, national policies and standards to protect children and promote their welfare.	Not Compliant	Orange	Head of Policy
Standard 3.2	Children receive a child protection and welfare service, which has effective leadership, governance and management arrangements with clear lines of accountability.	Substantially Compliant	Yellow	Audits commenced and will take place monthly. In place by 29/10/21 Service plan was finalised and for review at next Area Management Meeting 09/11/21

				Area Manager responsible for service plan
Standard 3.3	The service has a system to review and assess the effectiveness and safety of child protection and welfare provision and delivery.	Substantially compliant	Yellow	Audits commenced monthly and Service Improvement Plans to be developed from audits findings for 30/11/21 PSW responsible for Audits and Area Manager to oversee Service improvement plans.
Standard 2.6	Children's who are at risk of harm and neglect have child protection plans in place to protect and promote their welfare	Not compliant	Orange	Review of safety plans with Management team will take place and Service Improvement Plan to be developed by 30/11/21 PSWs and Area Manager to ensure service improvement plans takes place and audits check improvements implemented and maintained. Area Manager will review with PSW CPCC

				timelines for requests to ensure compliance in their Supervision every 4-6 weeks. Back up cover is in place should there need to be additional support with convening CPCs going forward. 30/11/21