Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Health Information and Quality Authority Regulation Directorate monitoring inspection of Child Protection and Welfare Services

Name of service area:	Mid-West
Type of inspection:	Child Protection and Welfare - Child Abuse Substantiation Procedure
Date of inspection:	05 December 2023
Lead inspector:	Mary Lillis
Support inspector(s):	Susan Talbot Bernadette Neville Rachel Kane Saragh McGarrigle
Fieldwork ID	MON-0041706

About this inspection

HIQA monitors services used by some of the most vulnerable children in the state. Monitoring provides assurance to the public that children are receiving a service that meets the national 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 continual improvement so that children have access to 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 and the Child and Family Agency.

This inspection was a monitoring inspection of Tusla Mid-West service areas to monitor compliance with the National Standards for the Protection and Welfare of Children. The scope of the inspection included standards 1.3, 2.5, 2.12, 3.1 and 3.2 of the National Standards for the Protection and Welfare of Children (2012). This inspection focused on of the implementation of Tusla's Child Abuse Substantiation Procedure (CASP) which came into operation on 27 June 2022.

Introduction to the Child Abuse Substantiation Procedure (CASP)

Tulsa's Child Abuse Substantiation Procedure was brought into effect as one of the actions on foot of the recommendations from an investigation by HIQA into the management of allegations of child sexual abuse against adults of concern by the Child and Family agency (Tusla) (2018). The findings of that investigation included some which will not be commented on here. There were a number of findings however which relate directly to the introduction of CASP, these include:

- Lack of standardised approach to the management of retrospective abuse allegations
- Inconsistencies in informing the alleged abuser about the allegation and when informed of the allegation, inconsistencies in the amount of information provided to them
- Delays in starting, conducting and concluding the assessment of the allegation that impacted on a person's ability to respond to the allegation

- Inconsistent understanding of and adherence to standardised processes or policies by staff
- Shortage of qualified social work staff which contributed to delays in the management of referrals
- Inconsistent practice in relation to joint working with An Garda Síochána.

In order to meet its statutory obligations to protect children and promote their welfare, Tusla must carry out an assessment of allegations of child abuse in line with fair procedures. This is called a 'substantiation assessment' – an assessment that examines and weighs up all the evidence and decides if the allegation is founded or unfounded on the balance of probabilities. This is not a criminal investigation. If the allegation is founded a determination is made that the person who is the subject of the abuse allegations poses a potential risk to a child or children. Tusla calls this process the CASP – Child Abuse Substantiation Procedure. It is part of Tusla's child protection and welfare service. It is applicable only when a disclosure of abuse meets certain criteria. The CASP process only applies to cases where:

- there is an allegation of abuse and there may be a need to inform a third party about this in order to protect children from harm. This arises when alleged abusers are engaged in activities outside of the home which would allow them access to children. The nature of the allegation gives rise to a concern such that Tusla must share the information with a third party, for example an employer.
- cases where Tusla's national approach to practice cannot be applied, that is, where there are no children identified who can be protected by a safety planning process involving their family and wider support network
- cases where the alleged abuser is a foster carer or a supported lodgings provider or an adult living in a foster home.

A case that is being worked under CASP goes through three stages before an outcome is reached. CASP outlines the length of time each stage should take. A case can be closed at any stage without an outcome being reached.

- Preliminary Enquiry – basic information is gathered from the alleged victim to confirm that the case meets the CASP criteria and that the person wishes to proceed with CASP. Contact with the person making the disclosure should be made within 14 days.
- Stage 1 – further in-depth information is gathered about the allegation from the alleged victim. This can take the form of reviewing information Gardaí have gathered such as specialist interviews with children or statements from adults. This should happen within 60 days or extended to 90 days if approved by a manager.
- Stage 2 – the allegation is put to the alleged abuser, they are provided with all the

information gathered on the allegation by the CASP social worker and their responses are received and considered. Stage two has a number of steps to allow time for the alleged abuser to respond to the allegations and could take up to 343 days for a final conclusion to be issued to the alleged abuser.

Addressing the risk to identified individual children is kept separate and is the responsibility of a different child protection and welfare team.

In any of these cases the person making the allegation may be a child or an adult. When an adult makes a disclosure of abuse which occurred when they were a child the term 'retrospective disclosure' applies.

In data provided by the service prior to the inspection there were 151 cases open under the CASP; 109 (72%) of which were retrospective disclosures of abuse and 42 (28%) were disclosures of abuse made by a child.

How we inspect

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

A CASP file relates to an allegation of abuse. This means it contains information on the alleged victim and the alleged abuser. In the case of a child, there may be another file, held separately from the CASP file, and maintained by the other teams within Tusla which contains information about child protection concerns and how they are being managed. This would include interventions under Tusla's national approach to practice and safety planning where required.

The Mid-West CASP team were responsible for four types of cases. Those that met the CASP criteria (please see outline earlier in report), cases which were referred to Tusla prior to the introduction of CASP in June 2022, but did not transfer over to the CASP process. In addition they were responsible for cases that did not meet the CASP criteria but where actions may be needed to ensure that children are safeguarded from future harm. They were also responsible for responding to queries or referrals from the Garda Vetting Bureau. Only the cases which were being worked under CASP were reviewed by inspectors for this inspection.

The key activities of this inspection involved:

- the analysis of data
- interview with the CASP lead practitioner/manager
- interview with social work team leader
- focus group with two CASP Social Workers and one Social Care Leader.
- focus group with three external professionals.
- focus group with An Garda Síochána
- two focus groups with Tusla professionals external to the CASP team
- the review of local policies and procedures, minutes of various meetings, staff supervision files, audits and service plans
- observation of meetings relevant to the standards being assessed
- the review of 37 CASP case files
- phone call with one person with experience of CASP as a service user.

The aim of the inspection was to assess the compliance of the implementation of the Child Abuse Substantiation Procedure with the national standards.

Acknowledgements
HIQA wishes to thank members of the public and external professionals who spoke with inspectors, as well as the staff and managers of the service for their cooperation during the course of this inspection.

Profile of the child protection and welfare service

The Child and Family Agency

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

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

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

Child and family services are organised into 17 service areas and are managed by area

managers. The areas are grouped into six regions, each with a regional manager known as a regional chief officer. The regional chief officers 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
Mid-West is one of the 17 areas within Tusla's service areas and also one of Tusla's six regions in its own right. The area includes the counties of Limerick, Clare and North Tipperary. The region is under the direction of a regional chief officer (RCO). There is one Principal Social Worker (PSW) for CASP who reports to the Professional Support Manager, who in turn reports to the area manager and onward to the RCO.

Compliance classifications

HIQA judges the service to be **compliant, substantially compliant or not 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
05 December 2023	10:30hrs to 17:00hrs 09:00hrs to 17:00hrs 10:00hrs to17:00hrs 10:30hrs to 17:00hrs 9:40hrs to 17:00hrs	Mary Lillis Susan Talbot Rachel Kane Saragh McGarrigle Bernadette Neville	Lead Inspector Support Inspector Support Inspector Support Inspector Support Inspector
06 December 2023	08:45hrs to 17:00 hrs 08:30hrs to 17:00 hrs 09:00hrs to 17:00 hrs 09:00hrs to 17:00 hrs 09:00hrs to 17:00 hrs	Mary Lillis Susan Talbot Rachel Kane Saragh McGarrigle Bernadette Neville	Lead Inspector Support Inspector Support Inspector Support Inspector Support Inspector
07 December 2023	08:45hrs to 16:30 hrs 08:30hrs to 15:30 hrs 09:00hrs to 15:45 hrs 10:00hrs to 15:30 hrs 09.00hrs to 14:30 hrs	Mary Lillis Susan Talbot Rachel Kane Saragh McGarrigle Bernadette Neville	Lead Inspector Support Inspector Support Inspector Support Inspector Support Inspector

Views of people who use the service

Hearing the voices of adults and children who have experience of a particular service is an essential part of understanding the impact a service has had on people's lives. Inspectors were conscious of the sensitive and often traumatic reason for people being involved with CASP. Their right to engage or not in the inspection process was respected. A dedicated telephone number was provided for any person who had experience of this service to contact HIQA and speak with inspectors during the inspection. This telephone number was given to people who had experience of CASP in the 12 months before the inspection. One person rang this number and spoke with an inspector about their experience of CASP.

This person had experience of CASP as they had an allegation made against them. At the time of the inspection the assessment of the allegation had concluded and the allegation was determined to be unfounded. The person spoke positively about the professionalism of the social worker who helped conclude the assessment of the allegation saying, "she was very nice, tactful, precise and professional." This person also spoke about how their rights were clearly explained to them saying, "I was helped to understand my rights. The social worker invited me to get back to them if I did not understand things".

This person spoke about the length of time it took for a conclusion to be reached and its impact on their wellbeing. "It is a very long process - for over two years, it hung over me." They were told the reason for the delays was due to staffing levels. They explained in detail the negative impact these delays had on their life and wellbeing. They told the inspector "this allegation has been detrimental to my mental health." In conclusion they said "overall I felt I was treated fairly, but the process took far too long".

Inspectors spoke to a number of professionals both within Tusla and external to Tusla who have had experience of working with the CASP team. These included managers from a range of relevant external services.

All professionals who spoke with inspectors were positive in their descriptions of the professional work and knowledge of those working on the CASP team. Many professionals spoke about clear open communication between the CASP team within Tusla and their organisation. However, others noted that the quality of communication was dependent on whether or not a case was allocated to a social worker. A number of professionals raised concerns regarding the resourcing of the team and the high number of staff vacancies.

Professionals internal to Tusla but not part of the CASP team reported that there was a very clear understanding of each of the team's roles. They reported that decisions as to whether a case met all criteria for CASP were clear and well managed through handover arrangements. These professionals reported that the establishment of the CASP team allowed their teams to focus on the child, ensuring safety plans were in place and the child or children at risk received the help they needed.

The impact of the length of the process was raised as a concern and an area of improvement that was needed, by the Tusla professionals external to CASP. They spoke in particular about the impact on foster carers who had allegations made against them saying "[CASP] cases are ongoing for longer than two years and we are not able to talk about it to foster carers". They went on to describe the emotional impact saying it "destroys foster carers" confidence. Foster carers feel very vulnerable for a long time afterwards". The professionals reported in their opinion delays in assessing allegations was contributing to some foster carers leaving fostering.

Capacity and capability

This was an inspection that assessed Tusla's compliance, in the application of Tusla's CASP, with the national standards. It is important to note that this is just one small part of the child protection and welfare service that Tusla provides. HIQA monitors the performance of the Child and Family Agency against the *National Standards for the Protection and Welfare of Children (2012),* and therefore the terms used in this report are those used in the standards and in Children First.

This inspection overall found that there was effective oversight and governance arrangement in place within the area as it applied to the CASP. The CASP process was lengthy and there were delays in concluding the substantiation processes. The CASP did not fully address the findings of the 2018 HIQA investigation. The area had identified the risks to the service due to low levels of staffing and were actively trying to address that risk within their means. However, there was a limit to the amount they could mitigate the risk if posts were not accepted by suitably qualified individuals. There were delays in sending notifications to the Garda Síochána National Vetting Bureau, Garda Vetting (police vetting). This meant that Tusla was not meeting its obligations under the 2012 Act, in a timely manner. However, the specific circumstances, at the time of the inspection, in this area meant that these delays did not place children at risk.

There were clearly defined governance arrangement and lines of responsibility and accountability. The team assigned to implement the child abuse substantiation procedure was managed by an experience principal social worker (PSW), who reported to the Professional Support Manager and upwards to the area manager and regional chief officer. These structures, as well as roles and responsibilities were well understood by the staff and managers who spoke with inspectors, both within the CASP team and at a wider area level. There was one team with responsibility to respond to CASP cases in the area. This team also had responsibility for abuse allegation assessments that were referred before the introduction of CASP (June 2022) and to a cohort of adults who may pose a risk to children such as adults with previous convictions for child abuse. The local area had developed a practice note on the management of allocated and unallocated cases referred to the CASP team. This included guidance on prioritisation, allocation and review of CASP cases and the other cases managed by the team that did not meet CASP criteria.

At the time of the inspection, this team was working at approximately 33% of their staffing capacity. There was one vacant social worker role, and two vacant senior social work practitioner roles. This meant that the team lost approximately 111 social work hours per week. A portion of a third senior practitioner role had been converted to the social care leader role, when that vacancy could not be filled. The team had been working with these vacancies since July 2023. There was one social care leader in post for one month, one full time social worker and one social worker from another team who worked on CASP cases one day a week. The senior social work practitioner had taken up the post of the CASP team leader the week of the inspection. The social work team leader had been promoted to a principal social worker on another team and the existing CASP PSW was due to move to another role in the area. In an effort to support staffing on the team the Regional Chief Officer agreed that both PSWs would remain in their CASP roles until at least one of the vacant senior social work practitioner roles were filled. This was expected to happen in January 2024. All of these changes and vacancies had a direct impact on the timeliness of the completion of substantiation assessments. Up until June 2023 there had been no unallocated CASP cases and by mid-November 2023, there were 98 cases awaiting allocation, with the majority (89 cases) waiting for preliminary enquiry.

The "operational risk to the safety of children due to numbers of unallocated referrals in the CASP service, due to cumulative staff vacancies" was identified on both the regional and area risk registers, which were reviewed by inspectors. The regional and area risks were regularly reviewed and updated with existing and additional control measures. Existing control measures, at the time of the inspection, included regular meetings with HR regarding recruitment. The recruitment of a social care leader to assist social workers in the completion of the assessments, with appropriate

supervision. The temporary reassignment of a social worker from a child protection team one day a week since November 2023 to focus on completion of CASP preliminary enquiries (PE). To support staff retention, regular external group clinical supervision and support was obtained and had begun in October 2023.

Additional control measures included exploring a bespoke recruitment campaign for the CASP team and increasing the reassigned social worker from one to two days a week for a period of one month to help further reduce PE wait times. The reassignment of the social worker with a focus on the completion of PEs had shown to be effective. Data provided two weeks before the inspection showed the team had 89 cases awaiting PE, this had been reduced by 19 cases or 21% to 70 by the final day of the inspection. While cases that were due to proceed to stage one after PE, would have to wait, the completion of the PE meant that basic information had been gathered about the case. The case could be more accurately prioritised. It also reduced the risk that there were children associated with a case, who had not been named in the initial referral detail but were at potential risk of harm. Management were taking a lot of steps to try to address the low levels of staffing including moving resources from different services to CASP. However, it was acknowledged there was a limit to what could be achieved if the roles were not accepted when offered to suitable candidates, as had happened several times in the previous six months.

Effective oversight of the service was achieved through supervision, auditing practices and use of key performance indicators (KPIs). Supervision took place every four to six weeks in line with Tusla policy. Supervision dates were agreed in advance and any changes were noted and a rationale clearly stated, this was monitored by the team leader and PSW. Supervision records were of a high standard. The records included comprehensive discussions of both case and service level topics where appropriate. The minutes reviewed by inspectors demonstrated a strong focus on professional development and support. There was good follow up on concerns from one supervision session to the next. It was noted that key issues or concerns raised in supervision, where appropriate, got escalated to the governance group meetings to be brought to the attention of the area manager.

There was evidence of good quality regular case supervision on CASP files reviewed by inspectors. Generally supervision provided clear discussion and direction regarding the next steps in order to progress the case. However, the timelines for individual actions and in general CASP stages, were noted to rarely be discussed in supervision. This led in a small number of cases to drift in the completion of actions, of note was drift in completion of notifications to the National Vetting Bureau, which will be discussed in more detail later.

The PSW carried out regular file audits on unallocated cases. Staff members carried out self-audits on open allocated cases and these audits were then shared with their supervisor. Inspectors found evidence of audits on files of both open and waiting list cases. A review of self-audited cases was carried out by the PSW in November 2023 and clear learnings from this were identified and actioned. For example the audit noted that few specified information notifications were sent to the National Vetting Bureau. This was noted to have then become a topic of discussion at the next team meeting.

Auditing of waiting list cases began in summer 2023, as prior to June 2023 all CASP cases were allocated. Auditing practices were found to be in line with the local area practice note regarding managing CASP cases. In a number of cases awaiting allocation, the priority level of a case increased from low to medium or medium to high following an audit for reasons such as the length of time waiting. While this demonstrated good practice and awareness of the risk associated with a case awaiting allocation, it had limited impact on the timeline for allocation as there was no suitably qualified person to begin working on the case.

There were systems in place that ensured good communication and accountability both within the CASP team and between CASP and other teams. These included quarterly CASP team meetings, monthly CASP governance meetings and quarterly child protection and welfare management meetings and quarterly meetings which were attended by the general managers and PSWs, included managers for alternative care. These meetings were well attended and held regularly. They demonstrated good communication and integrated working within the CASP team and the wider child protection and welfare teams. A range of matters were discussed depending on the meeting, including service updates, risks or issues arising, national policies and procedures. They demonstrated clear communication from front line staff to upper management and between services within the area. This resulted in strong oversight and accountability.

The principal social worker, general manager and area manager had oversight of key performance indicators for the CASP team. Performance was a standing agenda item on the service area's monthly CASP governance group. This group began meetings in March 2023 and consisted of the area manager, the professional services manager, the general manager for alternative care and the general manager for child protection and welfare and the CASP PSW. In addition to performance data, this group discussed staffing including skill development, practice issues, service integration, national guidelines, compliance with standards and it formed part of their well-structured approach to the management of risk.

The area's service improvement plan, staff training needs and complaints were consistently reviewed and updated. The service improvement plan was reviewed as part of the inspection. It was noted to have been reviewed and updated on a quarterly basis. Inspectors noted that a good level of attention was paid to the learning and development needs of the workforce. This was appropriate given that the CASP was a relatively new procedure and required some specialised skills to implement. Some items noted the impact of the low staffing levels on the completion of actions.

The area had a system for recording and managing complaints, however what was deemed a complaint for inclusion on this system required review by the area. There was one formal complaint recorded on the system as it related to CASP. However, in files reviewed by inspectors it was noted that there were two informal complaints that were dealt with locally by the assigned social worker. One related to a parent being unhappy with the wording of a closure letter from the team and one related to a foster carer being unhappy with the length of time the substantiation process was taking. These issues were raised with front line staff and appropriately dealt with by those staff. However they were not recorded as complaints on the complaints data base even though it was clear from the files that these people were expressing dissatisfaction with the service they had received. As a result learning from service user feedback may be missed.

The management within the area, requested a review of the implementation of CASP in the area from Tusla's internal quality assurance team to provide additional oversight. While it had been hoped this would be carried out by the end of 2023, it was delayed until quarter one 2024. However it demonstrated a proactive commitment to quality and service development on the part of the management in the area.

The "need-to-know" process by which management are informed in a timely manner of an incident or event was in place in the area. There were no need-to-knows in the 12 months prior to the inspection that related to the CASP.

Inspectors reviewed minutes of the CASP 'community of practice' forum, which was held jointly between the mid-west and the northwest regions. The community of practice discussed national and regional operational and practice issues. The minutes showed good collaboration, engagement and shared learning between the CASP teams. The minutes highlighted the challenges in the implementation of CASP and lessons learnt when applying a relatively new procedure.

Staff demonstrated knowledge of legislation, policy and standards relevant to their roles. They demonstrated awareness and knowledge of Children First, data protection legislations and the importance of fair procedures, especially impartiality in their work. Staff and management in the service also demonstrated sensitivity to the traumatic nature of disclosures. The newest member of the team was undergoing induction and received close supervision from the team leader. The induction was planned and specific to CASP and structured in a way to allow competence at each step in the procedure to be developed before moving on.

A review of the adherence to CASP timelines found that the timelines set out in the procedure were not being met. This was acknowledged by staff and managers and they expressed the opinion that in addition to the staffing challenges, timelines were difficult to adhere to as they were often reliant on the engagement of the alleged victim and or abuser to progress the case. The CASP is voluntary, neither the alleged victim nor alleged abuser are obliged to engage in the process. Mandatory reporters must report incidents of child abuse (current or retrospective) to Tusla, in line with Children First. Tulsa must attempt to investigate these reports. An example often given by staff is a counsellor who must make a report to Tusla when their adult client discloses they experienced abuse as a child, even if that adult has said they do not wish to engage in any way with Tusla regarding the abuse. This requirement is currently under review, at time of writing. Social workers can then spend a lot of time trying to contact this adult in order to determine if the CASP can proceed. Similarly social workers can spend considerable time trying to engage the alleged abuser at stage two of the procedure, in order to afford that person the right of reply and fair procedure. This was often observed on cases reviewed by inspectors.

There were delays at all stages, including delays at point of referral before transferring over to the CASP team for example one retrospective allegation waited two months from receipt of referral in April 23 by duty and intake teams to its transfer to the CASP team in June 23, while another waited seven months from March to November 2023 to be transferred to CASP. The area manager reported that early in 2023 the child protection and welfare duty and intake teams experienced staff shortages and while all referrals would have been prioritised for screening based on risk, retrospective allegations were not the high priority in the context of other competing priorities. .

Once the referral is received by CASP, it is screened to determine if it meets all CASP criteria. CASP screening was not consistently happening within one day. This compounded the earlier transfer delays. Of the 37 files reviewed 51% or 19 cases had a delay in either the duty social worker screening the case or in the sign off by the duty team leader.

Inspectors sampled 11 cases which were waiting for preliminary enquiries (PE) to begin. The length of time waiting for PE, the process where basic information about the referral is gathered, to start ranged from just one day to 469 days (15 and a half months). In the case waiting the longest, the initial period of delay, August 2022 to September 2023 (13 months), was due to the voluntary nature of CASP, as the person who alleged they experienced abuse was unsure if they wished to proceed. However, for a large portion of the cases the delay in starting a PE was due to an inability to allocate the case to a social worker.

Inspectors reviewed 34 cases of which 17 had preliminary enquiries completed. The length of time a case took to complete a preliminary enquiry (PE) once it had started varied widely. Eight of the 17 cases had their PEs completed within one week. While the remaining ranged from one month upwards, with one sampled case taking 195 days (6 and a half months) for the PE to be completed. Difficulties making contact with and engaging the person making the referral and or the alleged victim of abuse was identified as one of the reasons for the length of time taken to complete a PE.

Seven cases reviewed by inspectors had completed stage one of the substantiation process. The CASP timeline notes that stage one should be completed within 60 days but can be extended with managerial approval to 90 days. Only one of those sampled had completed this stage within 60 days, two cases were completed within 90 days, while the other four cases ranged from 94 days to 264 days for completion. There were also three cases where inspectors found it difficult to calculate how long stage one took. One case note indicated that it was awaiting stage 2 substantiation but did not have the PE or stage one forms completed. While another the forms appeared to be completed retrospectively, with the form started and completed in the one day but notes indicating work had begun weeks before the form was started. As previously noted while these cases were discussed in supervision, delays in timelines were rarely discussed and none of the cases that took more than 60 days had evidence of managerial approval for extending the timeline, in line with the procedure.

Inspectors reviewed five cases which were open at stage two, including one which had had a provisional conclusion issued. Two of these cases were unallocated and both were waiting more than four months for allocation to continue the substantiation assessment. The remaining three cases were open at stage two for between five and eight months at the time of the inspection. This is within the timeframes allowed for stage two within the CASP. Inspectors also reviewed two cases which had had final conclusions issued. One of which progressed within the timelines allowed for in CASP and took almost nine months (268 days) from screening to final conclusion. The other took 16.5 months (506 days) from screening to final conclusion. Even when cases

progressed within the timeframes allowed for in CASP, they were taking a significant period of time to come to a conclusion.

There was considerable concern for inspectors with regard to the protracted length of time that the CASP was taking to progress through the various stages to reach a founded or unfounded outcome. The concern related to both the impact on the children and adults with open cases but also in terms of Tusla's ability to act in a timely fashion to implement safeguarding actions for as yet unidentified children. While management were working to mitigate the impact of low staffing, and prevent further delays in process, these actions were focused and having impact on only one step of the procedure. This inspection found that not all cases of child abuse have a substantiation assessment carried out due to the reliance by Tusla on either alleged victims or abusers to engage in the CASP, as previously discussed. The procedure did not fully address the findings of the 2018 HIQA investigation.

Inspectors found that there were delays in the submission of notifications to the Garda Vetting Bureau and as a result Tusla was not meeting its obligations as a scheduled organisation under the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 (the 2012 Act) to notify the Garda Vetting Bureau as soon as may be of their concern and the reasons for it. However, the risk associated with the delay in sending these notifications in this area was low. In data provided to inspectors during the inspection there were a total of nine notifications made to the Garda Vetting Bureau in the 12 months before the inspection. Of these four were CASP cases, either ongoing or closed. The National Vetting Bureau Act provides a statutory basis for the vetting of people who carry out work with children and or vulnerable adults. This act stipulates which organisations are required to notify the National Vetting Bureau of a "bona fide" (genuine) concern that a person may harm or put at risk a child or vulnerable adult, as soon as may be (as soon as possible). Tusla is one such organisation. Notifications made under the 2012 Act are made separately to the notifications made to An Garda Síochana when Tusla staff suspect a crime has been committed.

Inspectors reviewed two cases where a notification had been sent the Vetting Bureau and three cases where a decision was made to send a notification to the Vetting Bureau but had not yet been sent. Delays were identified in all five cases. These delays ranged from between four and six months. In two of the cases these delays were as a direct result of the case being unallocated. For example, work was being carried out and a notification to the Vetting Bureau being considered on a case in May and June 2023. The social worker left the post in July 2023 and at the time of the inspection, over four months later, the case remained unallocated and the notification not sent. The case was marked high priority for allocation but there was no social

worker available to continue the substantiation process. In another case there was a delay in the transfer of the referral from the duty team to CASP of three months. The case was allocated when transferred and the notification sent one month later. In the three cases where the notification had yet to be sent, inspectors were assured that risk to children was low. In one case the Gardaí were aware of and informed Tusla that the alleged abuser had a conviction for child abuse in a different country. In the two other cases the alleged victims had made complaints to the Gardaí. As a result this information would be flagged should the alleged abuser apply for vetting, even without the notification being sent from Tusla to the Vetting Bureau. However, governance and oversight of this process required improvement so that all notifications are submitted in a timely manner, irrespective of whether the case is unallocated nor not, as not all cases may be known to the Gardaí.

Inspectors found from file reviews, speaking to the CASP team, and reviewing team meeting minutes, that staff were clear about their responsibility to identify and report genuine concerns to the Garda Vetting Bureau. Team meeting minutes discussed the need to consider the notification to the Vetting Bureau at any stage of the substantiation process, this was reiterated by staff and management in focus groups. The principal social worker acknowledged that ideally the notifications identified would have been sent in a timelier fashion however where risk was low other actions needed to prioritised given the staffing context in which they worked.

Standard 3.1

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

The service area had well-developed systems and processes in place that reflected relevant legislation, national policy and procedures. Staff demonstrated good knowledge of legislation and policies relevant to their roles.

There were delays in the submission of notification to the National Vetting Bureau. While the risk to children or vulnerable people in the specific examples reviewed by inspectors was low, Tusla was not meeting its obligations as a scheduled organisation under the 2012 Act.

A review of the adherence to CASP timelines found that the protracted timeline set out in the CASP were not consistently met. There were significant delays impacting on the ability of Tusla to act in a timely way to progress safeguarding actions for children not yet identified. The procedure did not fully address the findings of the HIQA 2018 investigation.

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.

The area had strong governance arrangements with clear lines of accountability and good communication between staff and managers. There was clear auditing in place to achieve better outcomes for children through the CASP.

There was a clear risk management system in place. Management were clear in the steps they were taking to address risk, however there was a limit to the impact on these steps as they relied on qualified social workers taking up posts. Improvements were needed in the governance of notifications to the Garda Vetting Bureau to ensure that all required notifications were sent in a timely manner.

Judgment: Substantially Compliant

Quality and safety

Overall, this inspection found that children and families were communicated with in a sensitive manner, which took account of their individual needs, however there were often delays in this communication. The documentation on CASP files regarding children was limited but provided sufficient assurance that the children were safe. Publically available leaflets on the CASP were complex and available only in English. There was good communication between the CASP team and An Garda Shíochána, however there were two retrospective cases where the notifications of a possible crime to the Gardaí were delayed. The CASP did not provide guidance on how to identify or respond to cases of possible or confirmed organisational or institutional abuse, however the area had developed local guidance to address this gap. The individual needs of children who possibly experienced organisational abuse or who were especially vulnerable were identified. However, the service was not able to respond to them promptly.

Inspectors found clear, sensitive child-centred communication took place between the CASP team and children and their families. However there were delays and gaps in the communication which were not in line with the Tusla procedure. Inspectors reviewed 17 cases where the alleged victim was a child, in two of these cases the alleged abuser was also a child. Inspectors found that in the main, the CASP team worked with other Tusla teams to determine who would be best placed to communicate with the child and their family, for example in a case involving a child in care, their child-in-care social worker explained the CASP to the child and this action was noted on the CASP file. The CASP social workers were noted to communicate more frequently with the parents of children rather than the children themselves. File reviews demonstrated that social workers worked with parents, offered children the option to speak with the social worker directly and respected the child's choice to speak with the social worker or not.

The Tusla CASP publically available leaflets, which were sent to children and their families, were reviewed by inspectors. While information in leaflets for children and young people was simpler than the leaflets for adults, they were found to be hard to understand and not child friendly. This was acknowledged and addressed by social workers who supplemented the standardised leaflets with phone calls to the child's family.

Inspectors found that the individual vulnerabilities of both children and adults were taken into account by the service. One example of good practice was in the case of a child with a disability, the social worker consulted with the child's clinical psychologist regarding how best to engage and communicate with the child. Inspectors came across a number of examples where when an adult identified they had difficulty reading, social workers changed their communication practices to include reading all written communication to the

adults and encouraging the adult to include a support person in their interactions with the team. Demonstrating a strong commitment by the service to upholding people's rights.

Inspectors questioned if the need for supports for people for whom English was not their first language was being identified and addressed. Publicly available leaflets were available only in English and none of the 37 cases reviewed made reference to the use of interpreters. Inspectors were assured that it was common practice in the area to engage interpreting services whenever needed and it would be seen as a key consideration in ensuring a fair procedure. Management reported that work was ongoing at a national level to translate the CASP information leaflets into other languages. However, the CASP had been in operation for 18 months at the time of the inspection so progress with this action was slow.

While families were communicated with and informed of delays, there were gaps between communication and delays in initiation contact with families which were not in line with the Tusla procedure. There was evidence on file that the CASP team updated children and their families both by phone and in writing. In cases where contact with families was made by a different Tusla team, such as the children-in-care team, this was noted in case notes of consultations between these teams. However, in five of the 17 cases reviewed that related to children, there were gaps and delays in communication. For example a family was written to in November to explain the delays in the case was due to staffing, but the case had been unallocated since June. The reason for such delays were inconsistently documented on file, it was usually clear when the delay was due to staffing shortages, as above, but in some cases the reason for delays was not referenced. In interviews social workers and managers reported that phone calls were used more frequently than letters to communicate with families. They reported that in some cases they were asked not to write to those involved and this is respected by the team. Inspectors found one example of this in the cases reviewed.

The inspection found good child-centred trauma informed practice with regard to gathering information from children. Every effort was made to minimise the number of times a person, especially a child, had to repeat their experience of abuse. Inspectors saw evidence of consultation between Tusla teams and evidence that the age and needs of the child were taken into consideration. This meant that often CASP social workers did not meet children but rather gathered information from transcripts of specialist interviews by the Gardaí or other specialist organisations responsible for interviewing children.

In the year before the inspection the CASP team engaged in information sharing on the procedure within Tusla and with some key external professionals such as the Gardaí and charities who worked directly with children and families and the wider public. They did not engage in raising general public awareness of the CASP. Management reported that there

were early plans in place for a conference with religious bodies regarding safeguarding and child protection, to take place in May 2024. Social workers reported that they responded to queries from the public on a regular basis, providing individualised information rather than general public awareness. Minutes of supervision and team meetings noted that the team were looking for ways to record this work as it was viewed as an integral and valuable part of their role but was not captured systematically.

External professionals reported mixed views of communication with the CASP team. The professionals spoke about good working relationships with the team. However they noted the difference between an allocated and unallocated case reporting that it was hard to get through to someone on the phone but noted that once the case was allocated communication was good. One professional also spoke about the impact of delays in cases progressing talking about an experience of receiving a call about a referral sent in a year before and how it was difficult for them to recall the information after a year.

Children First sets out how disclosures can be made by children or adults about current or past abuse. Information provided by the area before the inspection showed that the allegation assessment team had 151 CASP cases open to the team. 109 of which were retrospective disclosures, while 42 were made by children, some of whom had, since the time of the disclosure, become adults. All disclosures need to be assessed in line with Children First in order to be compliant with standards. There were a further 61 cases held which were referred prior to the introduction of CASP which were outside the scope of this inspection but which were on the team's caseload.

As this inspection was confined to the CASP, a review of the practice in relation to the screening and initial assessment of child protection concerns prior to referral to CASP was not included. However, inspectors found that while information about children on CASP files was limited, there was enough information for inspectors to be satisfied that concerns were being assessed in line with Children First and that the children were safe. Inspectors noted that notification to the Gardaí for cases involving children were timely.

There was evidence that children identified in the course of the substantiation process, as being at potential risk to harm, were referred to duty and intake teams for assessment of the concern. However, as of the final day of the inspection, 51% of the open CASP cases were waiting preliminary enquiry. This meant that the substantiation procedure had yet to begin. Inspectors reviewed a sample of 11 files (seven involving children and four involving adults) on the waiting list for PE and found that the immediate safeguarding risks were being well managed in those cases. Audits had been carried out on four of the files and there was evidence on one file of the duty team being requested to carry out safeguarding work with the alleged abuser when there was no capacity on the CASP team to do so.

When a referral of a retrospective allegation of abuse is received by a duty and intake team, it is transferred to CASP. Delays in this transfer were discussed earlier in the report. The referral is screened to ensure it meets CASP criteria (outlined at the start of the report) before being placed on a waitlist for allocation. Inspectors found that this screening did not consistently happen within one day as set out by Tusla standard business process. In the 18 retrospective cases reviewed by inspectors 11 (61%) had delays at point of screening. These delays ranged from a few days to three months, in one example the referral was received and case was opened in October, screened in November and signed off on by management in December, significantly outside of the timelines recommended.

In the Mid-west area, the responsibility for sending notifications of abuse to an Garda Síochána rested with the duty team in cases where the alleged victim is a child. However, the process was less clear for retrospective abuse cases. Social workers reported that if the notification had not been sent by duty it would be sent by the allocated CASP social worker. Inspectors found in most cases these notifications were completed promptly. However there were two cases identified with significant delays of four and six months from date of referral to date of the completion of the notification. In both cases this was due to a combination of a delay in transferring the case from duty to CASP and a delay in allocation of the case for PE. It was noted that there was no delay in sending the notification once it was allocated to a CASP social worker.

Inspectors found that in general there was good cooperative working and information sharing between An Garda Síochána. Strategy meetings were held between Tusla and the Gardaí. Information was shared and plans of action were developed and agreed and these were recorded and maintained on case files. In some cases An Garda Síochána asked CASP social workers not to make contact with the alleged abuser because of an ongoing criminal investigation. In the cases reviewed by inspectors, where this request was made it was complied with. In the examples reviewed by inspectors the safety of children was paramount and a request in a delay was only made and agreed to when it did not impact on the child. Members of the Gardaí who spoke with inspectors spoke about good, clear lines of communication between themselves and Tulsa and noted that even if a case was unallocated managers were aware of the case and were able to provide updates.

The inspection found that the CASP team considered, as part of the procedure that children may have been subjected to organised and or institutional abuse on a case by case basis. Children who were deemed to be especially vulnerable were appropriately identified and supported. However they were not responded to in a timely manner. The management team was in the process of developing a data base to support the identification of patterns of abuse among cases. Their ability to do so was limited up to the point of the inspection.

Inspectors reviewed the Tusla CASP document and found it did not contain specific information about how to identify and respond to organisational or institutional abuse or how to identify especially vulnerable children. In the absence of this national guidance the local area had developed an interim practice note to support staff, this was circulated to staff in October 2023. Staff and managers demonstrated a good understanding of this document during interviews and focus groups.

Inspectors found evidence of the consideration of possible abuse to other children in the assessment of concerns of abuse involving organisations and institutions. There were examples of good joint working between Tusla, the Gardaí and the institution or organisation in question, in order to reduce the risks within the organisation and identify other potential victims. However, this was not always the case when the allegation was retrospective and inspectors found one example where there was no apparent consideration given to the institutional setting where the abuse took place in the past.

Staff spoke clearly about their role in dealing with each individual case on its own merits for fair procedures and that while organisational abuse was considered for each individual, they did not look for patterns of abuse between cases. Management were in the early stages of establishing a dataset which would allow them to cross reference information that it was not possible to on Tusla's information management system - TCM. In addition TCM did not allow for the reporting on identified vulnerabilities and again this information was being included in the dataset for greater oversight.

Inspectors found delays in progressing the substantiation of allegations of institutional and organisational abuse and in allegations involving children identified as being especially vulnerable due to lack of workforce capacity. Of the 14 cases reviewed which were awaiting allocation to a social worker at PE, stage one or stage two of the process, seven (50%) were identified as involving an especially vulnerable child and or possible institutional or organised abuse. Two of these cases were identified as high priority. These cases were waiting a range of time periods from 35 days to 253 days (over eight months) for their cases to be progressed.

While the significant delays in progression of CASP were found not to impact on the safeguarding of those already identified children, they did impact on the ability of Tusla to act in a timely way to progress safeguarding actions for children not yet identified who may be at risk. Inspectors were also concerned about the emotional impact of the significant wait times on the children and adults involved in the cases as well as its impact on fair procedures. In the year before the inspection only three cases were brought to a final conclusion.

As a result, the CASP was not person centred or child-centred and given the resources required to implement it, the significant time and the low through-put of cases, at a time when there was a staffing crisis within Tusla, the efficiency of the procedure is questionable. Furthermore, it also did not fully address the findings of the 2018 HIQA investigation.

Standard 1.3

Children are communicated with effectively and are provided with information in an accessible format.

This inspection found that the service was child-centred and trauma informed in its approach to communication. Publically available leaflets were not child friendly or easy to understand and only available in English. The team took steps to address this through phone communication. However, there were long gaps and delays in communication that were not in line with the Tusla procedure.

Judgment: Substantially Compliant

Standard 2.5

All reports of child protection concerns are assessed in line with *Children First* and best available evidence.

This inspection was confined to the assessment of allegations of abuse and did not include a review of practice in relation to initial assessments of child protection concerns.
This inspection found there were clear child protection procedures and systems in place to ensure the effective safeguarding of children, identified as potentially being at risk at the time of the CASP report and for children identified during the substantiation process. Child protection concerns were assessed in line with Children First.

Judgment: Compliant

Standard 2.12

The specific circumstances and needs of children subjected to organisational and/or institutional abuse and children who are deemed to be especially vulnerable are identified and responded to.

Inspectors found that needs of especially vulnerable children and those subjected to organisational and or institutional abuse were identified and responded to on an individual

level. However, the service was not in a position to respond promptly to all cases that involved especially vulnerable children or those subjected to organisational abuse. There was close liaison between CASP staff and An Garda Síochána.

Tusla's Child Abuse Substantiation Procedure did not contain specific information about how to identify and respond to organisational or institutional abuse or how to identify especially vulnerable children and the area had developed local practice guidance to support staff.

There were delays at all stages of the CASP procedure for cases involving retrospective abuse but they were dealt with in line with Children First.

Judgment: Substantially Compliant

Compliance Plan for Mid-West OSV – 004401
Inspection ID: MON-0041706

Date of inspection: 05/12/2023

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 regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation 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 or person in charge has generally met the requirements of the regulation 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 or person in charge has not complied with a regulation 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 3.1	**Judgment: 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:

1. An audit is planned to commence before the end of quarter 1, 2024 to review a random sample of all cases allocated and unallocated to examine the timeliness of submissions of notifications to the GNVB and the criteria for same
2. Consideration in case discussions in supervision will be given by CASP SWTL and SW whether there are grounds to submit a specified information notification.
3. A bespoke campaign is underway to recruit for vacant posts to the CASP team.
4. Pending the outcome of the audit, any case awaiting allocation at any stage of the assessment process will be reviewed by the SWTL and PSW to see if a notification is required and if so, the PSW will complete same.

Persons Responsible:

SWTL - CASP, PSW - CASP and General Manager, PSW Performance Support, Midwest HR Manager

Completion:

Action 1 –In progress
Action 2- In progress
Action 3 - In progress

Actions will continue through Q1 2024 and will be formally reviewed at the CASP Governance Group and monitored through the quarterly Area's Service Improvement Plan Review mechanism.

Action:

5. CASP timelines will continue to be monitored by the PSW and General Manager using available performance data on TCM.
6. The timelines for individual actions and CASP timelines will be discussed in supervision between the SWTL and PSW and the rationale for non-adherence will be clearly recorded on case records on TCM, including timeframe extensions agreed as per policy. Timelines will also be reviewed in supervision between the PSW and General Manager. Performance data reviewed at the CASP monthly Governance meetings will include information on non - compliance with timelines.
7. The CASP timelines are currently under review and may be subject to change.

Person Responsible:

SWTL - CASP, PSW - CASP and General Manager, CASP Governance Group

Completion:

Action 5 - Current practice/ongoing
Action 6- In progress
Action 7 - National Action - Review of CASP has commenced and is due to be completed by Q2 2024

All actions will be included in revised Service Improvement Plan for review at end of Q1 2024 and for completion by end Q2 2024.

Standard 3.2	**Judgment: 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.

1. The planned audit described above will examine both screening practices and timeliness of submission of notifications to the GNVB and will assist in the development of a practice learning note to provide further guidance to staff.
2. Notifications to the GNVB will be regularly reviewed by the CASP Governance Group and monitored as part of the CASP Team's revised Service Improvement Plan
3. Notifications to the GNVB will be monitored at the quarterly Child Protection & Welfare Service GM and PSW governance group meetings, as they also apply to Duty and Intake Teams.

Persons Responsible:

SWTL - CASP, PSW - CASP and General Manager professional support, PSW Performance Support, General Manager CP&W

Completion:

Action 1 –In progress
Action 2- In progress
Action 3 - In progress

All actions will be included in revised Service improvement plan for review at end of Q1 2024 and for completion by end Q2 2024.

Standard 1.3	**Judgment: Substantially compliant**

Outline how you are going to come into compliance with Standard 1.3: Children are communicated with effectively and are provided with information in an accessible format.

Action:

1. As indicated above every effort will be made to recruit additional staff to increase capacity within the CASP team to address delays in allocation particularly those involving vulnerable children and to reduce delays in the CASP process.
2. Priorities for allocation will continue to be reviewed weekly by CASP SWTL and PSW and where possible resources from other teams including other CASP teams will be actively considered
3. There will be review by CASP PSW of the implementation of the Standard operating procedure with respect to the letters developed locally by the CASP team to notify service users of delays in allocation and /or delays in the assessment. This will include a review of the timeliness and frequency with which letters are sent out and evidence that communications are routinely uploaded on TCM.
4. The PSW will ensure communication is discussed at every supervision with the SWTL and the rationale for any gaps or delays is clearly recorded during supervision between the SWTL and SW.
5. The means of communication to persons making disclosures and persons subject to abuse allegations will continue to be discussed during supervision to ensure (PMDs) and (PSAAs) are both kept informed of the progress of the assessment as set out in the timelines of CASP and that the information is sensitive to individual needs. This will be recorded and updated on supervision records and on TCM.

6. The PSW will highlight the concerns about the CASP leaflets for children to the National CASP Planning & Development Group with particular reference to the child-friendly nature of same and need for versions of the CASP leaflets in other languages.
7. The CASP team are currently reviewing the most suitable tool kits to be used with children who may have special needs, disabilities, comprehension or language requirements so that they can complement the standard leaflets with tools to meet any gaps. Staff will also attend a webinar on 6th March which will launch the Mid-West Practice tool kit for work with children.
8. There will be a review of the cases that were screened out by CASP staff as not meeting the threshold as a complaint and which were not included in the complaints log to ensure compliance with the Tell US policy and to ensure that user feedback is not missed

Person Responsible:

CASP social Worker, CASP Social Work Team Leader and CASP PSW. General Manager, WLD National CASP Planning and Development Group- (Feedback re leaflets)

Completion:

Action 1- In progress
Action 2- In progress
Action 3 - in progress
Action 4 - in progress
Action 5 – in progress
Action 6 - in progress
action 7 – in progress
Action 8 – completed.

All actions will be included in revised Service improvement plan for review at end of Q1 2024 and for completion by end Q2 2024.

Standard 2.12	**Judgment: Substantially compliant**

Outline how you are going to come into compliance with Standard 2.12: The specific circumstances and needs of children subjected to organisational and/or institutional abuse and children who are deemed to be especially vulnerable are identified and responded to.

Action

1. Liaison between CASP PSW and PSW's for Duty/Intake teams will continue to ensure a timelier response to the screening of retrospective abuse cases and the transfer to CASP.

2. Timelines for screening will be reviewed and monitored through the quarterly Child Protection and Welfare GM/PSW Governance Group meetings and at the CASP Governance Group where the General Manager for child protection and welfare is also a member**.**
3. The Mid-West Interim Practice Note: Guidance on identifying and managing risk associated with allegations of child abuse in organised or institutional settings will be reviewed to ensure that all referrals involving retrospective abuse where possible institutional or organisational abuse has been considered is noted on file even where this has been ruled out.

Person responsible:
CASP PSW, Duty & Intake PSW'S, CP&W GM, CASP SWTL

Completion:
Action 1- In progress
Action 2- In progress
Action 3 - in progress

All actions will be included in the revised Service improvement plan for review at end of Q1 2024 and for completion by end Q2 2024.

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	Not compliant		30.4.2024 (National group review Q2 2024)

	policies and standards to protect children and promote their welfare.			
Standard 3.2	Children receive a child protection and welfare service, which has effective leadership, governance and management arrangements with clear lines of accountability.	Substantially compliant		29.3.2024
Standard 1.3	Children are communicated with effectively and are provided with information in an accessible format.	Substantially compliant		29.3.2024
Standard 2.12	The specific circumstances and needs of children subjected to organisational and/or institutional abuse and children who are deemed to be especially vulnerable are identified and responded to.	Substantially Compliant		29.3.2024

SIGNED: Aisling O'Neill **Date:** 21.02.2024

Provider

Aisling O'Neill

Midwest Area Manager