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

Health Information and Quality Authority Regulation Directorate monitoring inspection of Foster Care Services

Name of service area:	Dublin South Central
Type of inspection:	Focused
Date of inspection:	20-23 October 2025
Lead inspector:	Saragh McGarrigle
Support inspector(s):	Adekunle Oladejo Catherine Linehan Hazel Hanrahan Nicola Rossiter Rachel Kane
Fieldwork ID	MON-0047662

About this inspection

The Health Information and Quality Authority (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.

HIQA is authorised by the Minister for Children, Disability and Equality under Section 69 of the Child Care Act, 1991 as amended by Section 26 of the Child Care (Amendment) Act 2011 to inspect foster care services provided by the Child and Family Agency (Tusla)[1] and to report on its findings to the Minister.

HIQA monitors the performance of the Child and Family Agency against the National Standards for foster care and advises the Minister and the Child and Family Agency.

In September 2023, HIQA developed a specific risk-based monitoring programme of inspections to examine Tusla's governance arrangements in child protection and welfare and foster care services. The inspections focused on services where 25% or more of children did not have an allocated social worker. The purpose of the risk-based monitoring programme was to assess the effectiveness of the provider's governance arrangements in the management of unallocated cases, so as to support the delivery of a timely, safe and effective service for children and families. The programme aimed to establish how effective national governance arrangements were being implemented at local and regional level. It also aimed to improve compliance against the *National Foster Care Standards* (2003) and reduce waiting lists for children. The monitoring programme included onsite inspections and monthly meetings with nominated representatives of Tusla's executive team.

In response to HIQA's inspection programme, Tusla developed a national service improvement plan for child protection and welfare and foster care services (unallocated cases).

HIQA completed 10 inspections of Tusla services between February and April 2024. A single report of the findings across all 10 inspections was published on HIQA's website in January 2025. This *'Overview Report on the Governance of the Child and Family Agency (Tusla) Child Protection and Welfare and Foster Care Services'* can be found on the HIQA website.

[1] Tusla was established on 1 January 2014 under the *Child and Family Agency Act 2013.*

This inspection was a focused inspection to assess the progress made in relation to the actions identified to address non-compliances during the previous HIQA inspection in February 2024. The key issues that were followed up in this inspection, were as follows:

- the children in care service was not adequately resourced to ensure all children had an allocated social worker. There were not enough staffing resources to ensure a consistent service for all children in foster care. There were 12 cases dual-unallocated; this meant that both child and foster care did not have an allocated social worker to coordinate the child's care
- lack of adherence to some of Tusla policies and procedures as well as to the *National Standards for Foster Care* (2003). For example, social care staff were completing statutory visits instead of social workers, safeguarding visits were being inappropriately recorded as statutory visits and there was a lack of adherence to the Tusla national policy for transfers to other service areas.
- There were delays in child-in-care reviews and care plans were not recorded on children's files.

The Dublin South Central foster care inspection in 2024, found that the service was stretched beyond its capacity and the contingency plan in place had limited impact. The service area required a national response to ensure a safe and quality service was provided to children. Following the inspection the risks in relation to safeguarding visits and the dual unallocated cases were escalated to the regional chief officer and satisfactory assurances were provided to HIQA. It is also important to note that there was good practice found during the 2024 inspection in particular to child protection and welfare concerns and allegations against foster carers, in which the service was managing them in line with national policy.

Prior to the 2025 inspection, the service area submitted a self-assessment questionnaire (SAQ) of its performance against the five selected standards. Local managers rated their performance as substantially compliant in all five standards. The SAQ provided analysis of organisational priorities and areas of practice they were working to continually improve which will be further commented on in this report.

This inspection found that there had been improvement in Dublin South Central foster care service since the last HIQA inspection in 2024. This was in particular to standard five where, at the time of the inspection in 2024, 31% of children in foster care did not have a social worker allocated to their case. This inspection found this reduced to 15% of children in foster care without an allocated social worker. In addition, this inspection found that there were no dual unallocated cases. This was a notable improvement since the last inspection; however children in the service

remained unallocated to a social worker and this is not in line with the National Standards for Foster Care (2003).

However, the service continued to struggle to adhere to Tusla national policies and procedures, due to staffing resources being stretched and there were improvements needed in monitoring and oversight particularly with regard to safeguarding referrals and case management. This is discussed further under standard 10 and 19. This inspection also identified limited progress in respect to compliance with standard 7 and 18.

How we inspect

As part of this inspection, inspectors met with the relevant managers, child care professionals and with foster carers. 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 submitted by the area
- the review of local policies and procedures, minutes of various meetings, staff supervision files, audits and service plans
- the areas self-assessment questionnaire
- interviews with:
    - the area manager
    - the Tusla case management system (TCM) user liaison officer and childcare information officer
- focus groups with:
    - three principal social workers (PSW), one for children in care, one for children in care and aftercare, and one for fostering service
    - eight social workers
    - four foster carers
- observation of:
    - child-in-care review meeting
    - active on duty system for children in foster care
- conversations with:
    - a sample of four children and seven foster carers.
- the review of 48 children's case files

The aim of the inspection was to assess compliance with national standards of the service delivered to children who are referred to the foster care service.

Acknowledgements
HIQA wishes to thank parents, children, foster carers and external stakeholders that spoke with inspectors during the course of this inspection, along with 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, Disability and Equality. 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 protection and welfare services;
- Educational welfare services;
- Psychological services;
- Alternative care;
- Family and locally-based community supports;
- Early year's 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 (RCO). The regional chief officers report to the National Director of Services and Integration, who is a member of the executive management team.

Foster care services provided by Tusla are inspected by HIQA in each of the 17 Tusla service areas. Tusla also places children in privately-run foster care agencies and has specific responsibility for the quality of care these children in privately-provided services receive.

Service area

The information in this section of the report was provided by the service area for inclusion in the report.

Dublin South Central (DSC) is situated in Leinster, on the east coast of Ireland and part of the south-eastern side of Dublin. It is one of the 17 national service areas and

is part of the Dublin Mid-Leinster (DML) Region. Dublin South Central is located in the Dublin City Council and South County Dublin areas south of the river Liffey comprising of the South Inner City, Ringsend, Rialto, Inchicore, Rathmines, Rathfarnham, Rathgar, Terenure, Whitechurch, Palmerstown, Ballyfermot, Clondalkin, and Lucan. Newcastle, Rathcoole and Saggart.

It is a small and densely populated geographical area with distances of 25 kms from coast to the furthest point inland. The total population (Census 2022) of Dublin South Central is 305,278. The population of children is 73,730 which has increased from 65,564 since the previous census in 2016.

The area reflects a mixture of urban and suburban characteristic with a mix of social housing, private rentals, and gentrified propriety combined with established and new housing developments. There is evidence of significant population growth with areas such as Lucan, Saggart and southwest Dublin having significant increase between censuses. This growth is forecast to continue given the numerous planned developments including several large-scale Land Development Agency developments. The deprivation index (2023) indicated that the areas in DSC are between -22.5 in Clondalkin (Rowlagh) to 15.73 in the City centre (Usher Quay). Overall, the area displays high levels of deprivation with 13 electoral districts at various levels of disadvantages with the Small Areas (SAs) revealing more detailed information with very and extremely disadvantaged areas in Ronanstown, Collinstown, part of Ballyfermot and the Southwest Inner City.

Dublin South Central has a highly diverse population with 30% of population living in Dublin Central South having not been born in Ireland and 25% belong to ethnic minority groups. While this may be indicative of the urban population, similarly such diversity can be seen in the south-western suburbs of Clondalkin and Lucan.

As off the beginning of 2025, DSC had one International Protection Accommodation Service (IPAS) and 14 Emergency Accommodation Centre accommodating approximately 832 children. The area also contains several HUBs that support homeless families. Overall DSC could be characterised as an area balancing suburban expansion, urban renewal and persistent socioeconomic divides.

From the data provided by Dublin South Central service area prior to the inspection, there were 150 foster care households in the area. The service had no available general foster care placements, though there was five respite foster care placements available. In the twelve months prior to this inspection, there were 17 allegations made against foster carers. No allegation was upheld during the same period, though, at the time of the inspection, a number were still in process. Six foster carers left the panel voluntarily, in the 12 months prior to this inspection and there were no foster carers removed from the panel during the same period. The area had 12 foster

carers approved in the twelve months prior to this inspection, as result of the most recent recruitment campaign.

At the time of this inspection, the area had a total of 274 children in foster care. The service had placed 84 (31%) of these children in a relative foster care placements, and the remaining 190 (69%) children were placed in general foster care. The service was reliant on private foster care placements as 45% of the children in general foster care were placed in private foster care. At the time of the inspection, 201 foster care placements were outside the area. There were 24 children waiting for a foster care placement, and 11 of these had been waiting for more than three months.

The data provided outlined that 232 children were allocated to a social worker and a further three children were allocated to a social work team leader. Of the 42 children who were not allocated to a professionally qualified social worker, 12 were allocated to social care leaders. Twenty seven children had no allocated worker, they were instead managed by the active on duty team. Within the active on duty team, there was one senior practitioner social worker and three social workers, and they are managed by a social work team leader. All active on duty team members were allocated low priority cases to allow them to provide a service to children who were not allocated a social worker. The active on duty had a system in place whereby, children and families had the same worker dealing with their case on a consistent basis. Work completed by the active on duty team included statutory visits, child-in-care reviews and funding requests. There was a governance structure in place whereby fortnightly governance meetings reviews cases that are unallocated. At the time of the inspection, there was no dual unallocated[2] cases.

Compliance classifications

HIQA will judge 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.

[2] Refers to foster care households where both the foster carer and the child or young person in placement with them do not have an allocated social worker

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.

This inspection report sets out the findings of a monitoring inspection against the following standards:

National Standards for Foster Care		**Judgment**
Standard 5	The child and family social worker	Substantially compliant
Standard 7	Care planning and review	Substantially compliant
Standard 10	Safeguarding and child protection	Substantially compliant
Standard 18	Effective policies	Substantially compliant
Standard 19	Management and monitoring of foster care services	Not compliant

This inspection was carried out during the following times:

Date	Times of inspection	Inspector name	Role
20 October 2025	09:00hrs to 17:00hrs	Saragh McGarrigle	Inspector
	09:00hrs to 17:00hrs	Adekunle Oladejo	Inspector
	11:30hrs to 17:00hrs	Catherine Linehan	Inspector
	10:30hrs to 17:00hrs	Hazel Hanrahan	Inspector
	09:00hrs to 17:00hrs	Nicola Rossiter	Inspector
	09:00hrs to 17:00hrs	Rachel Kane	Inspector
21 October 2025	09:00hrs to 17:00hrs	Saragh McGarrigle	Inspector
	09:00hrs to 17:00hrs	Adekunle Oladejo	Inspector
	09:00hrs to 17:00hrs	Catherine Linehan	Inspector
	09:00hrs to 17:00hrs	Hazel Hanrahan	Inspector
	09:00hrs to 17:00hrs	Nicola Rossiter	Inspector
	09:00hrs to 17:00hrs	Rachel Kane	Inspector
22 October 2025	09:00hrs to 17:00hrs	Saragh McGarrigle	Inspector
	09:00hrs to 17:00hrs	Adekunle Oladejo	Inspector
	09:00hrs to 17:00hrs	Catherine Linehan	Inspector
	09:00hrs to 17:00hrs	Hazel Hanrahan	Inspector
	09:00hrs to 17:00hrs	Nicola Rossiter	Inspector
	09:00hrs to 17:00hrs	Rachel Kane	Inspector
23 October 2025	09:00hrs to 17:30hrs	Saragh McGarrigle	Inspector
	09:00hrs to 17:00hrs	Adekunle Oladejo	Inspector
	09:00hrs to 14:30hrs	Catherine Linehan	Inspector
	09:00hrs to 15:00hrs	Hazel Hanrahan	Inspector
	09:00hrs to 17:00hrs	Nicola Rossiter	Inspector
	09:00hrs to 17:30hrs	Rachel Kane	Inspector

Children's experience of the service

Children's experiences were established through speaking with a sample of four children, 11 foster carers, and 14 professionals. A sample of parents of children in foster care were offered the opportunity to engage with inspectors, however no parents were available to talk to inspectors during this inspection. The review of case files, minutes of various meetings, staff supervision files, policies and procedures, audits and service plans, also provided evidence on the experience of children in foster care.

This inspection found that, although not all children were allocated a social worker, there were systems in place to ensure children without a social worker still received a service. From talking to children and foster carers, as well as reviewing children's files, inspectors could see that the service provided to children in foster care was not dependent on a social worker being allocated to the child.

Of the four children who spoke with inspectors, one had an allocated social worker, two were managed by the active on duty team, and one had a social care leader allocated to them. Children told inspectors that they had regular contact with Tusla staff, and one of the children said they 'ask me if there's anything I need'. However, one child highlighted that they had experienced months without regular contact with Tusla staff and found "[the social worker] was slow at getting things done". However, they said things had improved in the months prior to the inspection, as they had more regular contact with Tusla staff and stated "things are fine now". When asked if they had advice for Tusla staff, one child stated 'visit when you can and stay in touch".

A review of files showed that while statutory visits were not always in line with the *National Standards for Foster Care* (2003), Tusla staff regularly undertook other types of contact with children, such as safeguarding visits or they supported access visits between children in foster care and their families.

For the most part, children's views were represented in child-in-care reviews, even when children did not attend their reviews. One of the four children said they attended their child-in-care reviews. They told inspectors that at the reviews they were asked 'do I want to say anything' and they said they saw their care plans and were 'happy with them'. In contrast, another child said they did not remember being asked to give their views for their child-in-care reviews, but they said they were going to attend their upcoming child-in-care review. Some foster carers said that children in their care were not interested in attending their child-in-care reviews and believed this was due to them being in settled long-term placements. Foster carers said that Tusla staff consulted with children in advance of child-in-care reviews, and used child friendly review forms to complete this work. Inspectors noted that children's records showed that, for the most part, Tusla staff met with children to seek their views, and these were recorded in review meeting records and care plans. Where children were too young to voice their views Tusla staff recorded observations of how children interacted with their foster carers in child-in-care review records. In some files there was also records of Tusla staff talking to children about decisions made at child-in-care reviews. Most foster carers said they received a copy of the care plans in the weeks after the child-in-care reviews, by registered post, though one foster carer stated they did not always get a copy of the care plan.

The complaints process was explained to children. One of the children who spoke with inspectors confirmed they knew how to make a complaint, while another child outlined that a social worker recently explained the process to them. Foster carers told inspectors that they had observed Tusla staff, when they visited, explaining the complaints process to children. Inspectors saw from case records, that Tusla staff explained to children how to make complaints.

Foster carers were positive about the services children received, whether or not they had an allocated social worker. Of the 11 foster carers who spoke to inspectors, nine had children in their care who did not have an allocated social worker. These children were either assigned a social care leader or were managed on the active on duty team. From what foster carers told inspectors, the service provided to children in their care was not dependent on the child having an allocated social worker. Foster carers reported that Tusla staff worked hard to provide a good service to the children in foster care. Foster carers said that the children in their care had their needs met despite not having an allocated social worker to coordinate their care. Foster carers said they believed the most important thing for children was having the same consistent worker, and this was more important than the staff title or grade. Foster carers told inspectors that social care leaders and social workers on the active on duty team worked closely with them and the children to support the placements.

- "[They] had no concerns with the arrangement..."
- "excellent communication and relationship"
- "always available" and "a good support, they were brilliant"
- 'carried on as normal, [social worker, active on duty team] touches base regularly'

It was clear from the way foster carers spoke about the children in their care that they cared deeply for them and worked to support children to achieve their full potential. For example, one foster carer spoke with pride about educational achievements of their foster child. Foster carers attended child-in-care reviews and advocated for the needs of the children in their care.

Children's parents attended child-in-care reviews where appropriate. In some of the cases reviewed, parents had contact with their children in foster care and attended child-in-care reviews. While in other cases, parents were not in contact with their children or Tusla staff. There were cases where ongoing efforts were made to encourage parents to remain involved, for example, a child-in-care review was rescheduled a number of times in an effort to support parents to attend. However, in other cases, where there was a record that parents were not engaged with Tusla, there was no record of efforts made or a plan to try to engage parents. When parents attended, their views were sought and were recorded in the child-in-care-review meetings records.

From speaking to social workers and social care leaders, inspectors could see that they had a good understanding of the needs of the children they were assigned to and worked to meet these needs, as recorded on care plans, so that their foster placements were stable and children could reach their full potential. From talking to staff and review of a sample of files, inspectors saw examples of good practice in respect to staff engaging with and supporting children, such as bringing them on outings to parks or cafes which allowed for longer discussions on topics such as self-care and skills development to stay safe. Where children were too young to talk or had communication difficulties, Tusla staff ensured they captured their views through observations. Tusla staff attended training on communicating with children with disabilities, and spoke about the importance of seeking advice and support on how to communicate effectively from other professionals working with these children.

While not all children were allocated a social worker, in line with the *National Standards for Foster Care* (2003), all children received a service from Tusla staff. For the most part, children had regular contact with Tusla staff and their views were represented at child-in-care reviews. While there was some indicators that Tusla staff tried to keep parents engaged with their children and Tusla, this was not always consistent. Tusla staff demonstrated that they had a good understanding of the needs of the children assigned to them and worked to follow through on actions agreed in their care plans.

Summary of inspection findings

Tusla has the legal responsibility to promote the welfare of children who are not receiving adequate care and protection. Children in foster care require a high-quality service which is safe and well-supported by social workers. Foster carers must be able to provide children with warm and nurturing relationships in order for them to achieve positive outcomes. Services must be well governed in order to produce these outcomes consistently.

This report reflects the findings of a focused inspection of Dublin South Central foster care service, which looked at the allocation of social workers to coordinate the care of children in foster care. In addition to this, the inspection focused on the care planning process, including the participation of children and their family in the preparation of the child's care plan and the child-in-care reviews. The inspection also assessed how children are protected and safeguarded from abuse and that the governance and management structures in place support delivery of a consistent high quality, safe and effective foster care service.

In this inspection, HIQA found that, of the five national standards assessed:

- four standards were substantially compliant
- one standard was not compliant.

Following the inspection, two systems risks in respect to case management oversight and the tracking and monitoring of allegations made against foster carers were escalated to the area manager. Two individual cases were also escalated, one was an allegation which had not been assessed effectively and there was delay in sending a Garda notification to An Garda Síochána. The second case was an allegation against a foster carer which was not being tracked and assurances were sought in respect to management oversight of this case. Satisfactory assurances were received for both the systems risks and the individual cases escalated to the area manager.

The 2025 inspection found that there had been improvement in Dublin South Central foster care service since the last HIQA inspection. The notable improvements were that the number of children without an allocated social worker had reduced. In 2024, there were 102 (31%) children without a social worker; however at the time of this inspection there were 42 (15%) children not allocated to a social worker. In addition, there were no dual unallocated cases, Accurate record keeping had been identified as an area in need of improvement in the last inspection, and this inspection found that improvements had been made, though there were some delays of a few weeks with updating children's case records or uploading care plans.

The national compliance plan had limited impact on the foster care service in this service area. The national compliance plan included an action to allocate an additional 50 positions, in line with the resource allocation analysis and planning framework, in the first quarter of 2025, to increase capacity in areas where resources are most required to address unallocated cases. At the time of the inspection, no additional resources had been allocated to this service. The foster care service remained challenged due to capacity issues and this continued to challenge the service's capabilities to effectively address gaps, fulfil all its statutory obligations and drive quality improvements. While nearly all staff vacancies had been filled at the time of this inspection, four vacancies on the children-in-care team remained; this included one team leader, two senior practitioner social workers and one social care worker. The management advised that data analysis showed that even with a full staff compliment, there would still not be adequate staffing to meet demands on the service, including the foster care service. Hence, the management response to this was to ensure all children in foster care had a worker and that they were in receipt of a service. The foster care service had arrangements in place for children who were not allocated to a social worker. These children either had a social care leader allocated to their case or were managed by the active on duty team.

The majority of children in foster care in Dublin South Central, had their care plans reviewed and updated in line with the national standards. Care plans and child-in-care review records sampled by inspectors were of good quality and demonstrated that children and their families, where appropriate, were involved and part of the process. The majority of child-in-care reviews were held at the required frequency, or within a few weeks of statutory requirements. However, there were a small number of cases where there were delays of between three and nine months. These delays did not impact on services being provided to these children. Placement plans, on the whole, were not updated in line with care plans. Instead the practice was for a placement plan to be developed at the start of every new placement, with no further updates.

Most child protection and welfare referrals were processed in line with Tusla guidance and policy in recent months. This included the majority of child welfare concerns about children-in-care. Children in foster care who required a safety plan had one in place, and these were monitored appropriately. However, the inspection found that there were gaps in managing some child protection and welfare concerns and there were also gaps in the system of oversight for the management of allegations against foster carers. These issues were a new concern since in the 2024 HIQA inspection. While the majority of Garda notifications were completed in a timely manner, there were delays of more than a month in three cases. Some children were in foster placements where the number of children placed exceeded the number as set out in the national standards[3]. From the cases sampled, there were no risks found in these placements. However, due to the lack of placements in the area, there was a potential risk that children would continue to be placed in foster care placements that were over numbers.

The service had clear up-to-date policies, procedures and guidance documents in place. The local service improvement plan was aligned with the three year strategic plan for fostering in Tusla and Tusla's national compliance plan for foster care. The service had identified a need for further guidance documents that both aligned with and supplemented national and regional guidance. These documents supported staff and aided in providing consistent service to children and families. However, some policies and procedures were not always fully implemented or local practice meant that the service did not always fully comply with statutory regulations and the national standards. The 2024 inspection found that Tusla's national transfer policy was not implemented. The 2025 inspection found that case transfers were paused until January 2026, as part of the reform programme and establishment of the new Tusla networks.

The oversight and management of the service needed strengthening to ensure children in foster care received a service in line with the national standards and to ensure there were effective oversight mechanisms with regard to child protection and safeguarding of children. The service was unable to provide a foster care placement to all children who required alternative care. While there had been progress in reducing the number of unallocated children there were still children without an allocated social worker, some for a number of years. Some of the impact of this on children was mitigated by the measures in place for all children without a social worker. Such measures ensured that all children in the foster care received a service, and efforts were made to ensure children had a consistent worker assigned to their case, so staff could develop trusting relationship with the children in this service. This was an improvement since 2024 as all children

[3] The national standards for foster care (2003) stated that generally no more than two children are placed in the same foster home at any one time, except in the case of sibling groups and these are not placed with other fostered children.

without a social worker were provided with a foster care service. At a national level, Tusla's allocation of adequate staffing resources to Dublin South Central had not been addressed. There were measures in place such as the area completed business cases for additional resources and prioritised high priority referrals and court work, as well as support for staff.

Standard 5: The child and family social worker

There is a designated social worker for each child and young person in foster care.

The Self-assessment questionnaire (SAQ), submitted by the area management team, judged the service to be substantially compliant with this standard. Inspectors agreed with this judgment.

This inspection found that Dublin South Central foster care service remained challenged and could not ensure that every child in foster care was allocated a social worker, as required by the *National Standards for Foster Care* (2003). Statutory visits, child in care reviews and updated care plans were not always at the frequency required by national standards and in line with regulatory requirements. However, there was improvement since the last inspection, as there were fewer children without an allocated social worker and the arrangements in place for children not allocated to a social worker ensured they received an adequate service. Similar to last year's inspection, inspectors found that children and their families were supported to participate in decisions about their care and the care planning process, there were good quality assessments and good co-ordination of children's care.

There was a limited impact of the national compliance plan for foster care in Dublin South Central foster care service. Following the 2024 HIQA inspections, Tusla's senior management team submitted a national compliance plan for foster care services which set out actions they intended to take to address deficits found during the risk-based monitoring programme in 2024. One of the compliance plan actions under standard five was to allocate additional resources, including staff, to increase capacity in service areas where resources were most required to address unallocated cases. The area management team advised that Dublin South Central had not been allocated any additional staff, this was despite a business case being made for additional resources in January 2025, and staffing shortage remaining on the area's risk register. As the service had filled existing staff vacancies, there were less children in foster care unallocated to a social worker. The area manager advised inspectors that even with a full staff complement, they do not have enough resources to sustain all children in care being allocated a social worker. The area was upskilling some of its existing staff team through an apprenticeship scheme which incorporates paid work experience with completing a master's

degree in social work. At the time of the inspection, ten staff were undergoing this apprentice scheme. While this is a positive development, the impact of this scheme has yet to be felt, given the duration of the programme, it will be 2027 before these staff members will be qualified. The area also ensured that children in foster care were in receipt of a service through the active on duty system.

The national standards for foster care place a duty on Tusla to allocate a social worker to a child as soon as the need for an admission to care is identified and for as long as they remain in care. The child's social worker is a key person in the child's life as they have responsibility for developing a relationship with the child, visiting the child and managing and coordinating their care. The child's social worker has responsibility to ensure that the child has an up-to-date care plan and that their care plan is regularly reviewed, updated and implemented.

As previously note, the HIQA inspection in 2024, found that 31% of children (102 children) in foster care did not have an allocated social worker. Furthermore, 4% of children (12 children), were dual unallocated. At the time of this inspection, 15% of children (42 children) in foster care were not allocated to a social worker, and there were no dual unallocated cases. Inspectors found that, on the whole, there were measures in place for children who did not have an allocated social worker. Out of the 42 children not allocated a social worker, 12 were allocated to social care leaders, three were allocated to a social work team leader, and the remaining 27 children's cases were managed through the active on duty social work team.

Some children who were not allocated to a social worker were allocated to social care leaders and they received a good quality service. However, statutory visits for all these children were not in line with regulations. A finding from last year's report was that visits undertaken by social care leaders were incorrectly recorded as statutory visits. This inspection found that visits completed by social care leaders were recorded as 'safeguarding visits'. Inspectors found that these visits were undertaken in a similar manner to statutory visits, in that the frequency was in line with the frequency required for statutory visits, included seeing children on their own and clear records of the visits were maintained. While the alternative arrangements put in place to ensure children were visited were not in line with the requirement that a social worker complete statutory visits, this did not pose a risk to children.

The active on duty system was effective in ensuring children who did not have an allocated social worker received a service. The active on duty system was in place to fulfil the statutory requirements of the social work service under this standard and ensure that while children were not allocated a social worker, they were visited by a social worker from the active on duty team as required. The criteria

for receiving the active on duty service had improved since the inspection in 2024; the service was provided to every child that had no allocated worker, instead of just those who had been unallocated for a period of two years or more, as per the finding in the 2024 HIQA inspection. The team was managed by a social work team leader, and had three qualified social workers and one senior social work practitioner. Those on the team held a mostly low priority caseload, which allowed them to do additional work as required. Efforts were made to have a consistent worker from the team for each unallocated case. There was an effective oversight structure in place which included fortnightly governance meetings, chaired by a principal social worker, which meant that, on average, every unallocated child's case was reviewed every eight weeks.

Regulations outlined that children are to be visited in their foster home by their social worker within the first month of placement, at least every three months for the first two years of placement and at intervals not exceeding six months thereafter.

Inspectors reviewed the statutory visits for six children managed through the active on duty system. They found, on the whole, these children's statutory visits were in line with regulations and standards, and they were of good quality, with children being met with on their own. In three of the cases reviewed statutory visits were completed in line with the regulations. In three cases there were delays ranging from a few weeks to four months but a clear rationale was recorded for this on the files. Inspectors spoke to some foster carers whose children were on the active on duty system and they all said the children in their care received a good service.

Children allocated to social care leaders, did not have statutory visits completed in line with the national standards. However, safeguarding visits were completed by social care leaders in lieu of statutory visits, which lessoned the risk posed by not having regular statutory visits, albeit not in line with national standards. Inspectors found the records of these visits to be of good quality, undertaken in line with statutory visits guidelines, including meeting with the child on their own. Six of the cases reviewed for statutory visits were held by social care leaders. Two of these had statutory visits completed by social workers were in line with the national standards. The other four either had safeguarding visits completed at the frequency required for statutory visits or had a mix of statutory visits and safeguarding visits completed.

Data provided by the service in advance of the inspection showed that 39 children had been unallocated for more than three months. Records reviewed by inspectors showed that some children were unallocated to a social worker for lengthy periods of time, a number were unallocated over a year and one was unallocated for two

years. While this meant that service was not in line with national standards, children were still receiving a service.

Overall, children who were allocated to a social worker also received a good service, as social workers ensured children received appropriate assessments and support. Of the 16 allocated cases where inspectors reviewed statutory visits, all but five were within or very close to the correct timeframes. Two of the cases had recorded a rationale for delays in statutory visits and three cases had not. Two cases had a gap of twelve months between statutory visits, and one of these subsequently had a placement breakdown. The gap between statutory visits meant that the social worker was not up-to-date on the progress of the placement The other case was identified in an audit and a statutory visit was completed within a few weeks. Of the case files sampled, children's files were up-to-date, with the exception of some delays in the sign off from management for some documents. Assessments and supports were put in place as required, including good work noted in cases where children had disabilities.

Some delays, of a few weeks were noted in uploading care plans after child-in-care reviews. From the cases reviewed, there was no difference in terms of quality of work recorded between children who were allocated and children not allocated to social workers. The majority of case files reviewed showed that statutory visits were completed in line with, or close to in line with the national standards. However, some were not in line with the standards. Of the 26 case files reviewed to see if statutory visits were in line with the standards, the majority, 17 were in line or very close to in line. Four of the nine that were not in line, had safeguarding visits completed which followed the same approach and frequency of statutory visits and the remaining five had one statutory visit in the last 12 months. Inspectors noted that, while statutory visits were not at the frequency required by regulations, children were being seen by other Tusla professionals in their placements. Three of the cases that had delays in the frequency of statutory visits were allocated to social workers, while of the seven cases managed by the active on duty team, five were in line with regulations and the other two had some delays in statutory visits.

Children's needs were effectively assessed and supports were put in place as needed. Children's case records showed that, when required specialist services were actively involved in care planning for children. Care plans and reviews, statutory visits and safeguarding visits records gave detailed descriptions of the child's assessed needs under a range of domains including education, or training, health, identity, personal development, family and social relationships, contact arrangements and complaints. Children's views and wishes were clearly outlined with an appropriate plan in place as to how these needs were to be met.

Significant events were effectively managed in a child-centred manner, irrespective of the grade of the case allocated worker. A timely response was provided and the child's welfare was promoted. Children's absence management plans were reviewed and followed in circumstances where children went missing.

Social workers and social care staff worked in partnership with families and foster carers to ensure that children were facilitated to keep in contact with their parents and siblings, when this was in their best interests.

Children were aware of the complaints process. Some of the children who spoke to inspectors said they knew how to make complaints. Foster carers told inspectors that social workers and social care leaders, during visits, explained to children how to make a compliant. Inspectors reviewed records of visits undertaken with children by social workers and social care leaders, which included informing children about how to make a compliant.

The service area was not able to allocate a social worker to all children in foster care. While, on the whole, all children's care needs were co-ordinated by a worker, it is a requirement of this standard that it is a social workers role to undertake this work with children and families. This includes but is not limited to visiting children, keeping up-to-date records, arranging assessments as well as other requirements of the standard. Children allocated to social care leaders did not have statutory visits completed in line with national standards. Further to this, although there were improvements in respect to the percentage of unallocated cases since the 2024 inspection; there was a limited impact in this area with regards Tusla's national compliance plan for foster care and children in this service (15%) remained without a social worker allocated to them. Therefore this standard is judged substantially compliant.

Judgment: Substantially compliant

Standard 7: Care planning and review

Each child and young person in foster care has a written care plan. The child or young person and his or her family participate in the preparation of the care plan.

In the self-assessment questionnaire (SAQ) submitted for the inspection, the area management team judged the service to be substantially compliant with this standard. Inspectors agreed with this judgment.

The previous HIQA inspection in 2024, found that there were up-to-date and comprehensive care plans for the majority of children. There were some delays in child-in-care reviews, though this did not impact on children receiving a service. Social work team leader's oversight and sign off of care plans and child-in-care

review records were often delayed. In addition, the 2024 inspection found that there was a need for increased supports for placements that were at risk.

This inspection found some improvements; however some of the areas of improvement from the 2024 HIQA inspection remained. This was particularly in respect to delays in child-in-care reviews. The inspectors found on this inspection that the majority of children, in foster care in Dublin South Central, had their care plans reviewed and updated in line with national standards. Care plans and child-in-care review records were of good quality and demonstrated that the children's views and their family's views, where appropriate, were documented, and that they were involved in the care planning process. There were, however some delays in reviews sampled by inspectors, and where significant delays happened, most cases had clear explanatory notes on the file. The majority of placement plans were not updated in line with care plans. Instead the practice was for a placement plan to be developed at the start of every new placement, with no further updates; therefore some placement plans were out of date and not consistent with updated care plans. While this was not in line with the *National Standards for Foster Care* (2003), inspectors did not identify an impact to children in their placements.

The service had strengthened staff skills to ensure good engagement with children and that their child-in-care reviews and care plans were completed to a good standard. The actions on the national compliance plan under standard seven included learning event workshops to improve compliance with care planning standards. Dublin South Central had a number of initiatives in place to develop and strengthen staff skills, particularly to support new staff to develop skills and complete child-in-care reviews and care plans to a good standard. These initiatives included training events including workshops on understanding the impact of trauma on children and using it in day-to-day practice, skills development workshops on rapport building and talking to children, as well as a workshop on interviewing children about allegations. In addition, the area had strengthened its induction programme for new staff, with a particular focus on supporting staff who had not worked previously in Ireland. These actions supported staff in their work with planning and completing child-in care reviews and care plans as well as implementing these plans.

Dublin South Central service had strengthened staff's responses to children with additional needs. Tusla's national compliance plan for foster care included an action to consider the additional needs for children in foster care through the completion of a gap analysis of service provision of children in care with disabilities. The Dublin South Central service had completed an audit and identified the need for additional guidance for staff working with children with disabilities.

The service had developed a comprehensive guide on working with children with a disability. There was also a practice memo to support staff to apply for funding for assessments and additional supports, as identified in children's care plans.

The area had a local service improvement plan in place and this had a number of actions in place to ensure effective care planning and review. This included a review of the active on duty system, and a review to identify the reasons why care plans were not up-to-date across the service. Actions had been completed for both these, and improvements were noted during this inspection as highlighted.

During this inspection inspectors found that, for the majority of cases, children had up-to-date comprehensive care plans in place. However, there were gaps in timely sign off by social work team leaders. For most these gaps were no longer than a few weeks, though for a small number the gaps were for a few months. This meant that children and their families did not receive an approved care plan in a timely manner. However, the gap in sign off did not prevent actions being taken following child-in-care reviews. The service was working to increase business support to ensure child-in-care review records and care plans were uploaded to Tusla's case management system (TCM) in a timely fashion, though this was not fully implemented at the time of the inspection. The majority of foster carers told inspectors that they received copies of care plans by registered post a few weeks after each child-in-care review.

Not all child-in-care reviews were held within statutory timeframes. However, while there were some delays, children still received an appropriate service. A social work team leader post had responsibility for organising and chairing the child-in-care reviews in the service. However, at the time of this inspection, this post had been vacant for over a year and instead there was cover for the post on a part-time basis with support also from other social work team leaders in the service. As previously highlighted, not all children had an allocated social worker, but they were in receipt of a service. Inspectors found there was no difference in quality of care plans and child-in-care reviews undertaken by allocated social workers, social care leaders or cases worked through the active on duty system.

The voice of the child was heard as part of the child-in-care review, through the child participating in the review. The service had a local best practice guidelines for child-in-care reviews that included guidance on how to ensure a child-centred approach was taken. Some children choose not to attend their reviews or were too young to attend, instead they met with a worker in advance of the review, who would then present their views at these meetings. For children who were too young, there were examples of observation reports, and in one case a young child was present during their child-in-care review and their interactions were recorded

in the review report. Some children and foster carers told us that children were not always interested in attending child-in-care reviews.

Some child-in-care reviews were held online. Managers told inspectors there were a variety of reasons for this, such as supporting foster carers and children to attend their child-in-care review meetings. Individual child-in-care reviews did not record whether it took place in person or online, and this was not tracked to see what, if any, impact the platform of the review had on levels of child and family participation. Some foster carers told inspectors that staff supported them and the child to attend child-in-care reviews by having them online or in one example it was held in a different office that was easier for the foster carer to get to.

Inspectors found examples of good practice in ensuring children with disabilities were provided with specialist services and their care was effectively coordinated. Specialised service provision was supported by joint meetings between Tusla and the Health Service Executive (HSE), where records showed discussions around support needs of children.

Placement plans were not regularly updated to reflect changes made to care plans. Instead, the practice in the area was to draw up placement plans only at the start of a new placement. Senior managers had identified this as an issue and, in May 2025 they issued a practice guidance on placement plans to the children-in-care teams. However, this did not have the desired impact as, at the time of the inspection, five months later, the majority of cases reviewed did not have an up-to-date placement plan.

This standard requires that when a placement ends in an unplanned way, a review should be held to bring them to a formal conclusion and to amend the care plan to take account of the changed circumstances. This service area took the approach of holding disruption meetings when placements broke down or were at risk of breaking down, and to then have a child-in-care review within two months of the placement breakdown. Inspectors reviewed one case where a placement ended in an unplanned way and the child-in-care review had taken place within two months. Where there was a risk to placements ending, supports were put in place to try to address the difficulties. A number of cases were reviewed where placements were identified as at risk of breakdown or the placement had ended within a few weeks of this inspection. There were good levels of supports and parallel planning in these cases. Placement breakdowns were tracked at principal social worker level and this included tracking dates that the Foster Care Committee were informed of the breakdown.

Permanency planning for children was adequately explored within their care plans and reviews. Inspectors noted arrangements put in place for foster carers to have

enhanced rights, where appropriate. At the time of this inspection, there were 21 children in foster care placements who were in the process of adoption applications. However, in terms of permanency planning, inspectors found a small number of cases that children remained in voluntary care for a number of years without adequate justification recorded in the child-in-care review meeting records.

The majority of children in foster care in Dublin South Central had their care plans reviewed and updated in line with the national standards. There were however some delays with child-in-care reviews and care plans being signed off by management. Some child-in-care reviews took place online, while others were in person. The service did not track this information so it was not possible for them to assess what if any impact online review meetings had on the level of engagement of children and families. The majority of placement plans were not updated in line with care plans. Instead the practice was for a placement plan to be developed at the start of every new placement, with no further updates. For these reasons this standard was judged to be substantially compliant

Judgment: Substantially compliant

Standard 10: Safeguarding and child protection

Children and young people in foster care are protected from abuse and neglect.

In the self-assessment questionnaire (SAQ) the service area judged themselves to be substantially compliant with this standard. Inspectors agreed with this judgment and deemed this standard to be substantially compliant.

This inspection found that child welfare concerns about children in care, were screened by the child-in-care team within 24 hours; however, some delays were found in respect to management sign off, and some staff were unsure about the process in respect to the management of concerns. Children in foster care who required a safety plan had one in place, and these were monitored appropriately. There were no dual unallocated foster care households. There was a delay in responding to one allegation against a foster carer, however the concerns were managed by the child's social worker and an appropriate safety plan was in place for the child. In another case, there was insufficient coordination between the child-in-care team and the fostering team with regard to an allegation. These cases were escalated to the area manager and satisfactory assurances were received. While the majority of Garda notifications were completed in a timely manner, there were delays of more than a month in three cases. Some children

were in foster placements that exceeded the number as set out in the national standards, however risks to children were not identified in these placements.

All referrals to Tusla should be screened on the day they are received, and preliminary enquiries should be completed within five days of the referral, in line with Tusla's standard business process. This includes referrals about children in care. Tusla's national compliance plan for foster care outlined plans to implement a revised guidance for responding to referrals about children in care, by the end of February 2025. This guidance outlined that child welfare concerns about children in care would be screened and managed by the children-in-care teams, while all child abuse concerns would continue to be screened by the child protection and welfare teams. While Dublin South Central had implemented this new guidance, initially the children-in-care teams had not screened the child welfare referrals in line with Tusla standard business process, however at the time of the inspection, the policy was being implemented.

HIQA inspected Dublin South Central's child protection and welfare (CPW) service in April 2025. That inspection found that referrals about children in care which were categorised as child welfare concerns, were not screened in line with Tusla's standard business process. As a result, an urgent compliance plan was sought from the area manager and a satisfactory response was received. The actions in this compliance plan included; a direction to all the children-in-care social work team leaders that child welfare referrals received must be screened in line with standard business process; principal social workers were directed to monitor new referrals to ensure compliance; and practice workshops on the new guidance were organised for all staff on the children-in-care teams. These actions had been completed, though inspectors noted in some cases, delays in monitoring and approval of completed screened referrals by social worker team leaders.

Overall, assessment of child welfare concerns, about children in foster care, followed Tusla processes, demonstrated good analyses of risks and reflected clear action plans to manage identified risk. This inspection found a notable improvement in the timely screening of child welfare concerns, since the HIQA CPW inspection in April 2025. The majority of child welfare referrals for children in foster care were screened on the day of the referral and either appropriately closed or progressed for further assessment in line with Tusla processes. However, there were some delays with oversight mechanisms, in that social work team leaders were signing off on screened referrals, in some cases, up to a week after they were screened.

The majority of child welfare and abuse concerns were managed in line with Tusla processes. However, not all staff were clear about the process to follow when they received a child welfare or child abuse concern. From a sample of nine child

welfare and abuse concerns about children in foster care, two had not followed Tusla processes. This meant that these child welfare and child abuse concerns were not recorded as a referral, in line with standard business processes. As a result the areas management team did not have appropriate oversight and in one case this led to a delay in a proper comprehensive assessment of the risks and a delay in a Garda notification being sent to An Garda Síochána. Of concern in these cases, case supervision records were poor quality and the errors had not been picked up through monitoring and oversight mechanisms. This will be discussed further under standard 19.

Safety plans were of good quality and were appropriately monitored and reviewed. Data provided by the area management prior to the inspection showed that five children in foster care had safety plans in place. Four of these were reviewed and inspectors were satisfied that when concerns emerged for children in foster care, the safety of children was prioritised. Immediate safety plans were developed and agreed with relevant people. These were monitored and reviewed as required.

All child abuse concerns should be reported to An Garda Síochána in line with Children First (2017). From the sample of cases reviewed, inspectors found that all notifications, except for one referred to above, were completed as appropriate. However, there were some delays in completing notifications. One physical abuse allegation, referred to earlier in this section, had not been notified to the Gardaí. This case was escalated and assurances were given that the Garda notification had since been completed. The inspection found that the Garda joint protocol was adhered to.

One of the actions on Tusla's national compliance plan for foster care was the implementation of a revised version of the Child Abuse Substantiation Procedure (CASP) version two and the implementation of the revised guidance for responding to concerns for children in care. This action was part of Dublin South Centrals local service improvement plan and had been completed. The CASP process is required if the foster carer is also working or volunteering within a role that would indicate a risk to other children, based on what has been alleged, and that information needs to be shared to safeguard those children from harm. In the twelve months prior to this inspection, 17 foster carers had allegations made against them. Eight of these allegations were closed, while nine were at assessment stage. Inspectors reviewed six of these and found all but two appropriately managed. In one case where a child welfare concern against a foster carer was being assessed, a second allegation with regard physical abuse was not managed in line with Tusla processes, and in the second case there was not sufficient coordination between the child-in-care team and the fostering team, this case was discussed above. At the time of the inspection, no foster carer was referred on to CASP as none had reached the threshold for being managed through that procedure. In one case

reviewed, an allegation of abuse against a family member that had been appropriately referred to CASP.

Staff and foster carers, who spoke with inspectors, demonstrated an understanding of their responsibilities and commitment to safeguarding children in foster care. They supported children to develop self-care and self-protection skills. Staff responded appropriately to significant events regarding children and kept families informed. Foster carers demonstrated their understanding of their responsibilities as mandated persons under Children First (2017), and told inspectors they had completed Children First training and refresher training where appropriate. They also spoke about what they needed to do, should a child go missing while in their care. Foster carers also told inspectors that they had been provided with information and background history of children prior to placements.

When children have a consistent social worker they can establish a safe and supportive relationship that promotes children's safety. Situations where both children and their foster carers do not have an allocated social worker, are referred to as 'dual unallocated' cases and are recognised as poor safeguarding practice. At the time of the HIQA inspection in 2024, 12 cases were dual unallocated. At the time of this inspection there were no dual unallocated cases. Furthermore, there were good systems in place, with both Tusla foster care teams and private foster care agencies to prevent cases becoming dual unallocated. Furthermore, they had bi-annual meetings with private foster care agencies, where these services were reminded of the requirement to inform the service should any foster carer not be allocated to a social worker.

Where placements were at risk of breakdown, supports were put in place to support the child and the foster carers. Inspectors reviewed cases where children had experienced a placement breakdown and where there was a risk of ending. The work undertaken in these cases showed that there was good coordination between Tusla and other services to support placements. This included counselling supports for children and foster carers, as well as arranging respite care for children, if required.

Children were placed in foster placements that exceed the numbers, as set out by the *National Standards for Foster Care* (2003), however risks to children were not identified in these placements. Information provided by the service as part of this inspection showed that 13 children were placed across four foster care placements that exceeded the number permitted under the national standards. The standards state that generally, no more than two children are placed in the same foster care placement at any one time, except in the case of sibling groups and these should not be placed with other fostered children. Three of these children's files were reviewed during inspection and no concerns for the placements were identified.

However, a recent child-in-care review for one of these children did not consider this factor in terms of the long term viability of the placement. While no risks were identified in these placements, this shows the ongoing difficulties in identifying foster placements for all children identified as in need of one.

The service had identified the placement of children outside the area as a safeguarding risk, in that there was a potential risk for a timely response should any concerns arise. However, there were appropriate mitigations and actions in place. Managers explained that provision was provided for staff to travel and visit children placed outside the area and that children were linked in with appropriate supports in the area. It is best practice for children's care to be coordinated by the area in which they are placed. Children placed outside Dublin were primarily placed with private foster carers, whose link workers were regionally based and provided some supports to both foster carers and children in the placement. At the time of this inspection, 32 cases that were outside the area were identified that needed to transfer to the local area. However, a decision had been made to pause all transfers until January 2026 when the new Tusla networks would be in place. This decision meant an added pressure on staff resources in this area.

There was a delay in responding to one allegation against foster carers, in line with Children First (2017), however there was effective safety planning in place. Some children were in foster placements that were over numbers, however risks to children were not identified in these placements. While the majority of Garda notifications were completed in a timely manner, there were some delays. For these reasons this standard is judged to be substantially compliant.

Judgment: Substantially compliant

Standard 18: Effective Policies

Health boards[4] have up-to-date effective policies and plans in place to promote the provision of high quality foster care for children and young people who require it.

The self-assessment questionnaire (SAQ) submitted by the management team judged the service to be substantially compliant with this standard and inspectors agreed with this judgement.

The service had clear and up-to-date local policies, procedures and guidance documents in place. The local service improvement plan was aligned with Tusla's three year strategic plan for fostering and with Tusla's national compliance plan

[4] These services were provided by former health boards at the time the standards were produced in 2003. These services are now provided by the Child and Family Agency (Tusla).

for foster care. The service had identified a need for further guidance documents that both aligned with and supplemented national and regional guidance. These documents supported staff and aided in providing a consistent service to children and families. However, some policies and procedures were not always fully implemented or local practice meant that the service did not always fully comply with the *National Standards for Foster Care* (2003).

While the HIQA 2024 inspection also found a lack of adherence to some policies and procedures, there were some improvements found in this inspection. For example, as noted previously in this report; last year social care staff were recording visits to children as statutory visits. Inspectors found this practice had stopped and instead visits undertaken by social care leaders were clearly recorded as 'safeguarding visits'. Social care leaders completed safeguarding visits to children in foster care that they were assigned to as these children did not have an allocated social worker to complete statutory visits. Inspectors found these visits were of good quality and aligned with the requirements of statutory visits, which meant children could develop a relationship with a trusted professional and this mitigated the risks. However, it still impacted on the services compliance with the *National Standards for Foster Care* (2003).

Dublin South Central had implemented some actions from Tusla's national compliance plan for foster care, for standard 18. However, two actions, that the Practice Assurance Service Monitoring (PASM) team reviews the implementation of relevant policies and the implementation of the transfer policy were outstanding.

Tusla's national compliance plan for foster care included a commitment that the PASM team would conduct priority reviews of the implementation of relevant policies as they pertain to children in care throughout 2025. At the time of the inspection, PASM had not completed a planned review of the staff supervision policy and the *Professional Practice Supervision Policy* (2023) had yet to be implemented. A new national policy was developed for staff supervision, though not all service areas were required to move to the new process and Tusla gave service areas the option of operating under the new policy or continuing to follow the previous policy. The areas service improvement plan indicated that an action to progress the implementation of the supervision policy was in progress. Staff supervision was an area identified as in need of improvement and is discussed further under standard 19.

An action from the national compliance plan was a national review of the management and oversight of dual unallocated cases. At the time of this inspection there were no dual unallocated cases, this was a notable improvement

since the 2024 inspection. Further to this, the foster care service also had a panel of foster carers in place.

Another action from the national compliance plan was to ensure that children with additional needs (disability/ mental health) would be dealt with under the existing Tusla HSE joint protocol and existing structures, which would be revised to enhance the collaboration and coordination between Tusla and the HSE, would continue to be dealt with under the existing Tusla, HSE Joint Protocol. A review of the joint protocol meeting minutes found that the July 2025 meeting had centred on reviewing the terms of reference for the group, it looked at existing and required structures and templates that would aid decision making. These meetings allowed for case discussions and sharing of relevant information for both agencies. As noted under standard seven, this inspection found good practice in respect to joint working which was child centred.

The area had developed a number of practice guidance documents, which aligned with national policy, to support staff in areas where a need was identified. For example, in response to emerging needs of children in care and to support staff working with children with disabilities, the service developed a guide to supporting children with disabilities. This guide explains the different types of disabilities, provides a framework to understand their needs, respond effectively, collaborate with others, and navigate the child's journey through care, aligning with national child welfare and disability frameworks. It includes information on the assessment of need, recommended interventions, support and advocacy services, financial supports for foster carers, assisted decision making for young adults leaving care and support in preschool and the education systems.

The service had also developed a guidance on child-in-care reviews and care plans. The guidance set out timescales for when reviews should take place, in line with the national standards. The guidance outlined the key considerations such as who attends, what a care plan is and what to consider for the child-in-care review, placement plan and absence management plan. This guide supported a consistent approach across the service and this was reflected in the quality of child-in-care reviews and care plan records reviewed by inspectors.

However, in contrast, a practice guidance on placement plans had not been as effective in improving placement plan records. This guidance was clear about the purpose of placement plans and the need for them to be updated to be consistent with care plans. However inspectors found, on the whole, placement plans were drawn up at the start of a child's placement but not updated in line with new care plans. Some staff told inspectors incorrectly that there was only a requirement to complete placement plans at the start of placements.

The service had a number of strategies in place at local, regional, and national level to try to address the shortages in foster care placements in the area. The service was proactive in placing children with family members where possible, in line with the standards. Data provided prior to the inspection showed that there were no general foster placements available in the area and there were 24 children awaiting a foster care placement. Furthermore, there was a significant reliance on private foster care placements, with 45% of children in general foster care placements, placed with private foster carers. At regional level, the Regional Care Placement Capacity Group was established, which Dublin South Central was part of. The overriding purpose of this group was to ensure that every placement opportunity is explored in the region for all children in need of a placement. Tusla, at national level had a national recruitment strategy and plan aimed at addressing the shortage in foster carers. The service area had a social work team leader lead on this in the area, with support from a social care leader. At a local level there was a family finding initiative which supported social workers in engaging extended family members to support children, and this area had a good proportion of children, 31%, placed with relative foster carers.

The service area were working toward being a trauma-informed service. A trauma informed approach recognises the widespread impact of trauma and integrates this understanding into policies, procedures and practise. In support of this work there were a number of initiatives and programmes in place. This included a project which was aimed at imbedding trauma-informed practices through an area wide approach in Dublin South Central.

As highlighted earlier in this report, the new national guidance for responding to child protection and welfare concerns of children in care was not fully adhered to by all staff in this area. The service management team had taken action to remedy this and had provided training events to staff to support them in understanding the processes. It would take time for the impact of this training to be fully embedded into practice especially for new staff.

The area was proactive in mitigating the risks posed to children who were not allocated a social worker. A number of local standard operating procedures were in place to support managers and staff. There was a standard operating procedure (SOP) for the management of unallocated children in care in Dublin South Central Area. This covered three strands for managing unallocated children, active on duty system, social care leader's assigned children and cases managed by a social work team leader. This document included the governance and oversight arrangements in place. As outlined earlier in this report, while children managed under this SOP received a good service, it was not in line with the national standards which required all children in care to have an allocated social worker. Another standard operating procedure in place was to allow for one or two child in care cases to be

allocated to fostering link workers, who are professionally qualified social workers. Inspectors reviewed two of these cases and found work on these cases to be of a good standard.

The service was not transferring cases outside the area in line with the national transfer policy. The national compliance plan outlined that the national transfer policy in foster care would be implemented by June 2025. The national policy had been approved, but at the time of the inspection, the policy had not been implemented. Instead transfers were paused until the implementation of the national reform programme in January 2026. The areas had identified 32 children to transfer in January 2026. As highlighted earlier in this report, this had impact on the staffing resources in this area.

Some policies and procedures were not always fully implemented and the area remained challenged with respect to the implementation of some national policies, for example the transfer policy. These gaps remained since the 2024 inspection, so for these reasons this standard is deemed to be substantially compliant.

Judgment: Substantially compliant

Standard 19 : Management and monitoring of foster care services

Health boards have effective structures in place for the management and monitoring of foster care services.

The self-assessment questionnaire submitted by the service area management team judged this standard to be substantially compliant. Inspectors did not agree with this, and judged the service to be not compliant with standard 19.

The oversight and management of the service needed strengthening to ensure children in foster care received a service in line with the national standards, and all children in need of foster care placements had access to one. The inspection found that case management was poor with regard to the frequency and quality, in particular, case discussion, direction and follow up actions. The system of monitoring allegations made against foster carers needed strengthening, as inspectors found two allegations which were not on the management's tracker for oversight. As a result, assurances were required from the area management team following fieldwork in respect to standard 19.

The service had a local service improvement plan, in line with the national compliance plan for foster care. A number of actions on the service improvement plan were completed or in progress such as completion of a staff and resources analysis, building staff capacity, and the review of the active on duty system.

However one action relevant to the foster care service, the implementation of the revised transfer policy had not started. There were less staff vacancies than at the time of the 2024 inspection, which helped the service reduce the number of children without an allocated social worker. At the time of this inspection, there were no dual unallocated children, another improvement from the 2024 inspection. However, some children remained without an allocated worker for long periods of time, and the service was unable to provide foster care placements to all children identified as in need of a placement. At a national level, Tusla's allocation of adequate staffing resources to Dublin South Central had not been addressed.

The national compliance plan had limited impact in this service area. The previous HIQA inspection found that oversight of the children in care service for children in foster care was inadequate. This was because children remained unallocated, including dual unallocated cases, for long periods of time without effective actions being implemented by Tusla at national level. This inspection found that the management structure and governance systems had been strengthened, however gaps still remained. The reduction in children not allocated to social workers was due to less staff vacancies than in 2024, but no extra staffing resources were assigned to the area. The number of unallocated children went from 31% at the time of last year's inspection to 15%, at the time of this inspection. However, similar issues to last year's inspection remained for this service, such as children being unallocated for a number of years, improvements needed in supervision records and inadequate staffing resources.

One of the areas in which governance had improved related to the tracking of unallocated children. The 2024 inspection found that the service did not track how long children were not allocated social worker for. This inspection found that the area had a tracker to support management oversight of unallocated children. Inspectors reviewed this tracker and found that 15 of the 42 children who were not allocated a social worker, had been unallocated for three years, while a further eight had been unallocated for two years. It noted that all these cases were assessed as low to medium priority and all had up-to-date care plans. As highlighted earlier in this report, there were adequate systems in place to provide a service to these children. However, these system did not bring the service into compliance with all of the *National Standards for Foster Care* (2003)

There were clearly defined governance arrangements in place that set out lines of authority and accountability. The Dublin South Central area had a consistent and experienced senior management team for children in care and fostering services. The area was managed by an experienced area manager, who had overall responsibility and authority for the delivery of the service, under the direction of the regional chief officer for Tusla's Dublin Mid Leinster region. There were three

principal social workers who were responsible for children-in-care and fostering teams in the area. All three principal social workers were experienced and were in their roles for a number of years. They were supported by four team leaders in the fostering pillar, and eight team leaders across the children-in-care and aftercare pillars. Ten of the team leaders had line management responsibilities for social workers, senior practitioner social workers and social care staff. Two social work team leaders were responsible for foster care reviews and the child-in-care reviews. There was also an access team coordinator, who had management responsibilities for a team of social care staff. Staff, who spoke with inspectors understood their roles and responsibilities. The teams were located in three different office locations in the area.

Since the last HIQA inspection, staffing levels in the children-in-care and fostering teams had increased as nearly all existing vacancies had been filled, including management posts. In the twelve months prior to this inspection, 13 staff left their posts and 15 staff started in new posts in the service. Seven social workers, two senior practitioners, one principal social worker, one social care leader, one psychologist and three team leaders took up new posts in the service. In contrast, 13 staff left their posts, though six of these were because they were promoted within the service. At the time of the inspection, the child-in-care review officer post was vacant, and there was cover on a part time basis by a social work team leader. There was also two senior practitioner vacancies and one social care worker vacancy. The area manager advised that it was not possible to fill the senior social work practitioner vacancies internally as staff on the teams did not have the required experience to apply for these roles. This was an indicator of the lack of experienced social workers in post at the time of the inspection and the level of support needed to those newly appointed staff.

There were structures in place to monitor and address staffing issues. At regional level there was an employment monitoring group, who met on a monthly basis to review, assess and evaluate employee figures, including projections of staff increases or decreases and future scope for recruitment in the Dublin Mid Leinster area. The Dublin South Central area manager completed a work force analysis plan in January 2025. This report showed that the area had moved from a situation where they had a risk of staff vacancies, to a risk of insufficient staffing allocation. The report outlined the ongoing need for an active on duty team, despite nearly all staff vacancies being filled, which indicated deficits in staffing resources. Another staffing related risk identified by managers was the high number of newly qualified frontline staff and staff who were recruited from other jurisdictions, and were not familiar with the Irish system. This meant a large number of staff needed significant supports to successfully induct them into the new roles. A number of initiatives were in place such as mentoring and strengthened induction processes to support the newly recruited staff.

Social work team leaders had limited capacity to complete all monitoring and oversight responsibilities. While team leader posts had been filled, senior managers advised that team leaders had limited capacity for oversight activities, such as audits, as much of their time was taken up with supporting newly recruited staff, and attending the family court as there were considerable number of child in care cases before the court. Inspectors also found some gaps in case management records, which was the responsibility of team leaders. A note on one case file from a team leader advised the gap in case supervision records was due to heightened pressures amongst the team and further advised there was ongoing informal supervision. Given the number of new staff recruits, the lack of consistent, quality case management records was a concern.

As previously noted under standard five in this report, the national compliance plan for foster care indicated that additional resources would be made available to areas in need of resources. The management team advised that no additional staffing resources were allocated to Dublin South Central in the last year, despite the business cases made for additional staffing as part of the work force analysis report.

Transfer of cases from the child protection and welfare (CPW) team to the children-in-care team in a timely manner remained an issue of concern, though there was some progress in addressing this. During the CPW inspection in April 2025, staff highlighted concern about the lack of adherence to the internal transfer policy which meant that CPW staff held children in care cases for months, rather than them transferring to the children-in-care teams. This meant the CPW team had to manage competing demands of their caseloads. Inspectors in this inspection noted a delay in one child's child-in-care review as a result of workload demands on the case allocated to a CPW team. At the time of this inspection, there were seven cases held on the CPW team, and three of these cases were in the process of being transferred to the children-in-care team. The issue of internal case transfers was monitored at the children in care management meetings and a tracker was maintained.

Inspectors found that while there were systems in place for monitoring and oversight of cases, there were gaps in these systems, particularly at social work team leader level. As part of Tusla standard business processes, social work team leaders are required to have oversight on processes such as care plans, placement plans, child-in-care reviews, screening, preliminary assessments and initial assessments. Inspectors found that frequently there were delays of days and in some cases weeks in the review and sign off of these processes by social work team leaders. There was one case where the child-in-care review and care plan had not been signed off by the appropriate line manager.

There was a mixed finding in relation to staff supervision. The 2024 HIQA inspection found that supervision needed improvement, this inspection found that while there were some good quality staff supervision records, others were of poor quality. In this inspection, inspectors found that the quality of staff supervision records, and frequency of supervision meetings across all staff grades were mixed. Some supervision records were to a good standard, with clear notes on what was discussed, the decisions made, as well as indicators that previous actions were reviewed and the frequency of supervision was in line or close to in line with the Tusla 2013 supervision policy. Supervision frequency varied from monthly to gaps of up to four months. Some supervision records were hand written and difficult to read, while other records were typed, making it easier to follow. Some supervision records did not have clear decisions recorded or tracked previous actions and decisions, so it was difficult to see how managers were monitoring work completed. Other supervision records showed good case discussion, directions and actions agreed. As noted above, a casenote from a team leader acknowledged lack of formal supervisions due to pressures on the team. In another supervision record, actions listed in supervision in February 2025 were the same actions noted in the August 2025 record, such as support placement, support respite and follow up on passport application for a child in foster care.

Quality assurance mechanisms required strengthening. The senior management team completed a number of audits and there was some evidence on files of follow through on actions identified. However, not all required actions were consistently followed up. This requires increased governance and oversight from the management team, in respect to actions from audits being addressed. For example, an audit of cases to check compliance with statutory visits found that a statutory visit had not taken place for a child in a year, and subsequently a visit was completed. However, the same audit also found that placement plans needed to be updated, but, at the time of the inspection, the placement plans in children's files had not been updated.

While overall communication systems in place were effective, there was a gap as children-in-care teams did not have regular team meetings. The service area held a range of meetings which supported and facilitated oversight and management, as well as information sharing and communication between pillars and teams. On a quarterly basis a department wide meeting took place which all staff attended. On a monthly basis there were senior management meetings, chaired by the area manager, which focused on areas such as the regional and national reform programme, staffing, and progress of actions from the service improvement plan, and policy and practice. The children in care pillar and fostering pillar held monthly meetings, attended by principal social workers and social work team leaders. A range of issues were addressed at these meetings such as updates on the progress of the national reform programme and business support. This meeting

had a number of standing items such as tracking case transfers from the CPW team and unallocated cases which ensured ongoing monitoring. The fostering teams held regular meetings with frontline staff and team leaders, but this was not an established practice in the child-in-care teams. This was identified as a gap in communication and a missed opportunity for these teams to engage in reflective practice and learning. The child-in-care principal social workers acknowledged that child-in-care teams holding regular meetings was an area for improvement. In relation to case management and oversight; there were regular active on duty governance meetings every two weeks, quarterly foster carer allegations and serious concerns meetings, a complex case forum and biannual meetings with the private foster care agencies.

The system of oversight and governance for foster carer allegations and serious concerns needed strengthening. Inspectors identified two allegations that were not on the allegations tracker and had not been discussed at the quarterly governance meetings. However, work was ongoing on these cases with regards to assessments and safety planning. These cases were escalated, as was the systems risk and assurances were provided with regard to the oversight and monitoring of allegations.

There were effective risk management systems in place that ensured risks at local level were escalated regionally as required. However, despite these processes not all risks were mitigated against. The area manager maintained logs on 'need to knows[5]' and significant events which were escalated to the regional chief officer. The areas risk register was reviewed every month and remained a standing item on the senior management team meetings. The area manager also attended the regional operations risk management and service improvement committee (ROMSIC) meetings. Risks recorded on the risk register that were relevant to foster care, included unallocated cases, insufficient levels of staff, and lack of placements. New risks added to the register in the 12 months prior to this inspection included the lack of respite foster placements and that lack of availability of a child-in-care reviewing team leader. While risks were effectively identified and control measures were put in place, inspectors found that the control measures were not always adequate to effectively address identified risks as a number of these risk remained on the register for years. Examples of these types of risks included insufficient staffing levels, the lack of foster care placements and children in care with no allocated social worker.

[5] Need to know is a reporting system which is used to escalate incidents and issues to senior management, which might pose a risk to individual children or to the organisation

The service area struggled to ensure there were enough foster care placements for all children who needed one and this was recorded on the risk register. At the time of the inspection, there were 24 children awaiting a foster care placement.

The oversight and management of the service needed strengthening to ensure children in foster care received a service in line with the national standards and that there was effective oversight of safeguarding and child protection and welfare concerns. The service continued to have children placed in foster care who did not have an allocated social worker. This inspection saw notable improvements in unallocated cases since the 2024 inspection; however children remained unallocated to a social worker. At the time of the inspection, there were 24 children waiting for a foster care placement that the service was unable to provide. The staffing resources for the service were not adequate to provide a service in line with the national standards. Improvements were required in respect to case management oversight, frequency and quality of supervision, and also in respect to the monitoring and effective oversight of the service. For these reasons this standard was judged to be not compliant.

Judgment: Not compliant

Appendix 1:
National Standards for Foster Care (2003)
and
Child Care (Placement of Children in Foster Care) Regulations,[6] 1995

Standard 5 Regulation Part IV, Article 17(1)	The child and family social worker Supervision and visiting of children
Standard 7 Regulations Part III, Article 11 Part IV, Article 18 Part IV, Article 19	Care planning and review Care plans Review of cases Special review
Standard 10	Safeguarding and child protection
Standard 18 Regulation Part III, Article 5 (1)	Effective policies Assessment of foster carers
Standard 19 Regulations Part IV, Article 12 Part IV, Article 17	Management and monitoring of foster care services Maintenance of register Supervision and visiting of children

[6] Child Care (Placement of Children in Foster Care) Regulations, 1995

Compliance Plan for Dublin South Central Service Area Foster Care Service] OSV – 0004417

Inspection ID: MON-0047662

Date of inspection: 20 - 23 October 2025

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 Foster Care, 2003.

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. In this section the provider must consider the overall standard when responding and not just the individual non compliances as listed in section 2.

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 5: The child and family social worker There is a designated social worker for each child and young person in foster care.	**Judgment: Substantially compliant**

Outline how you are going to come into compliance with Standard 5:

Action 1: The area will implement actions within their service plan to support the recruitment of staff. These actions are supported by Tusla's People and Change strategy relating to increased supply of social work staff and also improved retention. The actions include -

1. Continued onboarding of Professionally Qualified Social Workers (PQSW) including graduates, international and external candidates. At present this has meant that we have no PQSW vacancies.
2. Continued commitment to the apprenticeships schemes to increase supply. One apprentice is completing their apprenticeship in 2026 and 6 will finalise their apprenticeship in 2027.
3. We have strengthened our placement coordination system to support social work and social care students. The is supporting graduates to return to the Dublin South City (DSC) post qualifying.
4. Continued regional summer initiative whereby social work and social care students will be employed over summer months. This provides additional capacity over the summer months when staff are on leave, it also aims to support graduates to return to the agency post qualifying.

Responsible: Area Manager (AM)

Completed by: 30 June 2026

Action 2: The area will implement the actions within our service plan related to the retention of staff. The actions include

1. Focus on employee experience through retention & support strategy including awareness of Critical Incident Stress Management (CISM), Mentorship, first 100 days for all staff.
2. Improve induction experience & monitoring for all. This has focused on an integrated approach to induction but also enhanced support for staff not trained in Ireland and the completion of induction for all first timeline managers.
3. Continued focus on improving the work environments. This has including the refurbishment of the offices in Cherry Orchard and further work in Lord Edward Street.

Responsible: Area Manager
Completed by: 30 June 2026

Action 3: In line with the national case reallocation under the reform programme, DSC is reviewing the level of social work grades required to ensure the allocation of all children in care. As required, business cases will be submitted for additional staff. Mitigations will be used in the interim as required during the transition period.
Responsible: Area Manager
Completed by: 31 March 2026

Action 4: In the event that that there are children unallocated, the area will adhere to the DSC SOP for cases awaiting allocation and ensure that there are contingencies in place in terms of ensuring that there are supports in place and risks are escalated as per the national policy on cases awaiting allocation.
Responsible: Area Manager
Completed by: 31 March 2026

Action 5: A continued focus will be on statutory visits as per the Statutory Visits Practice Memo which was issued in October 2025. Monitoring of these will occur at supervison with a compliance audit being undertaken by the Quality Risk and Service Improvement (QRSI) officer in DSC.
Responsible: QRSI Officer and Area Manager
Completed by: 30 June 2026

Standard 7: Care planning and review Each child and young person in foster care has a written care plan. The child or young person and his or her family participate in the preparation of the care plan.	**Judgment: Substantially compliant**

Outline how you are going to come into compliance with Standard 7:
Action 1: The Care Plan SOP was introduced in Sept 2025 which aimed to improve the quality of care plans and to support the timely sign off of care plans after Child in Care Reviews (CICR) is held. This was accompanied by a guidance for business support to support minute taking, prompt upload to Tusla Case Management (TCM) and sending on minutes/ care plans to the relevant people. The area is continuing to implement these practice changes which had been in process of change at the time of the inspection.
Responsible: Local Integrated Team Principal Social Worker (LIT PSW) and Reviewing Team Leader (TL)
Completed by: 31 March 2026
Action 2: The area has made a revision to the Care Plan Standard Operating Procedure (SOP) and also to the placement plan guidance to ensure that all are aware to review at each child in care meeting, if circumstances have changed which would necessitate a new placement plan.

Responsible: LIT PSW and Reviewing TL
Completed by: 31 March 2026

Action 3: The area has made a second revision to the Care Plan SOP to ensure that all are reminded to include the reason as to why a child remains on a voluntary care agreement.
Responsible: LIT PSW and Reviewing TL
Completed by: 31 March 2026

Action 4: The area has revised the Child in Care (CIC) Minutes SOP to include recording if the CICR was held in person or on line. The area recognizes that there is a place for both approaches but that it is important to monitor effectiveness.
Responsible: Business Support Manager
Completed by: 31 March 2026

Action 5: The Child in Care Reviewing Team Leader (which was a vacant at the time of the inspection), commenced in the 2 January. The AM has identified a number of priorities for this TL including improving awareness and understanding of the statutory requirements and monitoring of the impact of the above SOPs. An infograph system has been developed to promote awareness.
Responsible: LIT PSW and Reviewing TL
Completed by: 31 March 2026

Action 6: Awareness of the Data Quality Tool which supports oversight of compliance with standards and regulations in terms of care planning and reviews will be refocused on in Qtr 2 to support AM, PSW, TL and all staff in have oversight of compliance and to escalate as required
Responsible: LIT PSW and Reviewing TL
Completed by: 30 June 2026

Standard 10: Safeguarding and child protection Children and young people in foster care are protected from abuse and neglect.	**Judgment: Substantially compliant**

Outline how you are going to come into compliance with Standard 10:

Action 1: As noted in the inspection, a Practice Guidance on Responding to Child Protection and Welfare Concerns of Children in Care was developed in 2025 and a series of workshops were provided. However, the area is reviewing this to develop a local SOP that focuses on all aspects of safeguarding (awareness, recognition and response) but will also including strengthening monitoring and oversight. It will also include information to reflect the national guidance on Gardai Notifications. SOP will integrate the guidance from 2025 with changes that are introduced as part of the new Local Integrated Service Delivery Model. When approved, this SOP will be disseminated to all staff.

Responsible: LIT PSW and Reviewing TL
Completed by: 30 June 2026

Action 2: In light of the changes in management structure of the fostering service under the reform, the area is reviewing the most effective way to track allegations and serious welfare concerns. This tracker is maintained by the fostering PSW but to strengthen this, the AM has taken an oversight role and has put in place a number of mechanisms to ensure that all allegations and serious concerns are identified and tracked. This includes the use of data on TCM but also direct communication with all allocated workers to identify all allocations.
Responsible: LIT PSW, PSW for Fostering and AM
Completed by: 31 March 2026

Action 3: A quarterly governance meeting to review serious concerns and allegations is being revised to integrate this into our monthly governance meetings. All serious concerns and allegations will be reviewed and tracked at this meeting. However, at the intervening governance meeting this will continue as an agenda item to ensure greater oversight.
Responsible: LIT PSW & AM
Completed by: 30 June 2026

Action 4: The area is developing a support document for placements that exceed numbers, this guidance will include information on the additional supports such as the housing adaptation policy, communication with housing authority and other foster care supports. There are a number of supports available for children and foster families but we would like to ensure there is a document provides an overview of all supports and options. Obviously, we will also continue to explore increasing our level of foster carers as noted below.
Responsible: LIT PSW and AM
Completed by: 30 June 2026

Standard 18: Effective Policies Health boards[7] have up-to-date effective policies and plans in place to promote the provision of high quality foster care for children and young people who require it.	**Judgment: Substantially compliant**
Outline how you are going to come into compliance with Standard 18: **Action 1:** A continued focus will be on implementing of the supervision policy and this includes supervision record part one (professional development) and part two (case management). The area has launched their trauma informed tool (Building Practitioner Resilience) in December 25 which will complement this action. A compliance audit will be undertaken by the Quality Risk & Service Improvement (QRSI) officer in DSC. **Responsible:** QRSI Officer and AM **Completed by:** 30 June 2026 **Action 2:** As noted above the area has revised to the Care Plan Standard Operating Procedure (SOP) and the CICR minutes SOP and is focusing on full implementation of these which will address the issues with minute taking, prompt upload to TCM and sending on minutes/ care plans to the relevant people. **Responsible:** LIT PSW and Reviewing TL **Completed by:** 30 June 2026 **Action 3:** The area will continue to work with the regional placement capacity group and local, regional and national fostering strategy on increasing on level of foster carers. **Responsible:** AM, PSW for Fostering and Regional Chief Officer (RCO) **Completed by:** 30 June 2026 **Responsible:** Executive Management Team (EMT) **Completed by:** 30 June 2026	

Standard 19 : Management and monitoring of foster care services Health boards have effective structures in place for the management and monitoring of foster care services.	**Judgment: not compliant**
Outline how you are going to come into compliance with Standard 19: **Action 1:** The administrative boundary of DSC have changed significantly as part of the structural changes taking place as part of the reform programme. This reform aims to achieve increased capacity for governance. **Responsible:** Executive Management Team **Completed by:** 5 January 2026	

[7] These services were provided by former health boards at the time the standards were produced in 2003. These services are now provided by the Child and Family Agency (Tusla).

Action 2: A continued focus will be on implementing of the supervision policy and this includes supervision record part one (professional development) and part two (case management). The area has launched their trauma informed tool (Buidling Practitioner Resilience) in December 25 which will complement this action. A compliance audit will be undertaken by the Quality Risk and Service Improvement (QRSI) officer in DSC.
Responsible: QRSI Officer and AM
Completed by: 30 June 2026

Action 3: In light of the changes in management structure of the fostering service under the reform, the area is reviewing the most effective way to track allegations and serious welfare concerns. This tracker is maintained by the fostering PSW but to strengthen this, the AM has taken a oversight role and has put in place a number of mechanisms to ensure that all allegations and serious concerns are identified and tracked. This includes the use of data on TCM but also direct communication with all allocated workers to identify all allocations.
Responsible: LIT PSW, PSW for Fostering and AM
Completed by: 31 March 2026

Action 4: A quarterly governance meeting to review serious concerns and allegations is being revised to integrate this into our monthly Governance meetings. All serious concerns and allegations will be reviewed and tracked at this meeting. However, at the intervening Governance meeting this will continue as an agenda item to ensure greater oversight.
Responsible: LIT PSW and Reviewing TL
Completed by: 30 June 2026

Action 5: In line with the national case reallocation under the reform programme, DSC is reviewing the level of social work grades required to ensure the allocation of all children in care. As required, business cases will be submitted for additional staff. Mitigations will be used in the interim as required during the transition period.
Responsible: Area Manager
Completed by: 31 March 2026
Action 6: DSC is reviewing our level of business support which was impacted by the reform programme to ensure we have the required level to fulfil our responsibilities such as upload case records, minutes of child in care reviews etc. As required, business cases will be submitted for additional staff.
Responsible: Area Manager
Completed by: 30 June 2026

Action 7: Under the new Local Integrated Service Delivery model, the focus is on increasing integration and removing barriers between teams. This is being

implemented by DSC with timely transitions of children entering care from the Integrated Front Door to the Local Integrated Teams (LITs) and within the LITs.
Responsible: PSWs
Completed by: 31 March 2026

Action 8: The PSW for the LITS are working with their teams to introduce an effective system of regular team meetings that are recorded. Given the new structures, the teams are reviewing their communication structures.
Responsible: PSWs
Completed by: 31 March 2026

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 MM YY) of when they will be compliant.
The provider has failed to comply with the following standards(s).

Standard	Judgment	Risk rating	Date to be complied with
Standard 5: The child and family social worker There is a designated social worker for each child and young person in foster care.	Substantially Compliant	Orange	30 June 2026
Standard 7: Care planning and review Each child and young person in foster care has a written care plan. The child or young person and his or her family participate in the preparation of the care plan.	Substantially compliant	Orange	30 June 2026

Standard 10: Safeguarding and child protection Children and young people in foster care are protected from abuse and neglect.	Substantially compliant	Orange	30 June 2026
Standard 18: Effective Policies Health boards[8] have up-to-date effective policies and plans in place to promote the provision of high quality foster care for children and young people who require it.	Substantially compliant	Orange	30 June 2026
Standard 19 : Management and monitoring of foster care services Health boards have effective structures in place for the management and monitoring of foster care services.	Not compliant	Orange	30 June 2026

[8] These services were provided by former health boards at the time the standards were produced in 2003. These services are now provided by the Child and Family Agency (Tusla).

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