



Report of an inspection of a Child Protection and Welfare Service

Name of service area:	Donegal
Name of provider:	Tusla
Type of inspection:	Thematic
Date of inspection:	10-12 March 2020
Lead inspector:	Tom Flanagan
Support inspectors:	Grace Lynam Sabine Buschmann Lorraine O'Reilly

About this inspection

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

This inspection report, which is part of a thematic inspection programme, is primarily focused on defined points along a pathway in child protection and welfare services provided by Tusla: from the point of initial contact or reporting of a concern to Tusla, through to the completion of an initial assessment.

This programme arose out of a commitment made by HIQA in its 2018 *Report of the investigation into the management of allegations of child sexual abuse against adults of concern by the Child and Family Agency (Tusla) upon the direction of the Minister for Children and Youth Affairs*. This investigation was carried out at the request of the Minister for Children and Youth Affairs under Section 9(2) of the Health Act 2007 (as amended) and looked at the management by Tusla of child sexual abuse allegations, including allegations made by adults who allege they were abused when they were children (these are termed retrospective allegations).

Thematic inspection programmes aim to promote quality improvement in a specific area of a service and to improve the quality of life of people receiving services. They assess compliance against the relevant national standards, in this case the *National Standards for the Protection and Welfare of Children* (2012). This thematic programme focuses on those national standards related to key aspects of quality and safety in the management of referrals to Tusla's child protection and welfare service, with the aim of supporting quality improvement in these and other areas of the service.

How we inspect

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

The key activities of this inspection involved:

- the analysis of data
- interviews with the area manager and four principal social workers
- focus groups with team leaders and with social workers

- speaking with children and families
- the review of local policies and procedures, minutes of various meetings, staff supervision files, audits and service plans
- the review of 63 children’s case files
- observing duty staff in their day-to-day work
- observing a team meeting
- observing a Review Evaluate Direct (RED) meeting.

The aim of the inspection was to assess compliance with national standards related to managing referrals to the point of completing an initial assessment, excluding children on the child protection notification system (CPNS).

Acknowledgements

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

Profile of the child protection and welfare service

The Child and Family Agency

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

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

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

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

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

Service area

Donegal is the most northerly county in Ireland and has a land mass of 4,861 sq kms or 6.9% of the total land area of the State. It is the fourth largest county in Ireland with a sparse population density and is predominately a rural county (27 % of the total population living in aggregate urban areas compared to 63% in the State). Donegal is home to 159,192 people and has a population of 42,865 children between the ages of 0 and 17yrs.

According to the Pobal deprivation index, Donegal has a score of -10.3, the second lowest in the Western region. High levels of deprivation result in many children growing up in households who struggle financially. The rural nature of the county creates added pressures for families in accessing services.

Donegal is situated within the Tusla West region and is under the direction of the service director for Tusla West region. It is managed by an area manager. There is a dedicated principal social worker for the Intake and Assessment Service.

The Intake and Assessment Service consists of a centralised team based in Letterkenny. There are two Team Leaders with activities divided into Screening and Preliminary Enquiries and Initial Assessments. There were 2066 referrals to the service in 2019 which represented an increase of 38% on referrals received in 2018.

Compliance classifications

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

Compliant	Substantially compliant	Partially compliant	Non-compliant
The service is meeting or exceeding the standard and is delivering a high-quality service which is responsive to the needs of children.	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.	Some of the requirements of the standard have been met while others have not. There is a low risk to children but this has the potential to increase if not addressed in a timely manner.	The service is not meeting the standard and this is placing children at significant risk of actual or potential harm.

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

This inspection was carried out during the following times:

Date	Times of inspection	Inspector	Role
10 March 2020	09:00 – 17:00	Tom Flanagan Lorraine O Reilly Grace Lynam Sabine Buschmann	Inspector Inspector Inspector Inspector
11 March 2020	09:00 – 17:00	Tom Flanagan Lorraine O Reilly Grace Lynam Sabine Buschmann	Inspector Inspector Inspector Inspector
12 March 2020	09:00 – 17:00	Tom Flanagan Lorraine O Reilly Grace Lynam Sabine Buschmann	Inspector Inspector Inspector Inspector

Views of people who use the service

HIQA inspectors met with a group of eight children who knew each other prior to the inspection and were involved in a participation programme with Tusla. Inspectors also met with two other children individually. Inspectors had telephone discussions or met with six parents whose children had been in receipt of a child protection and welfare service.

Children's views:

When asked what social workers talked to them about, children said:

- "They asked what happened"
- "They asked about my family and what its like at home"
- "What problems occur in your home and how you deal with them""
- "What do you do with your life and what do you plan to do"
- "They did fun stuff. They asked how I was feeling. Drawing"

Children also made some suggestions as to how social workers could be better at listening to them:

- "Just explain what's happening".
- "Just cos the case is closed doesn't mean you cant talk to them"
- "Make proper connections with your young people"
- "Keep in touch with the family"
- "Take into consideration your needs and wants"
- "Stop doing what is best they just think and consider what's actually best for the child"

Children also said "child should come first", "confidentiality is important", "don't make us do things we don't want to do".

Parents' views:

Inspectors spoke with 11 parents who were very positive in their comments about social workers and the service they received. All said that social workers spoke to them very clearly about the reason they became involved with the family.

Parents said that social workers communicated well. One said: "They made me feel comfortable. They were professional but down to earth and approachable." Others said that: "social workers were kind and listened" and "they offered good advice and guidance".

One parent said: "the incident had to be investigated. They had a job to do and they were clear about this."

Parents were clear that the children's needs came first and spoke about social workers visiting their homes to speak to the children and parents or sometimes visiting the children in their schools.

When asked what social workers could do better, one parent said that more support could be offered after initial contact. Two parents said that they felt that social workers were busy and that further services were required in the community.

Capacity and capability

At the time of the inspection, the staff and management team demonstrated a commitment to delivering a good quality child protection and welfare service that was responsive to the needs of children and the area also maintained a focus on improving the quality of the service provided. There was a shortage of permanent staff and there were delays in response times for some children and some key performance indicators in relation to timeframes for preliminaries and initial assessments were not being met. Strategies were in place to reduce the wait lists that were in operation. Managers ensured that there was also a strong focus on the quality of the service provided to children and families and the service had been proactive in providing training, guidance and support to staff in this regard. Some further improvements were required to ensure full compliance with the standards.

Prior to the announcement of the inspection, the service area's management team submitted a self-assessment to HIQA in Quarter 3, 2019. The self-assessment is part of the methodology for this type of inspection and it required the management team to assess their own performance in relation to the national standards. With regard to the four standards relating to leadership, governance and management, and workforce, that were the part of the focus of this inspection, inspectors agreed with the area's self-assessment and, during fieldwork, found evidence to support the area's self-assessment.

The area manager and the management team provided strong leadership to the service and had managed a period of significant change during the previous two years. They implemented a re-structuring of the intake and assessment service, which was as a result of an analysis of the operation of the child and protection service in the area. Changes that were introduced in 2018 saw the development of a centralised Intake and Assessment Team and the creation of a dedicated principal social work post for Intake and Assessment service. There was a strong focus on adherence to legislation and national policies. For example, the area maintained a tracker on the implementation of Children First: National Guidance on the Protection and Welfare of Children, 2017 (Children First, 2017) and this subject was a standing item on the agendas of team meetings at all levels.

The area manager assured himself of the quality and safety of the service in a number of ways. He chaired the monthly senior management meeting and quality risk and service improvement meeting. He reviewed and monitored monthly data on referrals and caseload management reports. He also reviewed monthly NCCIS metrics and audit reports, and records of his monthly supervision of the principal social worker for the Intake and Assessment team showed that he ensured that decisions

taken by the senior management team were implemented. He told inspectors that he was accountable to the regional service director and that, when key performance indicators were not reached by his service, he was required to present on how he was going to address this issue.

As the 2020 service plan had not yet been finalised at the time of inspection, inspectors reviewed the 2019 service plan which set out key actions to be completed in the areas of child participation, implementation of the Tusla child protection and welfare strategy, prevention partnership and family support in the community, and staffing. An end of year (2019) report was compiled which detailed how these actions were completed.

Following the self-assessment completed in Quarter 3, 2019, the area's management team developed a quality improvement plan which identified actions to improve the service. Many of these actions had been completed in the interim. Completed actions include the following:

- finalisation of governance mapping which led to the development of a statement of purpose for the Intake and Assessment team
- creation of a detailed audit plan for the Intake and Assessment service for 2020
- improvements to the recording systems for attendance and outcomes of group supervision sessions
- improvements in communication to children and families on a waiting list for allocation
- development of an Intake referral information pack for all children and families whose referral meets the threshold for a social work service.
- development of a protocol which outlined best practice for staff when interviewing children and families
- the move by the Intake and Assessment team to new offices which provided good quality accommodation for staff and more child-friendly and family-friendly facilities for interviews, meetings and family contact sessions.

A number of actions such as an audit of the supervision provided to the Intake and Assessment team and the participation of a children's group in the review of the Intake system had not yet been completed but timeframes were in place for the remaining outstanding actions.

The governance arrangements in place in the area were robust. Senior management meetings and Quality Risk and Service Improvement (QRSI) meetings were both held monthly. The principal social worker for the Intake and Assessment team held a management team meeting with the two team leaders each month and joint management teams took place monthly between the managers of the Intake and Assessment team and the Community Area teams. Individual team meetings were held approximately every two weeks. Terms of reference were developed for each type of meeting to ensure that the meetings were focused and that meetings were at all levels were aligned with each other.

Communication systems within the service were well organised and were effective. There were standard items on the agenda for team meetings at all levels. These included items such as data/statistics, Children First (2017) implementation, children/young people's participation, complaints, implementation of the Tusla practice model, training, and quality, risk and service improvement. Minutes of the Intake team meeting showed that feedback was provided on decisions taken by management and that, for example, the findings of a recent audit by a Tusla national team were shared with the Intake team for learning purposes. Staff told inspectors that the area manager attended various meetings and workshops with staff. Records showed that he participated with staff and staff told inspectors that he asked staff to ensure that he was made aware of any issues they might have. There was a process called "Need to Know", which was used to escalate information and issues of concern to the area manager and the national office and the criteria for its use were set out clearly. Inspectors reviewed that need to knows and found that they were used appropriately. Staff told inspectors that they were aware of and had access to sufficient information on their right to make protected disclosures.

There was also evidence of good communication between the Intake team and the various community agencies who made referrals to the service. The Intake and Assessment managers facilitated interdisciplinary workshops for the Tusla-funded agencies in relation to thresholds and the implications of Children First (2017). They provided family support forums and social work clinics in which agencies could meet with social work managers to discuss issues of relevance to the children they worked with and to receive guidance and advice. They also made presentations to multidisciplinary professionals, including hospital staff, and educators. Managers of the Intake and Assessment team facilitated training sessions every quarter for probationary and full-time Gardai. They held briefings for Gardai in local Garda stations in relation to Garda notifications. These initiatives promoted inter-agency working and a shared understanding of Tusla's remit.

Prior to this inspection, the area submitted data showing that, as of the beginning of March 2020, the Intake and Assessment team had 49 cases awaiting preliminary enquiries and 16 cases awaiting initial assessments. Managers told inspectors that there had been over 800 cases awaiting allocation in late 2017 and that the teams have systematically reduced that number in the interim. Protocols were in place to manage and monitor the current wait lists and the area manager indicated to inspectors that he expected that there would be no wait list for preliminary enquiries by early April 2020. A smaller number of cases were also awaiting allocation in the child protection area teams. The principal social worker for these teams maintained a tracker of these cases and reviewed it regularly. A duty system was in place to ensure that safety plans were reviewed and to address any issues that arose while the cases were waiting allocation.

There was good oversight of the management of referrals. Managers maintained oversight of the work of their teams and the area demonstrated a commitment to review the quantity and the quality of their work in a number of ways. Within the Intake and Assessment team, there were several mechanisms for ensuring that the progress of referrals was monitored. The area had developed a screening tool to provide evidence that screening of all referrals was carried out within 24 hours. These tools were signed by the relevant social worker and signed off by the team leader. A case meeting was held each Monday morning to discuss the referrals that had been received the previous week and the team leader often signed off on the screening tools at this meeting. When a case was allocated for initial assessment, the information to date was reviewed by the team leader who completed a post-intake prioritization sheet and included comments or guidance for the allocated worker.

A programme of audits by the Tusla national practice assurance and service monitoring team was in place. Audits by this team had been carried out as follows:

- August 2019 - review of cases awaiting allocation
- November 2019 - follow up audit of the national approach to practice
- February 2020 - the delivery of the child protection and welfare service from the point of initial reporting to Tusla through to the completion of initial assessment.

There was evidence that the findings of these audits were discussed by senior managers and that their recommendations were accepted and implemented. The findings of audits were also presented to individual teams at the regular team meetings. Findings from the August 2019 audit led to a change in the way the RED team operated. Preliminary findings from the most recent audit had been received by the area immediately prior to this inspection and the area manager had already made recommendations to his managers on foot of these findings. Further audits by the national team were scheduled for the remainder of 2020 at a rate of one audit per quarter.

The area had also completed two self-assessments in 2019 for the Tusla national office, one on safe services and the other on well-led services. These self-assessments led to a number of actions, including the development of improved quality assurance case audit templates for managers and the inclusion of discussion of local and national reviews as a standing item on the agenda for the QRSI meetings.

Principal social workers and team leaders were engaged in an ongoing process of auditing cases. The principal social workers audited cases monthly and their findings were captured on written templates and details of the auditor, the cases audited, and general findings were maintained on an overall tracker. While the records showed that the principal social worker for the Intake and Assessment team met with the team leaders and with the team to provide feedback on the audit findings, the mechanisms for ensuring that the audit findings were implemented required further improvement.

The area had a detailed audit plan in place for 2020. Each member of the Intake and Assessment team was scheduled to carry out a detailed audit on one of their cases every two months on average and this process had begun at the time of inspection. The focus of these audits included identifying that the Tusla business processes were followed, that timeframes were adhered to, that children's and families' views were sought, that they were given all relevant information and were invited to participate in meetings. The findings of the audits were to be discussed in supervision with the team leaders.

The team leaders were scheduled to carry out two collaborative audits each month, beginning in March 2020, as a pilot project in relation to a Tusla national initiative. Each audit would involve both team leaders meeting with a member of the team to audit one of their cases and engaging them in discussion of the cases for the purposes of learning and continually improving the social workers' practice. Principal social workers were scheduled to complete a minimum of 12 intake audits and 12 initial assessment audits for quality assurance purposes, identifying best practice and any issues of concern, with feedback provided to the team leaders and actions agreed for implementation. The area manager told inspectors that he would also audit a number of high priority cases awaiting allocation and that his priority was the quality of safety planning and the management of high risk.

There were arrangements in place to ensure monitoring and oversight of the use of recording systems. The National Child Care Information System(NCCIS) was used to electronically record and store information on the various practice activities of the service. Inspectors found the use of this system was embedded and, in the main, children's files were up to date and any documents required were easily retrieved. On a monthly basis, the data quality officer sent a data quality log to managers and to

the NCCIS user liaison officer. This included a summary of each team's data quality issues and specific issues related to each team. The user liaison officer forwarded individual team issues to the relevant team leaders and principal social worker and she then assisted teams to address any difficulties they had in updating their data. The data quality log was also presented to the area manager during supervision sessions.

Risk management systems were in place to identify and manage risks in the service. The area maintained a service risk register which fed into a regional risk register and risks which could not be managed by the area were escalated to the regional service director and to the national office, if necessary. Risks in the child protection and welfare service in relation to unallocated cases had been identified and addressed and measures that had been put in place to mitigate the risks were effective in reducing the wait lists and the associated risks.

The risk register was reviewed by the senior management team every quarter at quality, risk and service improvement (QRSI) meetings. It was also reviewed by the area manager in the interim. Records of regional QRSI reports from the West region showed that each area manager was accountable for ensuring that risk management systems were in place and the risk register was reviewed regularly. The issue of shortage of staff leading to delays in providing services to children was on the risk register and had been escalated to the service director and the Tusla national office. The area manager told inspectors that a business case had been made for these posts but that there was no funding available at present for these posts. The issue of funding for a service in the community was on the risk register and was in the process of being escalated to the Tusla national office.

Managers told inspectors that the service did not have sufficient staff to complete screening, preliminary enquiries and initial assessments within the timeframes recommended by Tusla. The staffing allocation to the Intake and Assessment team was two team leaders, seven social workers filling six whole time equivalent posts (five at senior practitioner grade), two administrative staff, one temporary social worker and one temporary social care worker. At the time of inspection, there was one vacancy at senior social work practitioner grade which was being filled by a temporary social worker. The area had recently carried out a resource analysis which identified the need for two additional social workers. Pending the sanction of these posts, a risk management plan was in place according to which one additional social care worker was employed on a temporary basis. However, the area manager told inspectors that additional permanent staff were required to ensure that timeframes for preliminary enquiries and initial assessments were met once the waiting lists had been eradicated.

Inspectors viewed a copy of the tracker the area maintained to ensure that up-to-date registration was in place for all social workers. The tracker was managed by

senior administrative staff who retained copies of social workers' registration certificates. Managers told inspectors that a tracker was also maintained of Garda Síochána (Irish police) vetting for all staff to ensure that all staff were Garda vetted and that updating of Garda vetting took place at regular intervals.

Staff told inspectors that they received regular supervision and were satisfied with the support they received from their managers. Inspectors found that staff supervision was of good quality. The frequency of supervision sessions was in line with supervision policy. Supervision sessions provided guidance and direction in relation to casework and they also focused on issues such as training and professional development and the wellbeing of staff. There was evidence that managers reviewed the caseloads of staff in line with the caseload management policy and that staff were not given unmanageable caseloads. The records of supervision sessions were also of good quality. There was evidence that any performance issues with staff were addressed and that support was provided to the staff concerned to assist in improving performance.

There were a number of other initiatives in place to support staff. These included an annual team development day, all-staff meetings four times yearly, and practice development meetings and group supervision each month. The area manager arranged for a psychologist to facilitate work with the Intake and Assessment team in order to build resilience in the team. Five sessions had taken place to date and the requirement for continuation of this resource was under review at the time of inspection.

Staff had the required skills and knowledge to manage and deliver effective services to children. Inspectors observed social workers on the Intake and Assessment team in the course of their work. Staff were polite when seeking information and they were diligent in clarifying information obtained and double-checking details of the calls. Inspectors also held a focus group with social workers and social care workers. Staff were knowledgeable and clear about the policies and procedures in relation to the management of referrals. Flow charts had been recently developed to assist staff in ensuring that these were implemented consistently. A small sample of parents told inspectors that social workers were professional, supportive, and clear in their dealings with them.

A training programme was provided to ensure that the staff team were competent and skilful in delivering a child protection and welfare service. The area finalised a training needs analysis in October 2018 and the training needs of staff were ranked in order of priority. Training in attachment, interviewing skills, advanced court skills, life story work with children, report writing and analysis, and training in the safety model adopted by Tusla, were ranked highest. A progress report for the area manager in December 2019 showed that significant numbers of staff had completed training in each of these. Records showed that a range of other training courses had also been provided, including, for example, in the areas of supervision, caseload management and practice development.

Mandatory training, such as training in Children First (2017), complaints handling, General Data Protection Regulation (GDPR), dignity at work, and health and safety, was also provided to staff and the area maintained a tracker to assist in ensuring that all staff attended this training. The area had also introduced a local induction training programme for new staff. A new principal social worker for the Intake and Assessment team had taken up her post in February 2020. She told inspectors that she had received a detailed handover from her predecessor and adequate support in her new role.

The area also held a number of “practice intensives”, two-day workshops which focussed on the implementation of Tusla’s national approach to practice. Managers and staff told inspectors that these were particularly helpful in ensuring that there was a consistent approach to the analysis of information and to decision-making.

<p>Standard 3.1 The service performs its functions in accordance with relevant legislation, regulations, national policies and standards to protect children and promote their welfare.</p>	<p>Judgment Substantially compliant</p>
<p>The service was well-managed and there were good governance structures in place. The service had focused on reducing wait lists and on the quality of the work undertaken. Further improvements were required in meeting key performance indicators to ensure that all children and families received a timely service.</p>	
<p>Standard 3.3 The service has a system to review and assess the effectiveness and safety of child protection and welfare service provision and delivery.</p>	<p>Judgment Substantially compliant</p>

Improvements in the area of quality assurance needed to be put in place to ensure that safety plans are monitored and reviewed in all cases, that all Garda notifications are timely, and that actions arising from internal audits are fully implemented.

Standard 5.2

Staff have the required skills and experience to manage and deliver effective services to children.

Judgment

Substantially compliant

While the staff group had the right mix of skills and experience to meet the needs of children, there was a shortage of staff on the Intake and Assessment team which resulted in delays to the service provided to children and their families.

Standard 5.3

All staff are supported and receive supervision in their work to protect children and promote their welfare.

Judgment

Compliant

Staff were well supported and supervision of staff was of good quality.

Quality and safety

Inspectors agreed with the area's self-assessment in relation to the theme of child-centred with Standard 1.3. Files reviewed by inspectors showed that the service provided to children was, for the most part, child-centred. Children were listened to and their voices were reflected in assessments. Children were kept informed and social workers and the social care worker interacted with children in ways that were appropriate to their age and development. Where possible, children were included in meetings such as safety planning meetings.

Since the self-assessment was completed, the area developed its quality improvement plan and undertook a number of initiatives to develop an even more child-centred approach. A new information pack with colourful child-friendly leaflets was available to give to all children to help them understand the role of the social work department in their lives. A young person's group was invited to help the social work department in ensuring that their new premises was child and family friendly. Children advised on the signage and the choice of furniture and colours for the access room and the family room. The area changed its screening tool to ensure that it captured information on whether or not a child had a disability or mental health difficulty so that any specific supports that were required could be put in place at an early stage. The Intake and Assessment team also decided that each child who had had an initial assessment would be sent a personal letter in child-friendly language explaining the outcome and the next steps to be taken. This was a recent initiative and inspectors viewed one such letter which was personal to the child and written in child-friendly language.

Records showed that social workers communicated in an open and transparent way with families so that they understood the reasons for social work involvement with them. Translators were used with families whose first language was not English to ensure they fully understood what was happening. Parents were kept informed about decisions taken in relation to the children's cases. They were informed by letter when cases were closing and asked for their feedback on the service they received. Managers told inspectors that the number of people returning feedback forms was small. Inspectors reviewed seven feedback forms and found that the main theme arising was the value of family support services.

In relation to the theme of safe and effective services (standard 2.1) inspectors did not agree with the area's self-assessment that it was, for the most part, meeting the standard. Prior to the inspection the area identified that, due to a shortage of staff and a significant increase in referrals in 2019, they were unable to meet the timeframes that Tusla set out for preliminary enquiries on referrals and for carrying out initial assessments of children's needs when these were required. As a result, they maintained wait lists, which they managed, reviewed and re-prioritized on a regular basis. While inspectors found that the service provided to children and families was of good quality when social workers were allocated to the cases, the existence of wait lists meant that some children did not receive the service they required in a timely manner.

In order to mitigate against the potential risks to children due to these delays, the area ensured that all referrals were screened and prioritized within 24 hours and that all new referrals were discussed by the Intake and Assessment team on a weekly basis. Thresholds to determine whether children required a social work service were applied and there was a robust system in place for referring children and families to other agencies in the community that may be able to provide support. The area had a good working relationship with An Garda Síochána but, due to delays in undertaking preliminary enquiries, not all notifications to An Garda Síochána were timely. The area prioritized the issue of children's safety and, while there was evidence that the safety of children was considered in all cases, the monitoring and review of safety plans needed to be strengthened, especially in cases that had not yet been allocated.

The receipt of referrals was well managed in the area. Child protection and welfare referrals were received in a number of ways: through a dedicated online portal; in writing; by telephone; or in person. These referrals were screened by social workers on the Intake and Assessment team who decided if they were appropriate to the service and required a social work response. All enquiries that did not name a child and required a social worker to provide advice or guidance were recorded on an electronic log which was maintained by an administrator.

Since Tusla's intake record does not always provide evidence that screening was carried out within 24 hours, the area devised their own screening tool to provide this evidence. Inspectors reviewed 37 referrals for evidence of screening and found this on 36 of the 37 (97%). In one case, the referral preceded the introduction of the screening tool. Data provided by the area indicated that all referrals were screened within 24 hours. Of the 37 referrals reviewed by inspectors, there was evidence that 31 (84%) were screened within 24 hours. One referral was screened within two days. In two cases, the screening tools were completed but not dated, and, in one case, the screening tool was dated eight days after the referral was received. In two cases, inspectors could not find evidence of screening.

While the area had reduced the number of unallocated cases during the previous two years, a shortage of staff on the Intake and Assessment team meant that the area was not able to complete preliminary enquiries within the timeframe of five days set out by Tusla. Data submitted by the area prior to the inspection showed that there were 49 cases on a waiting list for preliminary enquiries by the Intake and Assessment team.

Inspectors reviewed 27 cases for preliminary enquiries. All had intake records on file which were signed off by a team leader. However, in only two (7%) of these cases were the preliminary enquiries completed within the five-day recommended timeframes. In a small number of cases, the preliminary enquiries were completed within seven days but, in the majority of cases, they took between three weeks and three months to complete and, in one case, the preliminary enquiries were not completed for six months. In the majority of cases, details on referrals were clarified with the referrer. Social workers sought the consent of parents for network checks and checks with schools, medical professionals and Gardaí were completed. Referrals were consistently categorised and prioritised correctly. In some cases reviewed by inspectors, the intake records were not signed off when preliminary enquiries had been completed but, instead, when a considerable amount of work had been undertaken with the families concerned. The intake records also showed that consideration was given to previous referrals and the intake records of cases that went forward for initial assessments contained chronologies of all previous referrals and any previous social work involvement.

Thresholds of need were identified by the area and there was evidence of good cooperation between the social work department and agencies in the community to ensure that children and families received an appropriate response. The principal social worker told inspectors that there were approximately 70 Meitheals in operation in the area at the time of inspection. The RED meeting each fortnight, which comprised members of the social work department and coordinators of family support services in the community, met to consider referrals of children and families and to discuss the most appropriate service in each case. This was a two-way process. Children and families were referred to community services and, when necessary, social workers undertook assessments of children receiving a community service if risks escalated to the point where there were child protection concerns. The cooperation between the agencies ensured that services provided by community agencies were paused rather than ceased when the social work department resumed involvement with particular children and families. The area maintained good oversight of the services provided by the agencies to whom they provided funding.

Social workers took immediate action when this was required to ensure that children were safe and not subject to abuse. If it was suspected that children may be at immediate risk, appropriate action was taken in a timely manner. This included visits to the family home or the child's school to meet the child and make an assessment of their safety, immediate safety plans, or alternative arrangements for the child's care if this was required.

The Tusla and An Garda Síochána Children First joint protocol in December 2017 sets out the requirements in relation to formal communication, notification and joint working and decision-making. Inspectors found that there was extensive inter-agency collaboration took place with An Garda Síochána. There was also good liaison between social work and Garda managers at various levels in relation to shared cases and issues of mutual concern.

Under Children First (2017), if Tusla suspects that a crime has been committed and a child has been wilfully neglected or physically or sexually abused, it will formally notify An Garda Síochána without delay. Inspectors reviewed 11 cases for Garda notifications. Garda notifications had not been made in three of these cases and these cases were escalated to the area manager for review after the inspection. The area manager responded that notifications had subsequently been made in two of these cases. One case was allocated for preliminary enquiries which would indicate if a notification was warranted. Garda notifications had been made in the remaining eight cases but there were delays of between two to four weeks in making the notifications in four of these cases. As there were delays in undertaking preliminary enquiries in the area, there was a risk that not making Garda notifications until preliminary enquiries were completed might leave some children at increased risk of harm. In his response following the inspection, the area manager told inspectors that, in all cases to be waitlisted, Garda notifications would take place where abuse is indicated in the referral information in recognition of the fact that there may be a delay in the full preliminary enquiry process. He also indicated that the screening document would be amended to allow this to be verified and tracked.

The area maintained a wait list for initial assessments. Data provided by the area showed that, a week prior to the inspection, there were 16 cases awaiting allocation for initial assessment on the Intake and Assessment team, 10 high priority cases and six medium priority cases. There was evidence that the Intake and Assessment team leader carried out regular post-intake prioritization reviews, that the principal social worker reviewed the wait list each month, and that some cases were re-prioritized based on these reviews. However, this meant there continued to be delays for some children in receiving a service.

Inspectors reviewed 18 cases for initial assessments. In 14 of these cases, the initial assessments had been completed and assessments were in progress in four others. The average length of time between the receipt of the referral and the commencement of the initial assessment was 4.5 months. In three of these cases, the assessments were commenced within one week of the referral being received but in seven of these cases, there was a delay of between 6 months and 15 months before the initial assessment commenced. Once they had commenced, nine of the 14 assessments were completed within Tusla's 40-day timeframe.

Initial assessments were almost all of good quality. Children were seen or observed in the family home. Parents were consulted. The assessments included comprehensive analyses of children's needs and family strengths and weaknesses. Consultation also took place with other professionals involved with the children and support networks were identified. Risks, safety issues and the potential harm to children were considered. The outcome of the initial assessments were clearly recorded and recommendations were made about next steps to be taken. The outcomes were also shared with families. Appropriate action, such as the scheduling of child protection conferences, was taken where children were assessed as being at on-going risk of significant harm.

Consideration of and planning for children's safety was embedded in the area's management of referrals. However, improvements were required to improve the monitoring of children's safety. In case audits, the principal social worker identified that further work was required in the area of safety planning. Furthermore, the preliminary findings of a recent audit by the national practice assurance and monitoring identified that the monitoring of safety plans required strengthening, particularly while the area had an ongoing waiting list. On the basis of these findings, the area manager recommended a number of actions: that a full review of safety plans on unallocated high priority cases be undertaken and the findings discussed at the supervision of team leaders and the principal social worker; that a tracker be put in place to ensure safety plans are reviewed regularly and that this is reviewed monthly by the principal social worker and team leaders; that a schedule for review of individual safety plans on unallocated cases be drawn up, indicating who would review them and how often; and that a section on the monitoring and review of safety plans be included in local guidance on the management of unallocated cases.

A review of safety plans on this inspection arrived at similar findings to those identified by the area. Written safety plans were evident on many of the files reviewed by inspectors. Three types of safety plan were in use. An immediate safety plans was used at the initial stage of the process to address the specific issues of concern. An interim safety plan was generally put in place when it was decided that a child required an initial assessment. A long-term safety plan was drawn up when the child's needs had been assessed and a safety network had been established in the community and was involved in ongoing implementation of safety measures in the child's life. There was evidence that a social care worker was involved in reviewing safety plans on cases on the waiting list of the Intake and Assessment team. There was also evidence of duty social workers on the community area teams reviewing safety plans on cases awaiting allocation.

Inspectors reviewed 16 cases in which the need for safety plans was indicated and there were safety plans in place in 15 cases. One case was brought to the attention of the area manager and a safety plan was subsequently put in place. Good practice was evident in several of the safety plans reviewed. This included children and safety networks being involved in the development of the plans and children signing these plans, regular reviews of the plans, and plans being updated following review. However, inspectors found that in six of the 16 safety plans reviewed there was no evidence of monitoring and regular review of these plans.

Cases were closed when families no longer required social work intervention. Inspectors reviewed a sample of 26 closed cases and found that the closure of cases was appropriate. In almost half of these cases, the children and families were referred to other agencies in the community for support. There was evidence that families were informed of the case closures. The reasons for case closures were clearly documented.

<p>Standard 1.3 Children are communicated with effectively and are provided with information in an accessible format.</p>	<p>Judgment Compliant</p>
<p>The culture of the service was child-centred. Children were listened to and communicated with in an effective manner. Their voices were reflected in assessments and they were included in meetings and decision-making where appropriate.</p>	
<p>Standard 2.1 Children are protected and their welfare is promoted through the consistent implementation of <i>Children First</i>.</p>	<p>Judgment Partially compliant</p>

There were significant delays in the completion of preliminary enquiries and in the commencement of initial assessments. Notifications to An Garda Síochána were not timely in all cases. Safety planning required improvement to ensure that all safety plans were monitored and reviewed. For these reasons, this standard is judged to be partially compliant.