Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Child Protection and Welfare Service

Name of service area:	Sligo, Leitrim, West Cavan
Name of provider:	Tusla
Type of inspection:	Focused CPNS
Date of inspection:	01 – 03 March 2022
Lead inspector:	Una Coloe
Support inspector(s):	Sabine Buschmann Sharron Austin
Fieldwork ID	MON-0035729

About monitoring of child protection and welfare services

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

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

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

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

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

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

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

How we inspect

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

The key activities of this inspection involved:

- the analysis of data
- interview with the area manager,
- interview with one principal social workers
- interview with the child protection case conference chairperson
- focus groups with social work team leaders
- focus group with social workers & social care workers
- the review of local policies and procedures, minutes of various meetings, staff supervision files, audits and service plans
- the review of eight children's case files
- phone conversations with six parents
- phone conversations with four children

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

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

Profile of the child protection and welfare service

The Child and Family Agency

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

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

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

Child and family services are organised into 17 service areas and are managed by area managers. The areas are grouped into six regions, each with a manager known as a regional chief officer. The regional chief officers report to the national director of services and integration, who is a member of the executive management team. Child protection and welfare services are inspected by HIQA in each of the 17 service areas.

Service area

The area was under the direction of the Regional Chief Officer for Tusla West, and was managed by an area manager. The child protection and welfare social work team was managed by one principal social worker, who had line management responsibility for four team leaders. Children listed on the child protection notification system (CPNS) were case managed by three long term child protection teams based in Sligo, Tubbercurry and Carrick-on-Shannon and a fourth intake duty team with workers based in each of the three offices. The area manager delegated child protection conferencing responsibilities to one principal social worker who was the child protection conference (CPC) chairperson. Administration staff were employed to assist in the delivery of this service. Both of the principal social workers reported to the area manager.

At the time of the inspection there were 25 children listed as active on the CPNS. Seven children had been de-listed in the previous six months and nine children had been transferred to another service area.

Compliance classifications

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

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

This inspection was carried out during the following times:

Date	Times of inspection	Inspector	Role
28/02/2022	10:00 – 12:00	Una Coloe	Lead Inspector
01/03/2022	10:00 – 17:00	Una Coloe Sabine Buschmann Sharron Austin	Lead Inspector Inspector Remote Inspector
02/03/2022	09:00 – 17:30	Una Coloe Sabine Buschmann Sharron Austin	Lead Inspector Inspector Remote Inspector
03/03/2022	10:00 – 12:00	Una Coloe	Lead Inspector

Views of people who use the service

As part of this inspection, inspectors spoke with four children and six parents of children who were subject to a child protection conference (CPC) and listed on the child protection notification system (CPNS). This section of the report will provide an overview of the views of parents and children shared with inspectors, about their experience of the service and the CPC process.

The children who spoke with inspectors said they understood why the social work department were involved with their family. All of the children were aware of the reasons for their CPC and said their social worker obtained their views prior to the meeting taking place. Two children told inspectors that the social worker completed child friendly tools with them to obtain their views, which they said they liked. Of the four children who spoke with inspectors, none of the children had attended their CPC. Two of the children were too young, one child said they did not want to attend and one child told inspectors they were not invited. One child told inspectors that they were aware of their safety plan while another child said the social worker explained the outcome and decisions from the CPC. All of the children were happy with the contact they had with their social worker.

Some of the comments from the children are as follows:

- "she (social worker) talks to us, sometimes she plays with us"
- "usually listens to me"
- "things became better definitely"
- "definitely happy that they helped"
- "she (social worker) visits more or less once or twice a month"
- "she (social worker) usually speaks to Mum first and then to me"
- "all I see is a safety plan"

Inspectors spoke with six parents all of whom had attended their CPC. All parents told inspectors that they understood the reason for social work involvement with their families and the reason for the CPC process. They described good communication between themselves, the social work department and the CPC chairperson. Parents agreed that they were given information about the CPC service in advance of the meeting taking place. One parent said "they spent loads of time trying to explain the situation, trying to make us understand, trying their best to explain what was needed".

All parents said they had opportunities to discuss their views and felt listened too at the CPC. One parent told inspectors that they were "given every chance to speak and have our point of view", while another parent said the social work team was "very much open with us". A third parent told inspectors that "there are times when I felt Tusla

weren't doing things in my child's best interests – but can't fault them, they looked at my whole family and did have the family's best interests at heart".

Overall, parents were satisfied with the contact they had and the support they received from their social worker. They described a service which had a positive impact on them and their children; one family member told inspectors, "things have got better since Tusla became involved", while another said "things had improved".

Parents described positive relationships with their social workers and some of the comments are as follows:

- "absolutely unbelievable at her work" – " cannot commend that woman more and the team"
- "great support"
- "can't fault them"
- "dreaded having Tusla involved" but now "Thank God"
- "the social worker put in extra time and effort", "went beyond their pay package", "have a lot of respect for them"

All parents who spoke with inspectors were happy with the service they received and did not identify any challenges or ways the service could improve. One parent described a positive change to practice following feedback they provided. This parent said the social work department commenced the CPC outlining positives in their family, following the request from the parent. The parent described this as "the best meeting with Tusla". While this sample of parents and children generally outlined that their experience of the service was positive, inspectors found some areas that required improvement, in order to further enhance the service.

Capacity and capability

Overall the Sligo, Leitrim, West Cavan service area needed to strengthen governance arrangements in order to provide a consistent safe service to all children listed on the CPNS. Governance and management systems were established in the area but the effectiveness of these systems varied and improvements were required. The management team were committed and had implemented some recent changes to the governance of the CPNS, but more was required. This inspection found non-compliances with systems to review and assess the effectiveness and safety of the service. Risks were identified relating to seven out of the 25 children (28%) listed on the CPNS. Inspectors found that while four of the seven children had been seen by a social worker during home visits, they were seen irregularly over long periods of time and social workers had not met with the children to assess their needs or obtain their views. Three of seven children, one listed on the CPNS for six weeks and two for significantly longer, had not been seen by a social worker since they were listed. Appropriate assurances were provided to the inspector that these children were subsequently visited and met with by a social worker.

The focus of this inspection was on children placed on the CPNS who were subject to a child protection safety plan (CPSP) and the aligned governance arrangements in place to ensure effective and timely service delivery to these children. At the time of the inspection, there were 25 children listed on the CPNS. The numbers on the CPNS had increased significantly as data provided by Tusla national office showed that there were nine children on the CPNS in December 2021.

As per Children First, National Guidance for the Protection and Welfare of Children (2017), when concerns of ongoing risk of significant harm are identified during the assessment and intervention with children and families, Tusla is required to organise a CPC. In circumstances where a child has been identified as being at ongoing risk of significant harm at a CPC, their name is placed on the CPNS. This means that children on the register are closely monitored by the social work department to ensure they are safe and interventions are provided to children and families to reduce risks to children. Children who have CPSP continue to live at home, unless it emerges that a child is at ongoing risk, or if the child protection plan is deemed not to be working. These cases may result in a decision to remove the child from the home. This inspection also reviewed children whose names had been removed from the CPNS in the last 6 months.

Tusla National Guidelines on Child Protection Conferences and The Child Protection Notification System was developed in 2018. At the time of the inspection, the document was in the process of being reviewed by Tusla national office but it

remained an interim guideline. The management team were proactive in their response to address gaps in national policy or guidance. A locally produced workflow practice document, 'Sligo/Leitrim/West Cavan Child and Family Agency Social Work CPC and CPC Safety Planning process' was developed to provide guidance to staff on the practice required at all stages of the CPC process. This was comprehensive and aligned with the service approach to child protection. This guidance clearly outlined the expectations of staff in the management of cases on the CPNS including the process for requesting a CPC, preparing participants and the provision of reports for CPC and the requirement to ensure appropriate safety plans were agreed, as required, following CPC's. The area manager outlined that they had a standard practice of completing fortnightly visits to children listed on the CPNS. Social workers and management described clear procedures for the referral and organising of a CPC, and demonstrated their knowledge of policies, legislation and standards in relation to the protection of children.

The service area had an experienced management team and there were clearly defined roles and responsibilities in relation to the management of children listed on the CPNS. The area manager delegated conferencing duties to a principal social worker who was the CPC chairperson. The chairperson was responsible for managing requests for CPC's from social workers and determined if the referrals met the threshold for a CPC. The role of the CPC chairperson included scheduling, organising and facilitating the CPC meetings. In addition, they ensured the CPNS was updated and maintained. The chairperson commenced in the position in August 2021, following a period of three months where this role was vacant. The principal social worker for child protection and welfare had responsibility to maintain oversight of the day-to-day implementation of child protection safety plans and monitoring of children listed on the CPNS. She supervised social work team leaders and also maintained oversight of the service through team meetings and informal updates. The social work teams worked in three separate locations and held a range of duties across all aspects of the child protection and welfare service.

Overall accountability for the child protection notification system lies with the area manager who provided assurances to the Regional Chief Officer and the Director of Services and Integration about the safety and quality of the CPNS in the area. Inspectors found that governance systems required significant improvements. The area manager told inspectors that management meetings, supervision and quality, risk and safety meetings provided him with assurance on the safety of the service. However, the CPNS or CPC service was not routinely discussed at management meetings or quality, risk, safety and information (QRSI) meetings. It was not evident that performance data or reports from CPNS service were discussed at these management forums. In addition, it was not recorded if children on the CPNS were allocated a social worker, if safety plans were monitored or if timelines for

CPC's were within the timeframes required. Therefore, governance meetings did not provide assurance to the area manager on the quality or safety of the service.

Service planning required improvement in the area. The area had a service plan for 2021 but at the time of inspection, there was no service development plan for 2022. The regional chief officer was in the process of reviewing the approach to service planning. The proposed plan was to develop individual plans for different aspect of the services provided across the area, including the CPNS. Inspectors found, that in the absence of a service area development plan, some work had commenced by the recently established CPNS governance group in relation to a quality improvement initiative for the CPNS service. The chairperson had already systems in place to improve service provision including the roll out of training for the social work teams on safety planning and direct work with children, as well as, changes to their practices of obtaining feedback from parents. The chairperson intended to implement further quality improvements when the service plan for 2022 was developed.

There were some quality assurance systems in place but they required further development. Inspectors found that the senior management team and social work team leaders, had a high level of knowledge of individual cases of children listed on the CPNS and when clarification was sought on actions or decisions on individual children's files, this was provided to inspectors. The CPC chairperson examined the quality of reports she received prior to CPC's and had addressed deficits identified leading to improvements in the quality of the reports. The CPC chairperson had commenced a new auditing initiative, "joint practice review" in February 2022. The process reviewed the safety planning process, network involvement, and monitoring and review arrangements on the selected case for review. It was not possible to determine the effectiveness of this approach as only one audit had been completed at the time of inspection. However, this approach allowed for opportunities to reflect on cases, to improve practice and decision making to support better outcomes for children. The CPC chairperson intended to complete one of these reviews per month with social workers.

There was a lack of routine or systematic auditing to assure managers of the effectiveness of the service being provided over the last 12 months and managers told inspectors that the auditing of case files was not consistent due to time constraints. The area maintained a tracker of audits completed on child protection and welfare cases but it was not adequate as it did not identify if these were cases on the CPNS or if these cases were routinely audited. Inspectors were provided with copies of eight audits completed on individual cases in November 2021. The audits

reviewed the assessment of the child, case notes, safety plan network and work completed with the child.

A formal system to routinely audit data recorded on the CPNS had not been established at the time of the inspection. The chairperson told inspectors that she routinely monitored data on the CPNS but did not keep a record of these informal checks. The chairperson identified an error on the CPNS during inspection, where the incorrect abuse of category was listed for a child. The chairperson made amendments immediately but this error meant that there was the potential that professionals accessing the CPNS may not have received accurate information in relation to the risks identified for the child. The chairperson and an administration staff had access to the system and the chairperson was assured that no unauthorised or unnecessary personnel had accessed the system. The area manager said that he also received a notification if the CPNS was accessed outside of office hours.

The chairperson had responsibility to update the CPNS. Inspectors found that when a child was placed on the CPNS, the abuse category could not be changed nor could more than one category of abuse be recorded. This meant when one type of abuse was no longer a concern for the child but another type of abuse had emerged, the CPNS could not accurately reflect the concern for the child. To mitigate against the associated risks, the area had a system for adding a note to the record to advise if there was a secondary category of abuse related to a case. Inspectors found that this system was consistently used.

Systems to monitor the CPNS process including visits to children required improvement. The CPC chairperson monitored the CPC process through NCCIS and the area manager was assured that the chairperson tracked timeliness in accordance with their workflow process. The principal social worker said a formal tracker of children listed on the CPNS, was not developed because, until recently, the numbers of children listed on the CPNS had been relatively small and this had not been required. It was the responsibility of social workers and team leaders to ensure safety plans were monitored and children were safe and visited in line with local guidance. However, child protection safety planning was found to be ineffective for some children.

This inspection found deficits in the monitoring of child protection safety plans as not all children on the CPNS had been visited as required. As noted earlier, inspectors sought an urgent compliance plan with regard to the failure to ensure the safety of some children on the CPNS, including six children who had not met with a social worker to have their needs assessed since they been listed on the CPNS. Despite efforts of the social work department to engage with the family, the monitoring and oversight arrangements were inadequate to ensure their timely protection, safety and welfare. Due to significant non-compliances with the standards, an urgent compliance

plan was issued requesting assurances in relation to individual children. In addition, the area was required to outline their governance and oversight arrangements to ensure the provision of a safe service for children on the CPNS. A comprehensive response was returned which assured inspectors that all children had been visited and appropriate action was taken to ensure their safety. It also outlined plans to strengthen the governance and oversight of cases on the CPNS through improved supervision and monitoring systems. In addition, the area planned to implement new procedures regarding the allocation of a social worker to children and minimum requirements for visits to children on the CPNS, as well as an escalation process to senior management if the procedure is not adhered too.

Staff supervision was identified as an assurance mechanism by all managers who met with inspectors. Case supervision records were contained on all files reviewed and in some cases, the process was effective to ensure managers had sufficient oversight. However, records of supervision between team leaders and principal social workers, demonstrated that updates were provided in relation to child protection and welfare cases but it was not consistently recorded if all children on the CPNS were discussed. Supervision was not consistently occurring in line with the frequency required by policy. Records evidencing managerial oversight, particularly from informal case discussions were not routinely uploaded on children's case files, therefore it was not possible to track all decision making. The principal social worker identified this as an area for improvement.

The area operated a practice support forum to provide an objective review of referred cases, and to provide additional direction on complex cases. Social workers and managers told inspectors that the forum was a valued and effective process for supportive discussions regarding their work with families. The allocated social worker referred the cases and the forum was attended by senior managers and the area manager. This forum took place five times in the last 12 months and it was evident that children on the CPNS were referred to this forum, detailed discussed took place and actions listed to progress cases.

The service area had risk management systems in place in line with Tusla's risk management framework but some risks had not been identified or assessed, including unallocated children on the CPNS. The service had a risk register which included identified risks such as staffing deficits and non-compliance with standards or regulations. These risks were regularly reviewed at QRSI meetings and the necessary action taken to mitigate these service risks. However, other risks relating to the CPNS were not listed on the risk register such as, safety plans for children on the CPNS not being monitored, delays convening CPC's and or review CPC's as a result of a vacant CPC chair post. The area manager advised that this was not entered on the

risk register as the length of time the position was vacant, was prolonged unexpectedly.

The governance of data was inadequate. Inspectors found that the quarterly performance data published by Tusla national office in relation to the area was not accurate as it did not reflect the unallocated children relevant to the theme of this inspection in Quarter two 2021. The area manager outlined that he received monthly data directly from the team leaders but as a result of errors on NCCIS, this data was incorrect. As noted earlier, performance data was not presented at management meetings and therefore this error had not been identified until the inspection. The area manager assured the inspector that the data in respect of all cases on the child protection system would be reviewed to prevent a reoccurrence of such errors.

The senior management team were committed to continually improving the services they delivered to children and families. There was a strong focus on learning and development within the area. The CPC chairperson set up a learning and development group with another area within the region to share learning, analyse common emerging themes and overall to improve the quality of service provision.

The organisational culture in the service encouraged open communication and team working. Inspectors found that although there were communication systems in place, they required improvement to ensure all deficits relating to the service were communicated adequately. Social workers outlined that the service was well-led and described managers as supportive and approachable and said that they provided good quality management and leadership. They said case load management was considered but described staffing as a challenge in the area. This inspection found that there was no contingency plans in place for the management of cases on the CPNS, to ensure that safety plans were monitored if a staff member had unexpected leave. The principal social worker said that children were unallocated in 2021 due to staffing deficits.

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.

Staff demonstrated a knowledge of relevant legislation, guidelines and standards. The area had taken learnings from previous inspections and from local and national audits. Tusla National guidelines on child protection case conferencing and the child protection notification system was subject to review and required updating to ensure consistent delivery of service to children subject to child protection conferencing process. In the interim, the area had developed a local guidance document for staff in relation to the CPC process.

Judgment Substantially compliant
Standard 3.2 Children receive a child protection and welfare service, which has effective leadership, governance, and management arrangements with clear lines of accountability.
There was a committed management team in the area and lines of authority and accountability were clearly set out. They promoted a culture of learning and development amongst their staff. The management team had a clear vision for the service but there was no up-to-date service plan to guide the direction of the service. The governance structures were not effective as the CPNS service was not consistently discussed or reported on at governance and management meetings or at supervision. Therefore these systems did not provide assurances as to the safety and quality of service provided to children.
Judgment Not Compliant
Standard 3.3 The service has a system to review and assess the effectiveness and safety of child protection and welfare service provision and delivery.
Monitoring systems were not robust to ensure the service was delivered in line national guidelines and standards. Systems to monitor and track the service provided to children on the CPNS were not effective to ensure all children were safe, visited as required and their safety plans monitored appropriately. There was a lack of formal and systematic auditing of case files. The risk management system was not effective as not all risks were identified or assessed. Risks relating to the CPNS were not listed on the risk register. The management of data on CPNS and NCCIS was not adequately monitored to ensure the data was accurate.
Judgment Not Compliant

Quality and safety

Children who were assessed as being at ongoing risk of significant harm or neglect were referred to the CPC service in a timely manner and were the subject of a multi-disciplinary child protection conference. There was good interagency and inter-professional working relationships and interagency practice in the area promoted the protection and safety of children. However, inspectors found that some improvements were required in the delivery of services to children on the child protection notification system in order that every children received a consistent service. These improvements are outlined below.

Cases were appropriately referred for a CPC but the timeliness of convening initial CPC's was not consistent. Requests for CPC's were detailed and outlined the presenting risks as assessed through the initial assessment process, or from the ongoing assessment with the family. The CPC chairperson had responsibility to assess the referral and consider if it met the threshold for a CPC. The requests were very detailed and recorded on the child's file. Inspectors reviewed five files for the timeliness of initial CPC's. Initial CPC's were convened in a timely manner, within a month of the referral for the CPC, for three of the five children. There was a gap of two months between referral and convening of the CPC, for two children, which was outside of the requirements of the area's local process. The reasons for the delays were clearly recorded and related to staffing challenges and COVID 19. Robust safety plans had been put in place while the initial CPC's were being organised, and the children's safety had been maintained. Although there was a delay devising the safety plan in one of these cases, support services were liaising with the family and monitoring the safety within the home. Social workers told inspectors that requests for CPC and convening of initial CPCs were generally timely and in line with the local workflow process. There was no waiting list for initial CPC's.

Child protection conferences were found to be well planned and inclusive of all relevant family members. They were well attended by all relevant professionals, as required, to ensure the needs of children were appropriately represented and plans to address risks, included all relevant people. Child protection conferences were comprehensively facilitated by an independent, appropriately trained and professional chairperson. The chairperson was in position for six months and although had other duties across the service, the duties did not include case management responsibility. Inspectors found that initial CPC's were well chaired and facilitated, ensuring every aspect of risk, as well as children's needs were discussed and plans agreed, where required. Participation of all attendees was encouraged and each person's views sought, considered and recorded within conference records.

There was meaningful participation of children and families in the CPC process. Social workers and the CPC chairperson met with children and parents prior to the conference to ensure they understood the process and to obtain their views. Children were invited to reviews as appropriate and where children chose not to attend, their views were presented during the conference. Child-friendly tools had been developed to assist the children to participate and give their views in relation to their life and their family and social workers used these tools to assist children to present their views. In addition, the area had developed child-friendly leaflets regarding the role of the social worker and children's rights. These documents had been translated into various different languages and translators were provided to support families, when this was required.

Following every CPC, a child protection safety plan (CPSP) was put in place. Child protection safety plans reviewed as part of this inspection clearly listed the risks and or concerns as discussed during the CPC and identified actions to protect children subject of the CPSP against these risks. The standardised template was used to provide a comprehensive record of the key components of the safety plan, including the existing strengths and safety, identified risks and actions to be completed. The plans clearly recorded the identified person responsible for completing each action. According to the Tusla guidelines for CPC's and the CPNS, regular safety planning meetings were to be convened following the CPC to develop a more detailed child protection safety plan, review the safety of the child and also monitor the progress in relation to the case. It was the responsibility of the allocated social worker to implement a CPSP in partnership with the family, the identified safety network and relevant professionals involved with the child. The area manager outlined to inspectors the expectation that children on the CPNS were to be visited every two weeks. The frequency of safety network meetings was noted on the individual CPSP. Social workers identified difficulties in establishing a safety network for some families and there was evidence of social workers supporting families in respect of this.

Inspectors reviewed five children's files to assess if the plans had been monitored, as required. Inspectors found that safety plans were monitored and visits to children took place in line with the requirements of the safety plan for two children. In a third case, attempts were made to meet with the child, following the initial CPC, as required, but this could not be facilitated due to circumstances outside of the control of the social worker. Despite this, the social worker monitored safety through meetings with family members and inspectors found that when the work commenced with the child, this was of good quality. As noted earlier, inspectors sought assurances in relation to six children due to the services inability to implement child protection safety plans for a prolonged period of time. Although, social workers had observed some of the children while carrying out home visits with parents, despite

persistent efforts by social workers, they had been unable to meet with children to assess their needs. This meant that some children had not had their individual needs and risks adequately assessed and they had not had the opportunity to talk to social workers about their situation since they were listed on the CPNS more than a year earlier. Inspectors sought an urgent compliance plan following the inspection regarding this and as noted earlier, a comprehensive plan was returned to address the deficits. Verbal assurances were also sought relating to another child who had not been visited by a social worker and inspectors received appropriate assurances that the child was visited. Evidence provided to inspectors following inspection fieldwork, outlined that in the absence of a visit or observation of this child, the social work department had engaged with the safety network and the child's siblings. In addition, this child had been assessed by a medical professional since they were listed on CPNS.

Inspectors found that in the majority of cases, children and families were an integral part of their own safety network. Staff within the service were clear on their responsibility to ensure that children, in particular, fully understood the plans in place to ensure their safety. Inspectors saw evidence of some good examples of child-centred practice through social workers safety planning with children. The social work department were focused on enhancing their work with children by developing child friendly safety plans to assist in their safety planning interventions with children. Social workers were committed to supporting the family to identify safety networks and in most cases this had been achieved. Inspectors found that that social workers were innovative in ensuring families continued to have a safety network and they continued to monitor the safety of children when families travelled out of their service area or spent periods of time away from their normal residence. Parents were involved in the development of child protection plans and received copies of these in most cases.

At the time of this inspection, there were two families who were currently listed on the CPNS that had a review child protection conference (RCPC). As with initial child protection conferences, review child protection conferences were chaired by an independent professional who ensured these RCPC's considered multi-disciplinary input and involved active participation from all present. The reviews considered progress since the previous CPC and decisions were reached based on this progress. Clear and detailed decisions were recorded on the standardised template in relation to the next steps to be taken. Inspectors found that one RCPC was carried out in line with Children First (2017) but the RCPC for the second family was significantly delayed however, there was a clear rationale for this delay.

Inspectors reviewed three children that had recently been de-listed from the CPNS. Inspectors found that there were clear rationales recorded for the decision to de-list

these children and all were de-listed appropriately. Each case was appropriately overseen managed and monitored and there were comprehensive records to support decisions in each case.

The service supported and promoted interagency and inter-professional cooperation and input to ensure children's safety needs were met. There was evidence of good working relationships between the social work department and An Garda Síochána. The area had regular liaison meetings with An Garda Síochána and strategy meetings took place with An Garda Síochána, when this was required, on specific cases to promote safety for the children and families. The area met with the local child and adolescent mental health services (CAMHS) team to share information and to discuss and prioritise cases when this service was required. The CPC chair sought feedback from professionals following a CPC and collated this information to drive improvements in service provision.

Social workers and team leaders told inspectors that there were effective working relationships with external professionals and information was shared as required. Professionals provided reports for CPC's and there was regular contact recorded on files to assist in effective case management. Roles and responsibilities were clearly defined and it was evident that external professionals shared appropriate information to support assessments and interventions. Interagency working was found in all of the cases reviewed and it was evident that this practice was embedded in the area.

The service had a strong focus on inter-agency working and the sharing of information between services. Staff told inspectors that a multi-agency webinar was held in sept 2021 by Tusla, An Garda Síochána & the sexual assault treatment unit within the health service executive to facilitate information sharing in relation to sexual violence. The service also attended interagency meetings with an agency who brought together health, medical, therapeutic and policing services for children and adolescents in a child centred way where sexual abuse is suspected. Managers in the service identified the need for training for professionals regarding the CPC process and thresholds. This training was provided prior to COVID 19 but the area had commenced plans to roll out this training again in the coming months.

Standard 2.6
Children who are at risk of harm or neglect have child protection plans in place to protect and promote their welfare.

Child protection conferences were requested appropriately but improvements were required to ensure that all were convened within consistent timeframes. They were appropriately facilitated by independent persons. Parents and children were encouraged to attend and participate in their CPC meeting. Child protection safety plans were developed following the decision to list a child as active on the CPNS. Child protection safety plans were detailed but they were not monitored in line with the requirements of the safety plan in all cases. Not all children had been visited to ensure their safety and some child protection safety plans were not effective.

The CPNS was updated and managed in line with *Children First 2017.*

Judgment
Not Compliant

Standard 2.7
Children's protection plans and interventions are reviewed in line with requirements in Children First.

Review child protection conferences were chaired by an independent professional who ensured these RCPC's considered multi-disciplinary input and progress since the previous CPC. Not all reviews were carried out in line with Children First (2017).

The service ensured that the delisting of cases from the CPNS was planned and agreed by social work managers.

Judgment
Substantially compliant

Standard 2.9 Interagency and inter-professional cooperation supports and promotes the protection and welfare of children.
The service had a strong focus on inter-agency working and the sharing of information between services. The service supported and promoted interagency and inter-professional cooperation and input to ensure children's safety needs were met There were clearly defined mechanisms and procedures for sharing of information and joint training initiatives in place. Professionals were clear on their responsibilities as part of child protection safety plans and the role and function of each agency was explained to children and families.
Judgment Compliant

Compliance Plan for Sligo, Leitrim, West Cavan Child Protection and Welfare Service OSV – 0004395

Inspection ID: MON-0035729

Date of inspection: 01 – 03 March 2022

Introduction and instruction

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

The provider is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response

must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Standard Heading	**Judgment**
Standard 3.1	Substantially compliant

Outline how you are going to come into compliance with Standard 3.1: The service performs its functions in accordance with relevant legislation, regulations, national policies and standards to protect children and promote their welfare.
The National Interim Policy is under active review. In the interim, until the National Policy is finalised, Sligo Leitrim and West Cavan will continue to implement the local Area Standard Operating Procedure (SOP) and guidance which ensures that the gaps in the National Interim policy are bridged and the protection of children enhanced.

Standard 3.2	Not compliant

Outline how you are going to come into compliance with Standard 3.2: Children receive a child protection and welfare service, which has effective leadership, governance and management arrangements with clear lines of accountability.

Action: The development of a 2022 Area Service Plan will be completed by mid-July 2022. This will set out the strategic area and departmental goals in line with regional and national service objectives. All staff will be furnished with a revised organogram along with the 2022 Area Service Plan.

Action: Governance shall be systemically enhanced within the service to ensure that all children receive a child protection and welfare service, which has effective leadership, governance and management arrangements with clear lines of accountability:

(a) We currently have a local Child Protection Notification System group established since November 2021, this group consists of Senior Management, and Team Leaders for Child Protection and Welfare in the Area and shall be the key oversight and governance meeting to track quality and service provision to all children on CPNS within the area and will met every two months. The CPC Chairperson reports back from this group to the senior management meeting. This ensures that any gaps, risks or quality concerns in respect to children listed on CPNS are discussed and actioned with/in the senior management group on a regular consistent basis.

(b) Currently all CPNS cases are discussed in supervision between the allocated Social Worker and the Team Leader. CPNS cases are also now a standard agenda item on supervision records between Team Leader and Principal Social Worker for Child Protection and Welfare. Any cases identified requiring further governance (case complexity, concerns in relation to safety planning, legal planning) within this process will be brought to supervision by the PSW for Child Protection and Welfare with the Area Manager. This ensures that safety planning for all children on CPNS are discussed and reviewed at all levels of service provision within the department and ensures the safety and protection of children within CPNS.

(c) The area has a well-established Practice Support Forum where complex cases are brought for discussion. Currently all CPNS cases at the 3rd review stage shall be referred to the Practice Support Forum for discussion, planning and learning. This enhances the development of quality safety plans by exploring multi perspectives offered by different professionals at different levels within the service.

(d) It has been the practice within the area for some time that the PSW for Child Protection and Welfare attends the 3rd CPC review to allow for further governance to prevent cases drifting within the CPNS system.

(e) PSW for Child Protection and Welfare and CPC Chairperson have met with all Team Leaders to share these compliance measures and all staff are currently working towards same.

(f) PSW for Child Protection and Welfare has made a request to PASM to conduct a full audit of supervision files for the Child Protection service, this audit will be begin on the 7th June 2022. Learning from the audit will be shared within senior and middle management meetings and a plan for actioning any recommendation agreed.

Standard 3.3	Not Compliant

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

This compliance plan outlines how the area will enhance the monitoring systems in place for all children on CPNS to ensure the effectiveness and safety of child protection and welfare provision and delivery within Sligo, Leitrim & West Cavan:

Action: Principal Social Worker for Child Protection and Welfare will undertake a specific case review and file audit in respect of the children identified during this inspection to ensure that this and all other cases listed on CPNS are in full compliance with all policies, regulations, legislation and standards to protect and promote the welfare and safety of children. The learning from this file Audit shall be shared with the service at a learning event as part of the Practice Support Forum at the end of quarter three 2022. This exercise shall inform staff around all measures required to ensure all children within the CPNS service receive a safe and timely service that is monitored and reviewed effectively.

A finding from the inspection identified a case on CPNS where the children did not have an allocated social worker for a period of time as a result of staff shortages**.** To ensure this does not occur within the area again the following has been actioned:

(A) The Area Manager has issued a clear protocol through the Senior Management Team and to all relevant Team Leaders and staff that all children listed on the Child Protection Notification System must have an allocated social worker. Furthermore that all children listed on Child Protection Notification System must be visited within agreed timeframes of 1-2 weekly as per individual safety plans. In the event that a child on the Child Protection Notification system is not allocated the Area Manager must be notified. This is essential to ensure that all children active on CPNS have an allocated social worker, who visits the child frequently and works with the family to develop and monitor effective safety plans to ensure the safety of children.

(B) The staffing deficits within the service have been logged on the local and regional risk register. This is reviewed every 6 weeks at our local and regional Quality, Risk and Service Improvement meetings. The local area is proactive in their attempts to address staffing deficits and have a healthy working relationship with Sligo IT, providing placements for students in the hope of future recruitment. PSW for Child Protection and Welfare ensures she participates with local recruitment and sits on regular interview panels for social work staff the next one is scheduled for June 2022.

(C) Any risks associated with staffing deficits within the service needs to be explored and identified. They need to be escalated without delay to the local and regional risk register. This will ensure any potential gaps (e.g. risks to reviews been outside times frames) in respect of safety planning for children are identified and risk alerted in a timely manner. All risks are then reviewed on a six weekly basis within the local and regional Quality, Risk and Service Improvement meeting.

Action: A separate template has been developed for the 'child supervision record' for children on CPNS to include headings: 'child visits' and 'frequency of safety network meetings', 'purpose of visit', 'child seen' to ensure they are tracked and recorded. This adds a further layer of governance; Team Leaders are able to monitor the specifics of the child safety plan to ensure that they are addressed in every supervision and are in line with Children's First.
Action: If a CPC is delayed, safety plans in place need to be reviewed in the interim to ensure children remain safe. To ensure appropriate governance consideration is given to this review a meeting will be arranged between CPC Chairperson, Child Protection and Welfare PSW, Team Leader and Social Worker to review the progress, monitoring and effectiveness of the safety plan in place and make any recommendations as is required to ensure the effective safety planning is in place.
Action: If during normal monthly supervision when a safety plan for a child on CPNS is discussed and reviewed and it has been identified that the case is not progressing along the planned trajectory within the safety plan, this needs to be flagged with the PSW for Child Protection and Welfare without delay. Consideration at this juncture can be given to the case being brought to the Practice Case Forum. The monthly monitoring of safety plans in

supervision between Social Worker and Team Leader, Team Leader and PSW coupled with this additional governance oversight ensures that there is no drift in safety planning for children on the CPNS.

Action: The CPC chairperson has developed a yearly tracker of all cases on CPNS This tracker will be audited by the Chairperson on a monthly basis to ensure all data on CPNS is accurate, to keep abreast of themes emerging for children within the system, and ensure upcoming reviews are held within time frames. This information will be discussed in supervision with the Area Manager as a monthly standing item. This will also be a standing item for discussion at the local CPNS governance group. Information and learning will be shared and explored to allow for continues improvement of service delivery for children on CPNS.

Action: The area are currently in the process of implementing 'The Joint Practice Review', as our standard audit for cases on CPNS. Training has occurred and individual support is currently being given to team leader by the Regional Signs of Safety Learning and Development Practice Lead. The area aim to conduct 1 such Audit per Child Protection team every month. The audit tool offers a real opportunity for practice development as well as developing quality in our work.

Action: NCCIS User Liaison Officer sends a monthly data log to the area. In order to ensure all information on NCCIS is accurate, PSW for child protection and welfare will bring the data quality log to supervision with each Team Leader on a monthly basis, to ensure that any data inaccuracies are rectified in a timely manner. This will be a standing item for discussion at monthly supervision. PSW for Child Protection and Welfare also check in monthly supervision with Team Leaders that cases are recorded accurately on the system to ensure that cases are appropriately categorised as 'allocated' or 'awaiting allocation'. This data quality log will also be a standing item for discussion at the QRSI meeting.

Standard 2.6	Not compliant

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

Enhanced governance oversight has been introduced to ensure that children who are at risk of harm or neglect have child protection plans in place to protect and promote their welfare.

A finding from the inspection identified a case on CPNS where the children did not have an allocated social worker for a period of time as a result of staff shortages**.** This meant that safety plans were not reviewed and monitored in line with children first and as a result ineffective. To ensure this does not occur within the area again the following has been actioned:

The Area Manager has issued a clear protocol through the Senior Management

Team and to all relevant Team Leaders and staff that all children listed on the Child Protection Notification System must have an allocated social worker. Furthermore that all children listed on Child Protection Notification System must be visited within agreed timeframes of 1-2 weekly as per individual safety plans. In the event that a child on the Child Protection Notification system is not allocated the Area Manager must be notified. This is essential to ensure that all children active on CPNS have an allocated social worker, who visits the child frequently and works with the family to develop and monitor effective safety plans to ensure the safety of children.

Action: A separate template has been developed for the 'child supervision record' for children on CPNS to include headings: 'child visits' and 'frequency of safety network meetings', 'purpose of visit', and 'child seen' to ensure they are tracked and recorded. This adds a further layer of governance; Team Leaders are able to monitor the specifics of the child safety plan to ensure that they are addressed in every supervision and are in line with Children's First.

Action: If a CPC is delayed, safety plans in place need to be reviewed in the interim to ensure children remain safe. To ensure appropriate governance consideration is given to this review a meeting will be arranged between CPC Chairperson, Child Protection and Welfare PSW, Team Leader and Social Worker to review the progress, monitoring and effectiveness of the safety plan in place and make any recommendations as is required to ensure the effective safety planning is in place.

Action: If during normal monthly supervision when a safety plan for a child on CPNS is discussed and reviewed and it has been identified that the case is not progressing along the planned trajectory within the safety plan. This needs to be flagged with the PSW for Child Protection and Welfare without delay. Consideration at this juncture can be given to the case being brought to the Practice Case Forum. The monthly monitoring of safety plans in supervision between social worker and team leader, team leader and PSW coupled with this additional governance oversight ensures that there is no drift in safety planning for children on the CPNS.

Standard 2.7	Substantially Compliant

Outline how you are going to come into compliance with Standard 2.7: Children's protection plans and interventions are reviewed in line with requirements in Children First.
Action: If a CPC requires re-scheduling which may result in a delay, the CPC Chairperson will discuss with the Area Manager and PSW for Child Protection and Welfare. In some cases we now have a meeting with both PSW's in Child Protection and Welfare with the Team Leader and Allocated Social Worker to discuss the request to re-schedule the conference and make a decision on the request. In line with current practice a clear rationale for decision making in

this respect is imputed into the child's file by the CPC Chairperson. Safety plans in place need to be reviewed in the interim to ensure children remain safe as described above. This ensures that there are no delays in time frames for convening ICPC or RCPC and where this occurs there is clear layers of governance in respect of decision making which can be evidenced in the rationale in the child's case file.

Section 2:

Standards to be complied with

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

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

Standard	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Standard 3.1	The service performs its functions in accordance with relevant legislation, regulations, national policies and standards to protect children and promote their welfare.	Substantially compliant	Yellow	National office in discussion with HIQA in respect of National Policy review This issue relates to National Tusla Office Action
Standard 3.2	Children receive a child protection and	Not compliant	Orange	Service plan Mid July 22

	welfare service, which has effective leadership, governance and management arrangements with clear lines of accountability.			Area Service and Improvement Plan for SLWC Completed Pasm Audit June 22 PASM Audit of staff supervision files completed All others actioned
Standard 3.3	The service has a system to review and assess the effectiveness and safety of child protection and welfare provision and delivery.	Not compliant	Red	File Reviews and Audit on specific cases by end of quarter 3 File reviews and audit of specific cases not completed. To be completed before end of Q3. All others actions have been actioned
Standard 2.6	Children's protection plans and interventions are reviewed in line with requirements in Children First.	Not compliant	Orange	Actioned
Standard 2.7	Children's protection plans and interventions are reviewed in line with requirements in Children First.	Substantially Complaint	Orange	Actioned