

Statutory foster care service inspection report

Health Information and Quality Authority
Regulation Directorate monitoring inspection
report on a statutory foster care service under the
Child Care Act, 1991



Name of service area:	Mid West
Dates of inspection:	29 April – 2 May 2019
Number of fieldwork days:	4
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Type of inspection:	<input checked="" type="checkbox"/> Announced <input type="checkbox"/> Unannounced <input type="checkbox"/> Full <input checked="" type="checkbox"/> Focused
Fieldwork ID:	MON-0026597

About the Health Information and Quality Authority (HIQA)

The Health Information and Quality Authority (HIQA) is an independent statutory authority established to promote safety and quality in the provision of health and social care services for the benefit of the health and welfare of the public.

HIQA's mandate to date extends across a wide range of public, private and voluntary sector services. Reporting to the Minister for Health and engaging with the Minister for Children and Youth Affairs, HIQA has responsibility for the following:

- **Setting standards for health and social care services** — Developing person-centred standards and guidance, based on evidence and international best practice, for health and social care services in Ireland.
- **Regulating social care services** — The Office of the Chief Inspector within HIQA is responsible for registering and inspecting residential services for older people and people with a disability, and children's special care units.
- **Regulating health services** — Regulating medical exposure to ionising radiation.
- **Monitoring services** — Monitoring the safety and quality of health services and children's social services, and investigating as necessary serious concerns about the health and welfare of people who use these services.
- **Health technology assessment** — Evaluating the clinical and cost-effectiveness of health programmes, policies, medicines, medical equipment, diagnostic and surgical techniques, health promotion and protection activities, and providing advice to enable the best use of resources and the best outcomes for people who use our health service.
- **Health information** — Advising on the efficient and secure collection and sharing of health information, setting standards, evaluating information resources and publishing information on the delivery and performance of Ireland's health and social care services.
- **National Care Experience Programme** — Carrying out national service-user experience surveys across a range of health services, in conjunction with the Department of Health and the HSE.

About monitoring of statutory foster care services

HIQA monitors services used by some of the most vulnerable children in the State. Monitoring provides assurance to the public that children are receiving a service that meets the 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 continual improvement so that children have better, safer services.

HIQA is authorised by the Minister for Children and Youth Affairs under Section 69 of the Child Care Act, 1991 as amended by Section 26 of the Child Care (Amendment) Act 2011 to inspect foster care services provided by the Child and Family Agency (Tusla) and to report on its findings to the Minister for Children and Youth Affairs. HIQA monitors foster care services against the *National Standards for Foster Care*, published by the Department of Health and Children in 2003.

In order to promote quality and improve safety in the provision of foster care services, HIQA carries out inspections to:

- **assess** if the Child and Family Agency (Tusla) — the service provider — has all the elements in place to safeguard children
- **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 HIQA's findings.

HIQA inspects services to see if the National Standards are met. Inspections can be announced or unannounced.

As part of the HIQA 2019 monitoring programme, HIQA is conducting focused inspections across 17 Tusla service areas focusing on **The child and family social worker, Assessment of children and young people, Care planning and review, Matching carers with children and young people, Safeguarding and child protection and Preparation for leaving care and adult life**. These focused inspections will be announced, and will cover six of the national standards.

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

Theme 1: Child-centred Services	<input type="checkbox"/>
Theme 2: Safe and Effective Services	<input checked="" type="checkbox"/>
Theme 3: Health and Development	<input type="checkbox"/>
Theme 4: Leadership, Governance and Management	<input type="checkbox"/>
Theme 5: Use of Resources	<input type="checkbox"/>
Theme 6: Workforce	<input type="checkbox"/>

1. Inspection methodology

As part of this inspection, inspectors met with the relevant professionals involved in the child in care service and with children in care, young people availing of the aftercare service and with foster carers. Inspectors observed practices and reviewed documentation such as care files, and relevant documentation relating to the areas covered by the relevant standards.

During this inspection, the inspectors evaluated:

- the social worker role
- assessment of children in care
- matching of children in care and foster carers
- care plans, placement plans
- safeguarding processes
- the leaving and aftercare service.

The key activities of this inspection involved:

- the analysis of data submitted by the area
- meeting with or speaking to 19 children
- interviews with the area manager and the general manager for alternative care
- meetings with the principal social workers for alternative care and aftercare, the team leaders for the children in care teams, the aftercare manager, team leader and aftercare teams, team leaders for duty/intake and child protection teams, and the child in care reviewing officer
- home visits to nine foster care households
- separate focus groups with children in care social workers, child protection social workers, fostering social workers, and aftercare workers

- focus groups with foster carers
- review of the relevant sections of 63 files of children in care as they relate to the theme
- observation of a fostering matching meeting, the aftercare drop-in clinic and the aftercare steering committee
- review of 74 questionnaires completed by children and young people in foster care and one from a parent
- phone calls or meetings with six parents of children in care.

Acknowledgements

HIQA wishes to thank the staff and managers of the service for their cooperation with this inspection, the children in care who completed questionnaires, and the children in care, parents of children in care, and foster carers who met with or spoke to inspectors.

2. Profile of the foster care service

2.1 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 (Tusla) 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.

Foster care services provided by Tusla are inspected by HIQA in each of the 17 Tusla service areas. Tusla also places children in privately run foster care agencies and has

specific responsibility for the quality of care these children in privately provided services receive.

2.2 Service Area

According to data published by Tusla in 2018, the Mid West service area had a population of children from the ages of 0-17 years of 96,266.*

The area is under the direction of the service director for Tusla West, and is managed by an area manager. There were three principal social workers for the alternative care service in the area. One had responsibility for the foster care service and the other two principal social workers managed the child in care, leaving care and aftercare services.

The Mid West service area is the third largest of the 17 service areas of Tusla. It provides services to County Limerick including Limerick city and County Clare and North Tipperary. There are seven children in care teams across the service area with teams located in Limerick city, Ennis, Nenagh, Thurles and Newcastlewest. There was a general manager for alternative care, supported by two principal social workers for children in care, one for the Limerick city and county teams and one for the Clare and North Tipperary teams.

Child protection teams, who had responsibility for the care of children in care until they were transferred to the long-term children in care team, were located in offices throughout the service area.

At the time of the inspection there were 529 children in foster care in the area. Of these, 156 children were placed with relatives and the remaining 373 children were placed with general foster carers, four of whom were placed with private foster carers.

The organisational chart in Appendix 2 describes the management and team structure as provided by the Tusla service area.

*Annual Review on the Adequacy of Child Care and Family Support Services Available – 2016 (Tusla website, July 2018)

3. Summary of inspection findings

The Child and Family Agency (Tusla) has the legal responsibility to promote the welfare of children and protect those who are deemed to be at risk of harm. Children in foster care require a high-quality service which is safe and well supported by social workers. Foster carers must be able to provide children with warm and nurturing relationships in order for them to achieve positive outcomes. Services must be well governed in order to produce these outcomes consistently.

This report reflects the findings of the focused inspection, which looked at the role of the social worker, the assessment of children's needs, care planning and statutory reviews, matching, safeguarding and child protection, and preparation for leaving care and adult life.

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

- Two standards were compliant
- One standard was substantially compliant
- Three standards were non-compliant, of which two were moderate non-compliant and one was major non-compliant.

Children who met with or spoke to inspectors said they felt safe in their foster homes, they liked living there, were happy and felt they were well cared for by their foster carers. Some children said that their foster carers had helped them in so many positive ways. The majority of children spoke positively about their social worker and felt that they listened to them and respected them but some were unhappy about the number of different social workers they had. Contact with family was encouraged and facilitated by social workers and most children said they had regular contact with their families, while others would like to have more.

There were many examples of good practice in the area which were driven regionally by a task and finish group set up by the service director for the Tusla West region. Following a series of HIQA inspections of the foster care services in 2017 and 2018, representatives from all five of the service areas in the region reflected on the outcomes of these inspections so as to ensure that good practice was shared and that new systems were put in place to improve the foster care services as well as ensuring a consistent service across the region. These included the establishment of a governance group to oversee the management of allegations, serious concerns and complaints against foster carers and the introduction of safety and risk management plans for children. Some of these were evident during the inspection while others were still in the process of being implemented. The service director told inspectors that two service improvement posts for the region were recently established to drive consistent improvement across the region.

In preparation for this inspection, the area manager held two planning meetings with senior managers across the service and completed their own self assessment record against the standards being inspected. Each of the six standards were allocated to identified lead persons with responsibility for collating the evidence required to inform the self assessment record. A review of the self assessment document and minutes of meetings held showed that the area acknowledged what they considered was working well and the relevant standards where they were non-compliant.

The majority of children in care had an allocated social worker, but for some children there were gaps in the allocation of a social worker over the previous 24 months which children said they found difficult at times. At the time of inspection, 96 children (18%) did not have an allocated social worker.

Social workers coordinated the care of children, ensured that care plans were implemented and visited children in their foster homes. However, 30 children (5.6%) had not been visited within the prescribed timelines set out in the regulations. Assessments of need were carried out for all children placed in foster care including children placed on an emergency basis and were found to be of good quality.

Children with varying levels of disability had access to required services and their care plans were developed in consultation with other state agencies and their primary carers. There were good working relationships between Tusla and the Health Service Executive (HSE) in terms of services for children and their families. Although the views of the children with varying levels of disability were articulated in their care plans, it was not evident how children with moderate or severe learning disabilities were supported to contribute to the development of their care plans.

Care planning and review processes were well managed. The quality of care plans were generally found to be good and were based on the child's assessed needs and the majority of care plans were up to date. There were good levels of consultation and participation with children, foster carers, birth parents and other relevant professionals in review meetings for the development of the care plans. However, it was not always clear how decisions made at reviews were shared with children or those not present. While there was a focus by the area on capturing the views of children in their care plans, this was not always the case for children with a learning disability. The area did not consistently complete placement plans for children in foster care.

Care orders and or voluntary consent was in place for all children whose files were reviewed. However, there was no evidence that voluntary consent provided by parents at the time of the child's admission to care was discussed at child in care

review meetings, particularly for some children who had been in care for several years, as to its continued appropriateness.

The quality of case supervision records on children's files was mixed. Some records provided good detail and actions arising while others did not. Deficiencies in statutory visits and child in care reviews not being completed within the required timeframes were not consistently discussed or recorded.

While there was a matching process in place in the area to ensure that children were matched with foster carers who had the capacity to meet their needs, there was a back-log of long-term matches. Evidence of matching was not available on children's files and the quality of the matching process was mixed.

There were a number of safeguarding practices in place to ensure children were protected from all forms of abuse which were carried out by dedicated and competent social work staff who were committed to their role in putting children first. There were gaps in practice which included delays in scheduling strategy meetings and lack of appropriate safety planning for children in care who required it. The categorisation, management and oversight of complaints, concerns and allegations was good, however, some allegations made by children in care were not always assessed in a timely manner or investigated in line with Children First, *National Guidance for the Protection and Welfare of Children* (2017).

There was a well-developed aftercare service in the area. The team worked closely with the children in care teams to identify if young people were eligible or not for an aftercare service. Assessments of need undertaken with young people referred to the service were of good quality. Children and young people in foster care were helped to develop the skills and competence necessary for adult living and were supported and guided to attain independence on leaving care.

Issues outlined above and other issues identified during the inspection are contained in the action plan which can be found at the end of this report.

4. Summary of judgments under each standard and or regulation

During this inspection, inspectors made judgments against the National Standards for Foster Care. Inspectors used four categories that describe how the national standards were met as follows. The provider will be judged to be compliant, substantially compliant or non-compliant with the regulations and or national standards. These are defined as follows:

- **Compliant:** a judgment of compliant means that no action is required as the provider or person in charge (as appropriate) has fully met the standard and is in full compliance with the relevant regulation.
- **Substantially compliant:** a judgment of substantially compliant means that some action is required by the provider or person in charge (as appropriate) to fully meet a standard or to comply with a regulation.
- **Non-compliant:** a judgment of non-compliance means that substantive action is required by the provider or person in charge (as appropriate) to fully meet a standard or to comply with a regulation.

National Standards for Foster Care	Judgment
Theme 2: Safe and Effective Services	
Standard 5: The child and family social worker	Non-compliant Moderate
Standard 6: Assessment of children and young people	Compliant
Standard 7: Care planning and review	Non-compliant Moderate
Standard 8: Matching carers with children and young people	Substantially Compliant
Standard 10: Safeguarding and child protection	Non-compliant Major
Standard 13: Preparation for leaving care and adult life	Compliant

What children told us and what inspectors observed

During the inspection, inspectors met or spoke with 19 children living in foster care in the area. Six of these children were aged three or under and were observed by inspectors with their foster carers in their foster home. Inspectors also received 74 completed questionnaires from children and young people which expressed their views of the foster care service.

Children and young people responded generally positively. They liked living with their foster family, were happy and well cared for. Some of the comments children said when asked what they liked about their foster carers included:

"I like my family and the dogs! We have lots of fun and we do lots of things together"

"I like that it has lasted so long. I enjoy doing things with my foster family. We are always doing things"

"They are the best foster family in the world!!"

"They care about me and love me and my family and do their best for me"

"They're sound. It's not awkward to discuss a matter/topic with the foster family".

Sixty two children who returned questionnaires said they had an allocated social worker. The majority of children said that they saw their social worker regularly and met them on their own, sometimes outside of the foster home in a social venue, and social workers asked about how they were getting on and children felt listened to. Children's descriptions of their social workers were generally positive, but they also gave examples of what they did not like about their social worker:

"She is sound"

"She is one of a kind"

"She's new but she's nice"

"She's funny, caring and likes to help me"

"I don't have one"

"I have lost count of how many I have had"

"Social workers come and go and can't build a relationship but I'm lucky not to need them"

"The social workers that have been assigned to me have changed that many times I don't know who is assigned to me"

"When we ring there is rarely an answer".

Forty eight of 74 children commented in the questionnaires that they had a care plan and their views were heard in relation to this, while 15 children did not know if they had one. Most children attended a review meeting about their care plan or completed a review form which was read out at the meeting. The majority of

children said they had good contact with their families, some of the comments they made included:

"I see enough of my friends but not my family"

"I would like more time with my mum".

Six of the 19 children met by inspectors in their foster homes were aged three or under, and presented as happy and very much part of the family they were living with. The other 13 children of varying ages interacted comfortably with inspectors, were chatty and were keen to show inspectors their rooms, pets, photos and spoke about their interests, friends and family.

Fourteen young people over the age of 16 years completed questionnaires and were positive about their experiences of the aftercare service. Five said they had an aftercare worker who listens to them and four said their aftercare worker helped them to prepare for leaving care and adult living. Five young people said they had a say in their aftercare plan and were helped and supported to learn appropriate skills towards independent living.

5. Findings and judgments

Theme 2: Safe and Effective Services

Services promote the safety of children by protecting them from abuse and neglect and following policy and procedure in reporting any concerns of abuse and or neglect to the relevant authorities. Effective services ensure that the systems are in place to promote children's welfare. Assessment and planning is central to the identification of children's care needs. In order to provide the care children require, foster carers are assessed, approved and supported. Each child receives the supports they require to maintain their wellbeing.

Standard 5: The child and family social worker

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

Summary of inspection findings under Standard 5

Data submitted to HIQA by the service area prior to the inspection reported that of the 529 children in foster care, 436 (82%) children had an allocated social worker and 93 (17.5%) children did not have an allocated social worker. This figure had risen to 96 (18%) on the first day of the inspection fieldwork. The number of dual unallocated cases, where neither the child or foster carer had a link or social worker, was reported as six.

Senior managers told inspectors that the reason for the high number of unallocated cases was due to a high level of staff vacancies which has been a problem for the area over the past two to three years. The staff turnover rate in the previous 12 months to this inspection was 33%, with 12 whole time equivalent social work posts, 1.5 social work team leader posts and one social care worker post vacant across the children in care team. Within the fostering team, staffing had increased to almost full capacity in the area in the previous six months. North Tipperary and Clare fostering teams had a full staff complement and the Limerick team was reaching full complement. The next recruitment campaign for professionally qualified social workers was scheduled to be held in Limerick in the coming months as well as a senior social work practitioner recruitment campaign in September 2019. The area manager outlined that managers and staff had good links with third level institutions and students who had been on placements in the area were encouraged to apply

once qualified. The service area had also held an open day for students in one of the social work offices in Limerick city.

The area manager and general manager for alternative care told the inspector that the risks associated with unallocated cases had been escalated to the Service Director. These risks were previously recorded on the service area's risk register in April and October 2018. A review of the most up-to-date register in April 2019 found that these risks were still evident. This resulted in a HR Crisis Management Group being established to look at short and long-term measures to address the staffing deficits. Minutes of the meetings held by this group were provided to the inspector which showed clear recommendations, short and long-term objectives to be achieved and an action plan with named persons responsible and timeframes.

A local policy on managing unallocated cases of children in care was in place since December 2018 with associated tracker templates. A review of the policy and trackers by the inspectors found that the service area accepted that all children in care should have an allocated social worker and cases listed as high or intensive/highly intensive (as per the caseload management policy), should not be unallocated. Recommended practice was to unallocate medium or low/less intensive cases in order to allocate high/intensive cases in situations where staff changes had taken place or cases required transfer from duty/intake and child protection. The trackers used to monitor all unallocated and dual unallocated cases had been implemented since the first quarter in 2019. The principal social workers for alternative care and fostering meet with the alternative care manager on a monthly basis to examine these trackers. A review of the minutes of these meetings from August 2018 to February 2019 showed that unallocated and dual unallocated cases were discussed. Dual unallocated cases had reduced from 11 at the end of February 2019 to six at the time of the inspection.

A risk estimation tool was required to be completed by the social work team leader on every unallocated case as part of this policy and the priority level recorded on the child's case record. A review of 63 cases found priority levels recorded; however, as the policy and procedure was in its infancy stage, the risk estimation tool was not always evident on the case records reviewed by inspectors.

Three (50%) of the six dual unallocated cases at the time of the inspection with a high priority status were reviewed by inspectors. As a result, HIQA escalated each case to the area manager following the inspection to provide assurances that identified risks were dealt with in line with Children First, 2017 and Tusla's Serious Concerns and Allegations Procedure, and that all appropriate safeguarding measures have been put in place and statutory requirements have been fulfilled. An appropriate response was received prior to completing this report.

Data provided by the area indicated that 30 children (5.6%) had not been visited by a social worker in line with regulations. Inspectors reviewed a total of 25 children's files for this purpose. In relation to unallocated cases, inspectors sampled the files of eight children for evidence of statutory visits. This resulted in the escalation of three of these cases to the area manager following the inspection as they were also dual unallocated and there was no evidence that statutory visits to these two children had taken place since 2017. There was also no evidence that the third child had been visited since April 2018.

For the majority of children who were allocated, statutory visits had been carried out. However, for seven children, statutory visits over the previous two years had not taken place within the regulatory time frames, which requires that children be visited within the first month of the placement, then at three monthly intervals for the first two years, and thereafter at intervals not exceeding six months. Examples of this included one child where only two records of visits in 2018 were undertaken, but they did receive two visits to date in 2019. A 10 month gap between visits was found on another child's file while there were six month gaps over a 24 month period for another child.

The recording of statutory visits was mixed and inspectors found that while the system indicated that a statutory visit had been scheduled or taken place, the corresponding case note of the visit was not always uploaded to the system or the case note provided no detail regarding the visit. However, examples of good quality recording were also found in case notes which described the child's presentation during the visit, whether the child was met on their own, as well as conversations with the child around aspects of their care.

Managers and staff told inspectors that the most recent visit to a child or an upcoming visit to a child would be referred to during case supervision sessions or noted at the child in care review. However, at the time of inspection, the oversight mechanism to ensure statutory visits took place within the prescribed time frames was poor. This was escalated to the area manager and service director following the inspection. Assurances from senior management was provided to HIQA within five working days of the inspection. Senior managers outlined that a tracker system will be implemented to monitor adherence to regulations for all statutory safeguarding visits. The information recorded on this tracker will be updated on a monthly basis by social work team leaders and forwarded to the principal social workers for alternative care and fostering. The alternative care service was also developing a duty system for children in care which is scheduled to be completed by the end of June 2019. The purpose of this is to ensure that while cases are awaiting allocation, children and young people will receive their statutory visits in line with the regulations.

Maintaining good links with families was encouraged and facilitated where appropriate. This was considered as part of the matching process as well as in the care plan and review processes. Of the 74 children or young people who returned questionnaires, 55 (74%) said that their social worker kept in contact with their family and made sure they saw them. A number of birth parents who contacted HIQA over the course of the inspection described either their satisfaction or dissatisfaction with the family contact arrangements in place.

Forty six (9%) children in foster care in the area were reported as having a disability and or complex medical need. Inspectors were told by the area manager that joint protocol meetings between the Health Service Executive (HSE) and Tusla were established, and both parties had committed to attending. The area manager also reported that the Head of Services for Mental Health and a senior manager from primary care were part of these meetings to ensure a more comprehensive and coordinated pathway for children in care. Two sub-groups were established within this forum, one to look at operational processes and the other to look at cases that have been escalated. Minutes of joint protocol meetings held in the previous 12 months were reviewed by inspectors. These demonstrated clear discussions on relevant issues and arising actions were noted with persons responsible named. Resources and funding of services to children with a disability and or complex need was an ongoing issue. Inspectors reviewed five cases related to children with a disability and found that there was good coordination of services for each child and their care plans were developed in consultation with other state agencies and their primary carers and each child had an allocated social worker. These children's cases were found to have been reviewed on a more frequent basis due to the child's individual needs.

Significant events were reported by all those interviewed as being responded to appropriately and relevant persons were kept informed of these. The service area reported that in the previous 12 months, there were seven occasions when a child went missing from care. Case notes demonstrated where foster carers notified any incidents to social workers appropriately. Inspectors reviewed one child's file who had been reported as missing from care. This child was unallocated a social worker at the time of the inspection. The social work team leaders provided the inspectors with an update on the case as there had been a number of placement endings which resulted in the social work department seeking an interim care order and the child was subsequently moved to a new placement prior to the inspection.

Data provided by the area showed that there was only one formal complaint made by a child in care in the previous 12 months. Complaints were generally managed in the first instance on an informal basis through the child in care social worker or

fostering link worker. Team leaders and social workers told inspectors that information leaflets about Tusla's complaints process was provided to older children and that social workers would explain the process to younger children in an age appropriate way. In the questionnaires submitted by children, 49 (66%) said that their social worker had explained how to make a complaint if they were unhappy with something. Of the 28 children who had made a complaint, 21 (75%) said it was taken seriously of which 18 (85%) were happy with the outcome. The recording of verbal or informal complaints was not consistent which meant that the service area could not track issues arising for children in care and inspectors could not sample these complaints on the children's files.

Senior managers told the inspectors that on a day-to-day basis, any complaints, serious concerns or allegations were notified to the area manager and were logged appropriately. If an allegation or serious concern reached the threshold for Children First, then the child protection team managed this. The service area had set up a governance group to review and track all complaints, serious concerns or allegations against foster carers as notified to the area manager in order to ensure a safe service for children in care. Terms of reference for the allegations, serious concerns and complaints governance meetings dated October 2018 were viewed by the inspectors. Three meetings had been held to date and minutes of these meetings were provided for review. These demonstrated discussions on relevant issues and arising actions were noted with persons responsible named.

Information about children was held electronically on Tusla's national integrated information system (National Child Care Information System [NCCIS]). This was to ensure information held by Tusla services was safe, accessible for safeguarding of children, retrievable and available for monitoring by managers. The Mid West service area was a pilot site for this system in 2007 and had been using it since 2014. Despite the fact that the area had been using NCCIS for a number of years, those interviewed told inspectors that challenges with the system still existed and it would take more time to fully embed across the service. The NCCIS support staff audited 20 children in care cases each month which had highlighted gaps on children's case records. Feedback was provided to allocated social workers and or senior managers. A number of these audits were found on some of the files reviewed which confirmed missing information. However, inspectors could not confirm if actions had been taken to address the deficits as not all records of case supervision meetings were on NCCIS. An information manager had been recently appointed just prior to the inspection. Their role was to assist in developing, verifying and quality assuring all information systems in the service area.

The regulations do not require the child's case record to be held in one location and the service area operated both a paper-based and electronic information systems. Paper-based records were required to ensure original copies of specific documents, such as court orders, parental consent forms and birth certificates are filed securely.

Case records reviewed for children in care were found to be secure and well maintained. There was some good practice in a small number of files reviewed such as keeping case chronologies, but this was not a consistent practice across the area. Senior managers told inspectors that there was an expectation that case records were updated as new information came in or there was activity in the case.

A significant number of children were unallocated at the time of inspection and as a result were not visited in line with statutory requirements. For some children there were gaps in the allocation of a social worker over the previous 24 months and the oversight mechanism to ensure statutory visits took place within the prescribed timelines required improvement. The risks identified by inspectors in three of the six dual unallocated cases at the time of the inspection with a high priority status were escalated to the area manager following the inspection. While the accessibility of information on the electronic system was good, the quality of some home visit records was mixed or had not been uploaded to the child's file. For these reasons, the area was judged to be in moderate non-compliance with the standard.

Judgment: Non-compliant Moderate

Standard 6: Assessment of children and young people

An assessment of the child's or young person's needs is made prior to any placement or, in the case of emergencies, as soon as possible thereafter.

Summary of inspection findings under Standard 6

The decision to use a foster care placement should be based on an assessment which determines this to be in the best interests of the child or young person. The assessment of need is required prior to any placement or, in the case of emergencies, as soon as possible thereafter and considers the emotional, psychological, medical, educational and other needs of children and young people.

Staff interviewed outlined that the assessment of the child's needs was carried out by social workers and recorded across a number of documents such as the intake record, initial assessment record, further assessment record, care plans, court reports and placement request referral forms. Depending on how the child was received into care, the assessment of need would be found in the most relevant document or record. For example, where a child was being admitted to care for the first time, the child's assessed needs were set out in the social worker report for the first child in care review within two months of admission. If a child is taken into care under emergency circumstances, the assessment of need was usually found within the court reports prepared by the social worker. This was evidenced in the review of children's files.

Data submitted by the area showed that there were 198 children placed in foster care in the 24 months prior to the inspection, of which all had an assessment of need carried out before being placed in foster care and there were no assessments of need ongoing.

Inspectors sampled 16 files to assess the quality of the assessment of children's needs and found they were of good quality. The majority of the assessment of needs were contained within children's care plans with one child's assessed needs recorded in the initial assessment and further assessment records. These were found to be comprehensive in relation to the information recorded regarding the identified health, education, physical and emotional needs of the child. Children, parents (where appropriate) and any relevant professionals contributed to the assessment of needs within the care plan and review processes which set out clearly the child's needs going forward.

Eighty children had experienced a placement change during the same time period. In this instance, the child's assessed needs were contained within the statutory care plan and the request form for a new placement. Inspectors sampled four files in relation to unplanned endings and placement moves. Due to the sensitive nature of a placement ending for one child, the records demonstrated the efforts to manage this with appropriate communication between relevant services. However, the records did not show how the transition to the new placement was managed. For another child, the child in care review had taken place but the assessment of needs had not been collated into a corresponding care plan.

Assessments of need were carried out for all children placed in foster care including children placed on an emergency basis. The assessments were of good quality and for this reason, the area was judged to be compliant with this standard.

Judgment: Compliant

Standard 7: Care planning and review

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

Summary of inspection findings under Standard 7

Care planning and child in care reviews were well managed. A full-time independent reviewing officer for child in care review meetings for the Limerick children in care teams was in place. Social work team leaders in the other areas (Clare and North Tipperary) undertook this role. The reviewing officer had been in post for the past two years. During interview, she clearly outlined her role and responsibility for chairing and minuting review meetings as well as writing up the review record. Social work area teams were responsible for sending out invitations, booking venues for the review meetings and distributing the review record once finalised. Prior to the meeting, the reviewing officer would read through the child's review form, if submitted, and would write back to thank the child for completing the form where appropriate. She would also be available to meet with children and or parents prior to or after the review if they wished.

The reviewing officer maintained a tracker for child in care reviews held for the Limerick children in care teams. Information pertaining to the meeting occurrence, child's attendance and reason for not attending, the completion of a review form by a child, date when the child in care database was updated, the date when a draft review record was sent out to the area team for factual accuracy, the date the record was completed and signed off and whether the review was held within the statutory time frames. The reviewing officer told the inspector that the number of child in care reviews held in the last 12 months was 285. Review meetings were generally held in social work offices, but there was also flexibility in terms of locations for the meetings and in some instances reviews had been held in the foster carer's home.

A report in relation to child in care reviews was completed by the independent reviewing officer in 2018 which looked at the number of reviews undertaken in total per area team, if the reviews were convened within the statutory time frames, if children attended their reviews, the reasons for non-attendance and if children submitted a review form for the meeting. The findings of the review were completed in January 2019 and presented to managers and staff. The findings demonstrated that of the 265 child in care reviews in 2018, 80.7% were undertaken within the statutory timelines. The number of children who did not attend their review was 212

of which 102 were too young. Other reasons for not attending a review included, the child's own choice, geographical distances or concerns as to the emotional impact on the child. It was noted that many of the children who did not attend their review did not submit a review form in order to have a say in their care planning and decision making.

Data provided by the area prior to the inspection outlined that 458 children (86.5%) had an up-to-date care plan and 71 (13.4%) did not. Forty eight children who completed questionnaires said that they had a care plan, while six said they did not and 15 (31%) children did not know if they had a care plan.

The quality of care plans reviewed by inspectors were generally found to be good and outlined the plan for the child's care based on their assessed needs. The indicators of quality used by inspectors were that an up-to-date care plan was in place, that it was developed within the required time frames and that the content reflected those set out in the regulations to meet the assessed needs of the child, the foster carer and where appropriate the child's family. The care plan is an essential part of the delivery of care to the child as it demonstrates forward planning. There was evidence of therapeutic, educational and mental health supports for children and inter-agency working was also in place for children with complex needs. The contact arrangements between children and their families and other significant people in their lives were well recorded in care plans and social work case notes showed that these were adhered to.

Inspectors reviewed care plans for 27 children and found 21 (77%) were up to date at the time of inspection. A number of care plan review meetings for some children were held just prior to the inspection and therefore the care plans were still in progress as they had not been signed off by managers. The care plans outlined the supports to be provided by Tusla to the child, their parents (where appropriate) and the foster carers, as well as contact arrangements between the child and their family and the arrangements in place to review the plan at different intervals throughout the child's time in care. However, six of the care plans reviewed demonstrated that while there was a good assessment of current needs, the care plans lacked clear decisions and time frames and consideration of longer-term needs. It was also difficult to evidence the child's involvement in the care planning process.

Inspectors found that there were generally good levels of consultation and participation in the development of children's care plans and the standard template in place for social workers provided for the views of children and their parents. This was found to be the case in the majority of care plans reviewed. While there was a

focus by the area on capturing the views of children in their care plans, this was not always the case for children with a learning disability.

Children received specialist supports as agreed in their care plans. Data submitted by the area showed that there were 46 children in foster care in the area with a disability. A review of five files of children who had varying levels of disability demonstrated that their care plans were developed in consultation with other state agencies and their primary carers. Each child had an allocated social worker. These children's cases were found to have been reviewed on a more frequent basis due to the child's individual needs. Managers and staff told inspectors that the service area had a number of relevant services available to them to support children and families and to maintain placements. However, resources and funding of services to children with a disability and or complex need was an ongoing issue. Inspectors found that enhanced payments and other supports were provided to families where this was required. Although the views of the children with varying levels of disability were articulated in their care plans, it was not evident how children with moderate or severe learning disabilities were supported to contribute to their development. As previously referenced in Standard 5, HSE and Tusla joint protocol meetings were established, and both parties had committed to attending. Minutes of joint protocol meetings held in the previous 12 months were reviewed by inspectors. These demonstrated clear discussions on relevant issues and arising actions were noted with persons responsible named.

Data provided by the area prior to the inspection outlined that 71 (13.4%) care plan reviews were overdue. In the 24 months prior to the inspection, inspectors found that the care planning and review processes were in line with statutory requirements for 18 (67%) out of 27 children whose files were reviewed for this purpose. There were seven children's files where the child in care review did not take place within the required time frames. Two children under the age of 12 years were not having regular reviews as required and delays in convening reviews ranged from two to four months for two children, and up to two years for three children. One of these cases was escalated to the area manager as it was a dual unallocated case in which inspectors had identified other risks.

Each child should be facilitated to participate in the review process and inspectors found that where it was appropriate for children to attend, they were encouraged and facilitated by the service area to do so and contribute. In addition to having the option to attend their review, children could meet with their social worker or complete a review form. Inspectors saw a sample of review forms completed by children and it was evident that they were either presented by the child or on their behalf if they did not attend their review meeting. The independent reviewing

officer's review 2018 report demonstrated that of the 265 reviews undertaken in 2018, the number of children who attended their review was 73 (27%). The total figure in relation to children who submitted a review form who either attended or did not attend their review was 79 (30%).

Of the total of 74 questionnaires returned by children, 39 (53%) said that they had either been invited to attend or attended their child in care review while 23 (31%) said they had not. Forty eight children said they felt listened to and that their views were included in the care plans. Of the 19 children visited by inspectors, six were too young to comment but the other 13 (68%) were aware of or had attended their review meeting. A sample of case notes on children's files demonstrated where review meetings were discussed with children during home visits by the social worker in preparation for completing a review form and or to attend the review. With the exception of three of the 19 children visited by inspectors, all were aware of their reviews and exercised their right to choose to attend or to complete a review form if not.

Inspectors were told by managers and staff that child in care review meetings considered the implementation of the child's previous care plan. The review also considered foster carers in relation to enhanced rights or whether adoption was a possibility for the child. Reference to or discussion of statutory visits to the child were not always recorded on review records. Following the review, an updated care plan was sent to parents (where appropriate), foster carers and children. Inspectors reviewed case records to confirm these plans were consistently shared and found that this was not always well recorded. Although inspectors were satisfied that those parties who contributed to the development of these plans at child in care review meetings were aware of their content, it was not always evident that the decisions arising from a review were discussed with children or if the information was shared with those not present. Of the sample of files reviewed, inspectors only found evidence of this in 10 (37%) out of 27 files.

There was no evidence that the voluntary consent given by parents at the time of the children's admission to care was discussed at reviews. Inspectors viewed seven cases where children were admitted to care under voluntary consent. In two cases the copy of the voluntary consent was not uploaded to the system and one child was in care for over two years with no evidence that parental consent had been reviewed.

There had been 46 placement breakdowns in the 12 months prior to the inspection for which 27 (57%) reviews had taken place following the placement ending. This was to establish the reasons for the breakdown and any learning arising from it. Data submitted by the area also showed that 17 reviews were carried out where

placements were at risk of ending. Inspectors reviewed the files for three children where placements had ended and found that they were managed well. Reasons for the placement breakdown were specific to individual children with no common issues identified. Managers and staff told inspectors that any learning arising from these breakdowns were shared at staff team meetings. This was evident in a sample of meeting minutes across the fostering and children in care teams reviewed by inspectors.

Case supervision records should be completed by social work team leaders who provide supervision to child in care social workers and uploaded to NCCIS. Of the sample of case files reviewed by inspectors, the number of case supervision records was low and of mixed quality. Six records provided good detail of discussion and actions agreed while 18 records were of either of poor quality providing no clear discussion or actions agreed and not carried out in line with required time frames, or were not on the child's file. Deficits in statutory visits to a child and care planning and review processes not being completed within required timelines were not consistently discussed or recorded. The general manager for alternative care told the inspectors that a tracker for unallocated cases has been in place since December 2018 and a tracker for statutory visits to children was to be introduced to ensure staff were compliant with the requirements of the regulations.

The development of placement plans is outlined as a requirement in the *National Standards for Foster Care*, as well as in Tusla's alternative handbook as a key social work task following the admission of a child to care. While the child's placement was discussed as part of the care planning and review process, the care plan did not set out how a child's needs would be met on a day-to-day basis. Data provided by the area showed that three children had up-to-date placement plans, this was confirmed by inspectors in the review of the 63 children's files sampled.

Care planning and child in care reviews were well managed and care plans were generally of good quality. However, 71 children did not have an up-to-date care plan as the same number of child in care reviews were overdue at the time of inspection. However, it was not always evident that the decisions arising from a review were discussed with children or if the information was shared with those not present. Placement plans which set out how a child's needs would be met on a day-to-day basis as required by the standards were not consistently completed. For these reasons, the area was judged to be in moderate non-compliance with the standard.

Judgment: Non-compliant Moderate

Standard 8: Matching carers with children and young people

Children and young people are placed with carers who are chosen for their capacity to meet the assessed needs of the children or young people.

Summary of inspection findings under Standard 8

There was a matching process in place in the area to ensure that children were matched with foster carers who had the capacity to meet their needs. The matching process was the responsibility of the fostering department following receipt of a referral from the child's social worker. The fostering department then sourced an appropriate match depending on the availability of suitable carers. Matching meetings took place as required or during planned meetings. A number of factors as outlined by those interviewed had to be discussed when considering a placement match, such as the prospective foster carers' capacity and experience to meet the child's needs, the child's assessed needs, the children already in the household, sibling groups, as well as geographical considerations which included where the child goes to school. Managers and staff told inspectors that information sharing and discussion involving all relevant persons was taken into consideration as part of the matching process. Foster carers who met with inspectors spoke of their experience of matching. While some were positive and said they were provided with sufficient information pertaining to the child, others were not as positive as they said they did not get sufficient information. Some said they were asked to take children outside of their approval status and said that information provided was insufficient.

Inspectors observed a matching meeting during the inspection fieldwork and found that there was good discussion in relation to the potential foster carers, their experience, strengths and how they could meet the child's needs. The social work team leader and fostering link social workers present at the meeting told the inspectors that they did not have a large pool of carers to choose from. Decisions were made in some cases discussed to either obtain more information from the child in care social worker or to meet the identified foster carers to discuss the placement request in more detail. The recording of this process was not reflected in the children's files. A review of the minutes of matching meetings provided some of the information outlined above. Some foster carers also told inspectors that they had children placed with them without a matching process occurring or meeting the child prior to the placement.

Inspectors reviewed six files for the purposes of matching and found that the quality of the process was mixed. While placement request forms were uploaded to the child's file, there was no formal record of comprehensive matching of children's needs with the capacity of the foster carer to meet those needs available on NCCIS. Social workers outlined the process to inspectors and described the meetings that

took place or information shared regarding matching but this was not always clearly reflected on the child's file.

Data submitted by the area showed that there were no children awaiting a foster care placement in the area. Of the 404 foster care placements in the area, there were 16 (4%) households available to take placements. Of the 529 children in foster care, four children were in private foster care of which two were placed outside of the area and there was a clear rationale recorded for this. Reports from private foster care providers were on children's files and provided a detailed update of the child's placement to the social work department.

There should be no more than two children placed in the foster home, except in the case of sibling groups and these should not be placed with other fostered children. Placements where the number of unrelated children placed in a foster home exceeded recommendations outlined in the National Standards was reported as 21 by the service area. In this instance, the proposed placements were notified to the Foster Care Committee (FCC) who considered the placements for approval. Inspectors visited one such household with two siblings and one unrelated child in the placement and found that the children were very happy and settled in their placement. Each child had their own bedroom and their long-term needs were being met by the foster carers. A review of a total of 10 (48%) files where the number of children placed exceeded the standards found that three children were unallocated and two children and their foster carers were dual unallocated. This raised further concerns regarding the oversight and systems in place in relation to the management of unallocated cases, which was already outlined under Standard 5 of this report.

Where appropriate, practice in the area was that children had an opportunity to meet their prospective foster carers and their views to be sought about the proposed placement. Forty six (62%) of 74 children who completed questionnaires said they had an opportunity to meet or stay with their foster carers before they moved in, and 31 (42%) were asked how they felt about moving to a new foster home. Fifty six (75%) children said that their family also got to meet their foster family. While the responses suggested there was good practice in this regard, 19 (26%) children did not get the opportunity to meet or stay with their foster carers and 15 (20%) said they were not asked about how they felt in relation to the move to a new foster home. The majority of foster carers met during visits to 19 foster care households by inspectors were very positive about the information provided to them before the child was placed, while others said they were not provided with sufficient information. Inspectors could not confirm the information provided to foster carers as their files were not reviewed as part of this inspection. Children's files reviewed did not evidence this information either.

The area tried to ensure that children maintained contact with their local community when they were admitted to foster care. Of the 74 children and young people who completed questionnaires, 59 (79%) felt their background and culture was understood and respected. Fifty (67%) said they were happy with the amount of contact they had with their family and friends. When children did move to their new foster home, 21 (28%) said they had to change school, while 26 (35%) were able to remain in their previous school placements. In all, 156 of 529 children were placed with a relative carer which accounted for 29% of the overall placements. Joint visits by the child's social worker and fostering social worker were carried out to the prospective relative carers to provide information, discuss the viability of the placement and carry out an initial assessment of the proposed placement.

Data submitted by the area outlined that there were 100 children awaiting approval for long-term placements and 12 children had been approved for a long-term match with foster carers in the 12 months prior to the inspection. The capacity of foster carers to meet the needs of children is not always apparent at the beginning of a placement and therefore the suitability of long-term matches between children in care and foster carers, where there is no possibility of reunification with the children's birth family, is considered and approved by the Foster Care Committee. Inspectors reviewed six files where there had been an approval of a long-term match. Documentation relating to the long-term matching process was not routinely uploaded to NCCIS and was maintained on the foster carer file which was not part of the NCCIS. Managers provided copies of matching reports and minutes of Foster Care Committee meetings to inspectors for the purpose of reviewing the long-term matching process. While these records were comprehensive and demonstrated the consideration and approval of the long-term match by the committee, they also showed that some children were placed for a number of years prior to the long-term match being completed. Managers outlined to inspectors that the long-term matching process was not always in line with time frames set out in the standards due to regular review of care orders that were not necessarily long-term orders. Inspectors saw examples of this through court reports uploaded to NCCIS.

While there was a matching process in place in the area to ensure that children were matched with foster carers who had the capacity to meet their needs, there was a back-log of long-term matches. Evidence of matching was not available on children's files and the quality of the matching process was mixed. For these reasons, the area was judged to be substantially compliant with the standard.

Judgment: Substantially compliant

Standard 10: Safeguarding and child protection

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

Summary of inspection findings under Standard 10

While complaints, concerns and allegations against foster carers and allegations made by children in care that did not relate to foster carers were correctly categorised, some allegations were not always assessed in a timely manner or investigated in line with Children First. There was no formal safety planning process in place in the area.

Inspectors found that there was a governance system in place for the management of serious concerns, allegations and complaints made against foster carers. Inspectors were provided with a copy of the terms of reference for this governance group dated October 2018. The scope of this forum across each of the operational areas within the Tusla West region was to ensure that each service area was compliant with its obligations to track, monitor and report complaints, allegations and serious concerns against foster carers in line with the national standards. This group included managers from the fostering, child protection and children in care teams. Minutes of three meetings held in the service area since December 2018 to date were reviewed by inspectors, of which the most recent meeting in March 2019 demonstrated good discussion of five cases within these categories. Senior managers told inspectors that an overarching tracker recording system to ensure management oversight of all investigations into allegations, concerns and complaints against foster carers was in place. This was managed by the principal social worker for fostering.

However, when a child made an allegation against a person who was not the child's foster carer, inspectors could not evidence if these were formally tracked in the same way that concerns and allegations against foster carers were reviewed by the governance group. Consideration should be given to ensuring all allegations, complaints and serious concerns made by children in care are maintained on an overall tracking system so as to ensure full oversight.

A local policy, procedure and best practice guidance document was in place which aimed to provide advice and guidance to social workers who work with children in foster care, relative care, residential care and supported lodgings when reports in relation to child protection and welfare concerns, allegations, serious welfare concerns, complaints and difficult placements are received. Managers and staff who met with inspectors spoke of the governance group in place to oversee these

concerns and the local policy and procedure that supports them in dealing with all reports in relation to children in care.

Data submitted by the area showed that there were 18 child protection and welfare concerns pertaining to children in foster care in the last 12 months, all of which had been closed. There were 16 allegations and six serious concerns against foster carers in the past 12 months. Nine children had been removed from foster carers in the past 12 months due to child protection and welfare concerns.

Inspectors reviewed the files of 12 children in relation to the management of serious concerns, allegations against foster carers and other child protection and welfare concerns. Six of the 12 were allegations against foster carers, two were serious concerns and four were child protection and welfare concerns.

Of the six allegations against foster carers, all were correctly classified; however, not all of these allegations were managed and assessed in line with Children First (2017). At the time of inspection, two of these cases were unallocated and remained unallocated after the concern had been received. Due to the risks identified during the review of these files, inspectors escalated three of the six cases where allegations were made against foster carers and both of the serious concerns to the area manager following the inspection fieldwork.

One child's file showed that allegations were made against one foster carer and a further allegation made against a relative of the foster carer in November 2018. The child who made the allegation had since left the placement, but two children remained in the placement. Inspectors found that the initial assessment had not commenced at that time despite actions from a strategy meeting requiring an initial assessment for each child in the placement and a safety plan had not been put in place for the remaining children in the foster care placement. At the time of inspection, the initial assessments were carried out for two children still in the placement but were not adequate, as they did not identify the risks and a specific home visit in relation to these children did not take place.

A second child's file showed that numerous concerns were reported on file from the child, their family members and another sibling's foster carer. Inspectors found that not all of the concerns were investigated in line with Children First as gaps were identified, for example, actions arising from an initial assessment in 2017 and 2018 were not carried out and there was no safety plan in place for the child and their sibling in the interim while assessing the concerns.

Another child's file found concerns relating from 2013 to the time of inspection against a foster carer, and the concern had not been assessed in line with Children First. The child who made the allegation had since moved to another foster

placement but their sibling remained in the placement. Given the risk identified, inspectors escalated the need for an immediate safety plan. This was provided and although it identified safeguarding measures to ensure the child has contact with professionals and safe people to talk to, it did not address risks within the foster home and the responsibilities of the foster carer to keep the child safe. There was no discussion with the child in relation to a safety plan should he or she feel at risk within the foster home.

All three cases were escalated and assurances were provided outlining that the cases had been fully reviewed. The area manager confirmed that all risks and child protection concerns had been addressed and investigated in line with Children First and standard business processes. The safety plan that had been put in place during the inspection had been reviewed also to address all risks.

The two serious concerns reviewed by inspectors found that in one case, while an intake record was completed on the referral, it did not address all aspects of the concern. Inspectors were provided with the record of a home visit to the child where the concern was addressed and the fostering link worker gave verbal assurances of the support provided to the foster carer; however, this was not evident on the file. There was no evidence that the child had been met with on their own since the concern was reported in August 2018. Case notes showed that one statutory visit was recorded but did not reference if the child was met on their own. While protective factors and a backup plan were in place, it was clear that the foster carer would require regular support. The second case identified concerns relating to the inappropriate response to an alleged serious incident involving a child. A strategy meeting was not held to make a decision on whether this issue met the threshold for a serious concern or allegation and the Foster Care Committee had not been notified. While there was a governance group in place for the management of allegations, serious concerns and complaints against foster carers, it was only recently established and therefore not all the above cases had been reviewed by them.

A review of four other child protection and welfare concerns found that they were addressed appropriately and in a timely manner. Inspectors found that initial assessments were completed in all cases and the children were seen as part of the assessment. Appropriate safety measures were put in place and regular strategy meetings were held when required.

Social workers were competent and dedicated to safeguarding children in care. Inspectors met with children in care social workers and with fostering link social workers with responsibility for supporting foster carers. They presented as having appropriate knowledge and skills and despite the challenges within their caseloads, they were committed to their roles. While there were a number of good practices in

the area to ensure children were protected from abuse, there were also gaps in practice. These included the lack of or delays in scheduling of strategy meetings and lack of appropriate safety planning for children in care who required it.

There were a number of safeguarding measures in place in the area which included 433 (82%) children having an allocated social worker, 499 (94%) children were visited by a social worker in line with regulations and the majority of child in care reviews were up to date. However, at the time of inspection, there were 96 (18%) unallocated children in care which included six dual unallocated cases, where neither the child or the foster carer had an allocated social worker. Seventy child in care reviews were overdue and 30 (5.6%) children had not been visited by a social worker in line with regulations. The area also did not record formal safety plans for children who required them.

A review of three (50%) of the six dual unallocated cases with a high priority status by inspectors found that statutory requirements were not fulfilled in relation to care planning, reviews and visits to children. When cases are dual unallocated this means that no social worker is visiting the child, nor is there a link worker visiting the foster carers. Therefore Tusla has no oversight of the children in these placements, and this is poor safeguarding practice. In one of the cases, an allegation had been made during a child in care review meeting with no evidence that this had been followed up. Each of these cases were escalated to the area manager following the inspection to provide assurances that identified risks are dealt with in line with Children First, 2017 and Tusla's Serious Concerns and Allegations Procedure, that all appropriate safeguarding measures have been put in place and statutory requirements have been fulfilled. An appropriate response was received prior to completion of this report. This included a direction being given by the Area Manager that as and from May 2019 no children in care were to be dual unallocated.

Of the total number of seven cases escalated to the area manager, three required safety plans to be put in place; one of these was an immediate request for a safety plan during the inspection fieldwork. While there was no nationally recognised formal safety plan template available, managers told inspectors that issues regarding the safety of children were addressed through the child in care review and care planning process, the assessment of risk through the child protection system and through the recruitment, supervision and training of their foster carers. Inspectors highlighted the gaps identified in the safety planning process with the area manager and requested assurances in relation to specific cases that appropriate and timely safety plans were in place for children who required one.

The lack of learning by the area from previous inspections and the 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, published in June 2018 in relation to practice regarding safety planning, is a concern.

Of the 74 children who returned questionnaires, 68 (92%) said they knew how to keep safe and 56 (75%) children said that their social worker had told them who to talk to if they felt unsafe. Inspectors found that children had absence management plans which guided the foster carers on steps to take if the child was missing from care.

While there was no evidence of the involvement of an independent advocate with children whose files were reviewed, senior managers told inspectors that independent advocates were involved with young people in the area. A Mid West forum had been in operation in 2016 and 2017 which recruited young participants from a cohort of 600 young people in care. It engaged in reflective sessions on young people's care experience as well as fun activities and overnight stays. Staff involved included participation coordinators and advocates from external organisations and Tusla staff who reported to the area manager. Thirty six children under the age of 18 years and 19 young people aged between 18 and 24 years participated in this fora. The Mid West fora contributed to a wider research project undertaken by UNESCO Child and Family research centre, National University of Ireland, Galway.

In line with Children First (2017), foster carers are now considered mandated persons and are responsible for mandatory reporting of any concerns of a child protection and welfare nature to the duty social work team as appropriate. Managers told inspectors that foster carers had been written to regarding their responsibilities as mandated persons. Foster carers who met with inspectors said while they understood the legal obligation to report concerns, there was some confusion as to the actual reporting mechanism as some said there was a fear of reporting as the child would be taken from them while others contacted the child's allocated social worker directly. Further support and guidance was required for foster carers in the area of mandatory reporting.

There was a system in place to manage complaints in line with Tusla's complaints policy. Data submitted by the area showed that there were nine complaints made by foster carers, parents or family members and one complaint made by a child in the past 12 months. Inspectors reviewed the complaint register which was held by the general manager for alternative care. Of the total of 10 complaints, two were upheld in full, five were upheld in part and two were not upheld with one complaint still open at the time of inspection. All were correctly classified as complaints. The register contained comprehensive records and information pertaining to all of the respective complaints. Foster carers and children who met with inspectors during

visits said they were given information on how to make a complaint if they were unhappy about anything.

Inspectors reviewed the one complaint made by a child in October 2018. This was investigated by a child in care principal social worker who completed a comprehensive complaints officer's report into the matter dated December 2018. The report provided adequate information pertaining to the child's complaint and the steps taken to investigate which included meeting with the child, speaking with relevant social workers, other professionals involved and the child's foster carer as well as a review of relevant available information. The report acknowledges that despite significant efforts by those involved, Tusla had not provided the child with an appropriate response prior to or throughout the process in relation to the issue. Clear recommendations were noted and an option for appeal was included. The record also demonstrated that the circumstances pertaining to the child were risk escalated to senior managers from September to December 2018.

Not all child protection and welfare concerns and allegations made by children were assessed and investigated in line with Children First and standard business processes. Therefore, determinations as to whether the allegations were founded or not, and whether more robust protective measures were needed to ensure the child's safety were not timely. In addition, formal safety plans were not in place when required and there was no process in place in the area to ensure that safety planning was implemented, reviewed and monitored, as required. Therefore, the area was judged to be in major non-compliance with this standard.

Judgment: Non-compliant Major

Standard 13: Preparation for leaving care and adult life

Children and young people in foster care are helped to develop the skills, knowledge and competence necessary for adult living. They are given support and guidance to help them attain independence on leaving care.

Summary of inspection findings under Standard 13

Children and young people in foster care were helped to develop the skills, knowledge and competence necessary for adult living. They were also given the support and guidance to help them attain independence on leaving care.

There was a long standing and well-developed aftercare service in the area. A Tusla aftercare service operated between North Tipperary and Limerick, while the services in Clare were operated by community aftercare service with a full time manager. There were seven full-time aftercare workers, including two qualified social workers who also carried cases of children in care. The aftercare manager in Limerick was covering the North Tipperary service while the recruitment of an aftercare manager was being finalised. Their work was informed by the Tusla national aftercare policy and associated guidance and the policy was implemented in the area. The aftercare staff told inspectors that there were quite a number of unallocated cases in the team. The service is largely crisis driven and responsive to young people who are the highest priority.

The team worked closely with the children in care teams to identify if young people were eligible or not for a service. Young people who were eligible for a service but had been discharged from care can be assessed by the aftercare team. Staff told inspectors during focus groups and interactions that they were confident in making a decision as to whether a young person was eligible or not. In some circumstances where a young person did not qualify for an aftercare service, this had been escalated to the area manager for an appeals decision based on the vulnerability of the young person and a decision made on whether they should be offered a service. Inspectors were given an example one young person's case who, after an appeal decision was made, was subsequently offered a service.

Aftercare staff told inspectors that the children in care team makes the referral to the aftercare service and the case is co-worked when an aftercare worker is allocated until 18 years of age. At this point the aftercare worker becomes the allocated worker and main point of contact assigned to the young person.

Data submitted by the area showed that 41 (8%) of 529 children in foster care aged 16 years and over were eligible for an aftercare service. Twenty eight (68%) of eligible children over 16 years had been referred to the aftercare service. Therefore, 13 of the 41 children (31.7%) who were eligible for an aftercare service had not been referred to the after care service. This contradicted what inspectors were told by managers and staff during the inspection that all children who turned 16 years were referred to the aftercare service. Other data provided by the area outlined that 19 assessments of need had been carried out with children leaving care, 84 children had a statutory after care plan and 101 children had an allocated aftercare worker.

Inspectors reviewed the files of nine young people aged 16 years and over and each one had been assessed as eligible and referred for an aftercare service. Six young people had been allocated an aftercare worker of which four had an aftercare plan in place. The aftercare plans for three of the four young people had been completed in a timely way and were based on the assessment of need undertaken. The plan was drawn up with the young person and it may change many times before being finalised. The assessments were undertaken with the young people during one or more meetings between the young person, the foster carers and the aftercare worker. The format used to address the identified needs was in line with the standards and regulations. Inspectors found that the majority of these assessments were of good quality. While inspectors could see a copy of the referral to the aftercare service, the assessment of need completed and the aftercare plan where applicable on NCCIS, records of individual visits to the young person by the aftercare worker could not be confirmed as information pertaining to the aftercare service was paper based and the aftercare team were not set up on NCCIS.

The aftercare team provided a drop-in service on specific days per week for young adults with a care history which provided practical support, advice or signposting to other relevant agencies. The services available to young people were dependent on where they lived. Young people living in urban areas could drop in or call anytime to the social work offices where aftercare workers were based but this was more difficult for a young person living rurally. An inspector accompanied an aftercare worker to meet a young person who was living in a designated care leavers accommodation. It was clear that the young person had a good relationship with the aftercare staff and was supported by the service.

Inspectors observed an aftercare steering committee meeting that had only recently been established in the area. The purpose of this committee was to ensure a multidisciplinary response to children in care who had a disability or complex need. The steering committee comprised of an independent chairperson with senior representatives from Tusla, the local authority, the HSE disability and mental health services as well as other voluntary agencies relevant to the child's needs. Referrals

to the steering committee were made by the children's social workers. This committee were due to discuss its first referral at the time of the inspection. Managers and staff told inspectors during a focus group that the effectiveness of the steering committee had potential but it was at an early stage in its development. Aftercare staff told the inspectors that the establishment of the committee was a means of strengthening links with relevant agencies which was key to the provision of a quality service. Multidisciplinary meetings were held in order to jointly work on individual cases.

The aftercare manager did not complete an annual review report on the adequacy of the service. However, she did maintain records or statistics on young people who had left care and were provided with an aftercare service. Quarterly returns were made to the Tusla national office on referrals, numbers in receipt of an aftercare service, assessments undertaken, aftercare plans, allocation of an aftercare worker, review of aftercare plans as well as figures in relation to the drop in service and the aftercare steering committee as of quarter 1 of 2019.

Of the 144 young people in receipt of an aftercare service between the ages of 18 and 22 years, 114 (79%) were in full-time education or on accredited training courses as follows:

- 29 (25%) were in second level schools
- 18 (16%) were in vocational training
- 25 (22%) were in post-leaving certificate courses
- 33 (29%) were in third level college
- 3 (2.6%) were in accredited training
- 6 (5.2%) were in other placements.

The accommodation arrangements for the 144 young people in receipt of an aftercare service between the ages of 18 and 22 years were as follows:

- 3 (2%) were in residential care
- 70 (48.6%) remained with their foster carers
- 32 (22%) were living independently
- 13 (9%) were in designated care leavers accommodation
- 16 (11%) were living at home
- 6 (4%) were in supported lodgings

- 4 (2.7%) were in other accommodation

There was no evidence of the involvement of an independent advocate with any of the nine children's files reviewed aged 16 years and over. However, senior managers told inspectors that an independent advocacy organisation were involved with young people in aftercare. As previously noted in the report, a Mid West forum had been in operation in 2016 and 2017 of which 19 young people aged between 18 and 24 years had participated in.

The principal social workers for children in care and aftercare had undertaken an audit of eight aftercare files in April 2019. Inspectors were provided with the resulting action plan which made six recommendations in relation to recording deficits. A review of the team meeting minutes demonstrated where feedback was given to the aftercare team. The actions required and persons responsible were clearly recorded, however, there was no required time frame for completion of the actions required.

There were a number of examples of good practice in relation to the aftercare service in this area, including the following:

- Children who required support but who were not eligible for an aftercare service were allocated an aftercare worker and were provided with a service
- Social workers in the area demonstrated a commitment to young adults with a complex care history and in some instances, provided daily contact and support to enable these young adults to remain in their aftercare accommodation
- Children were supported to remain in residential care beyond the age of 18 years when it was assessed as being in their best interests or to pursue third level education courses or training courses.

The area did not produce an annual report on the adequacy of the aftercare service in compliance with the National Aftercare Policy for Alternative Care, 2017, but did provide monthly and quarterly data to the national office. However, the aftercare team provided a good service to care leavers and children and young people in foster care were supported to develop the skills, knowledge and competency necessary for adult living. The area had ensured that the requirements of the National Standards were in place. Therefore the area was judged to be compliant with this standard.

Judgment: Compliant

Appendix 1 — Standards and regulations for statutory foster care services

<i>National Standards for Foster Care (April 2003)</i>
Theme 1: Child-centred Services
<p>Standard 1: Positive sense of identity Children and young people are provided with foster care services that promote a positive sense of identity for them.</p>
<p>Standard 2: Family and friends Children and young people in foster care are encouraged and facilitated to maintain and develop family relationships and friendships.</p>
<p>Standard 3: Children’s Rights Children and young people are treated with dignity, their privacy is respected, they make choices based on information provided to them in an age-appropriate manner, and have their views, including complaints, heard when decisions are made which affect them or the care they receive.</p>
<p>Standard 4: Valuing diversity Children and young people are provided with foster care services that take account of their age, stage of development, individual assessed needs, illness or disability, gender, family background, culture and ethnicity (including membership of the Traveller community), religion and sexual identity.</p>
<p><i>Child Care (Placement of Children in Foster Care) Regulations, 1995</i> <i>Part III Article 8 Religion</i></p>
<p>Standard 25: Representations and complaints Health boards* have policies and procedures designed to ensure that children and young people, their families, foster carers and others with a bona fide interest in their welfare can make effective representations, including complaints, about any aspect of the fostering service, whether provided directly by a health board or by a non-statutory agency.</p>

* These services were provided by former health boards at the time the standards were produced. These services are now provided by the Child and Family Agency (Tusla).

National Standards for Foster Care (April 2003)

Theme 2: Safe and Effective Services

Standard 5: The child and family social worker

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

Child Care (Placement of Children in Foster Care) Regulations, 1995
Part IV, Article 17(1) Supervision and visiting of children

Standard 6: Assessment of children and young people

An assessment of the child's or young person's needs is made prior to any placement or, in the case of emergencies, as soon as possible thereafter.

Child Care (Placement of Children in Foster Care) Regulations, 1995
Part III, Article 6: Assessment of circumstances of child

Standard 7: Care planning and review

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

Child Care (Placement of Children in Foster Care) Regulations, 1995
Part III, Article 11: Care plans
Part IV, Article 18: Review of cases
Part IV, Article 19: Special review

Standard 8: Matching carers with children and young people

Children and young people are placed with carers who are chosen for their capacity to meet the assessed needs of the children or young people.

Child Care (Placement of Children in Foster Care) Regulations, 1995
Part III, Article 7: Capacity of foster parents to meet the needs of child

Child Care (Placement of Children with Relatives) Regulations, 1995
Part III, Article 7: Assessment of circumstances of the child

National Standards for Foster Care (April 2003)

Standard 9: A safe and positive environment

Foster carers' homes provide a safe, healthy and nurturing environment for the children or young people.

Standard 10: Safeguarding and child protection

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

Standard 13: Preparation for leaving care and adult life

Children and young people in foster care are helped to develop the skills, knowledge and competence necessary for adult living. They are given support and guidance to help them attain independence on leaving care.

Standard 14a — Assessment and approval of non-relative foster carers

Foster care applicants participate in a comprehensive assessment of their ability to carry out the fostering task and are formally approved by the health board* prior to any child or young person being placed with them.

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

Part III, Article 5 Assessment of foster parents

Part III, Article 9 Contract

Standard 14b — Assessment and approval of relative foster carers

Relatives who apply, or are requested to apply, to care for a child or young person under Section 36(1) (d) of the Child Care Act, 1991 participate in a comprehensive assessment of their ability to care for the child or young person and are formally approved by the health board.

Child Care (Placement of Children with Relatives) Regulations, 1995

Part III, Article 5 Assessment of relatives

Part III, Article 6 Emergency Placements

Part III, Article 9 Contract

* These services were provided by former health boards at the time the standards were produced. These services are now provided by the Child and Family Agency (Tusla).

National Standards for Foster Care (April 2003)

Standard 15: Supervision and support

Approved foster carers are supervised by a professionally qualified social worker. This person, known as the link worker, ensures that foster carers have access to the information, advice and professional support necessary to enable them to provide high-quality care.

Standard 16: Training

Foster carers participate in the training necessary to equip them with the skills and knowledge required to provide high-quality care.

Standard 17: Reviews of foster carers

Foster carers participate in regular reviews of their continuing capacity to provide high-quality care and to assist with the identification of gaps in the fostering service.

Standard 22: Special Foster care

Health boards provide for a special foster care service for children and young people with serious behavioural difficulties.

Standard 23: The Foster Care Committee

Health boards* have foster care committees to make recommendations regarding foster care applications and to approve long-term placements. The committees contribute to the development of health boards' policies, procedures and practice.

Child Care (Placement of Children in Foster Care) Regulations, 1995
Part III, Article 5 (3) Assessment of foster carers

Child Care (Placement of Children with Relatives) Regulations, 1995
Part III, Article 5 (2) Assessment of relatives

* These services were provided by former health boards at the time the standards were produced. These services are now provided by the Child and Family Agency (Tusla).

National Standard for Foster Care (April 2003)**Theme 3: Health and Development****Standard 11: Health and development**

The health and developmental needs of children and young people in foster care are assessed and met. They are given information, guidance and support to make appropriate choices in relation to their health and development.

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

Part III, Article 6 Assessment of circumstances of child

Part IV, Article 16 (2)(d) Duties of foster parents

Standard 12: Education

The educational needs of children and young people in foster care are given high priority and they are encouraged to attain their full potential. Education is understood to include the development of social and life skills.

National Standards for Foster Care (April 2003)**Theme 4: Leadership, Governance and Management****Standard 18: Effective policies**

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

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

Part III, Article 5 (1) Assessment of foster carers

Standard 19: Management and monitoring of foster care agency

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

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

Part IV, Article 12 Maintenance of register

Part IV, Article 17 Supervision and visiting of children

* These services were provided by former health boards at the time the standards were produced. These services are now provided by the Child and Family Agency (Tusla).

Standard 24: Placement of children through non-statutory agencies

Health boards placing children or young people with a foster carer through a non-statutory agency are responsible for satisfying themselves that the statutory requirements are met and that the children or young people receive a high-quality service.

Child Care (Placement of Children in Foster Care) Regulations, 1995
Part VI, Article 24: Arrangements with voluntary bodies and other persons

National Standards for Foster Care (April 2003)**Theme 5: Use of Resources****Standard 21: Recruitment and retention of an appropriate range of foster carers**

Health boards are actively involved in recruiting and retaining an appropriate range of foster carers to meet the diverse needs of the children and young people in their care.

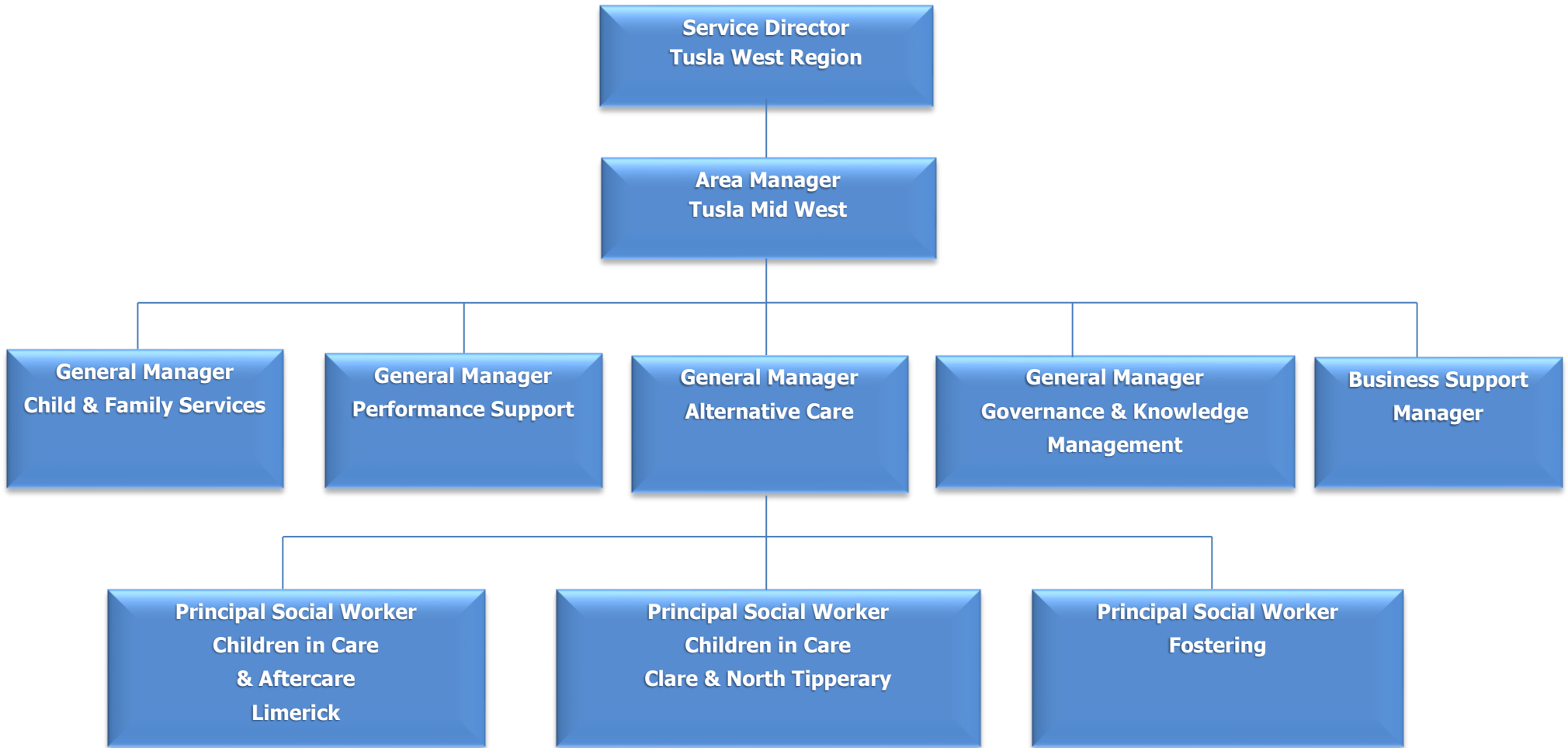
National Standards for Foster Care (April 2003)**Theme 6: Workforce****Standard 20: Training and Qualifications**

Health boards* ensure that the staff employed to work with children and young people, their families and foster carers are professionally qualified and suitably trained.

* These services were provided by former health boards at the time the standards were produced. These services are now provided by the Child and Family Agency (Tusla).

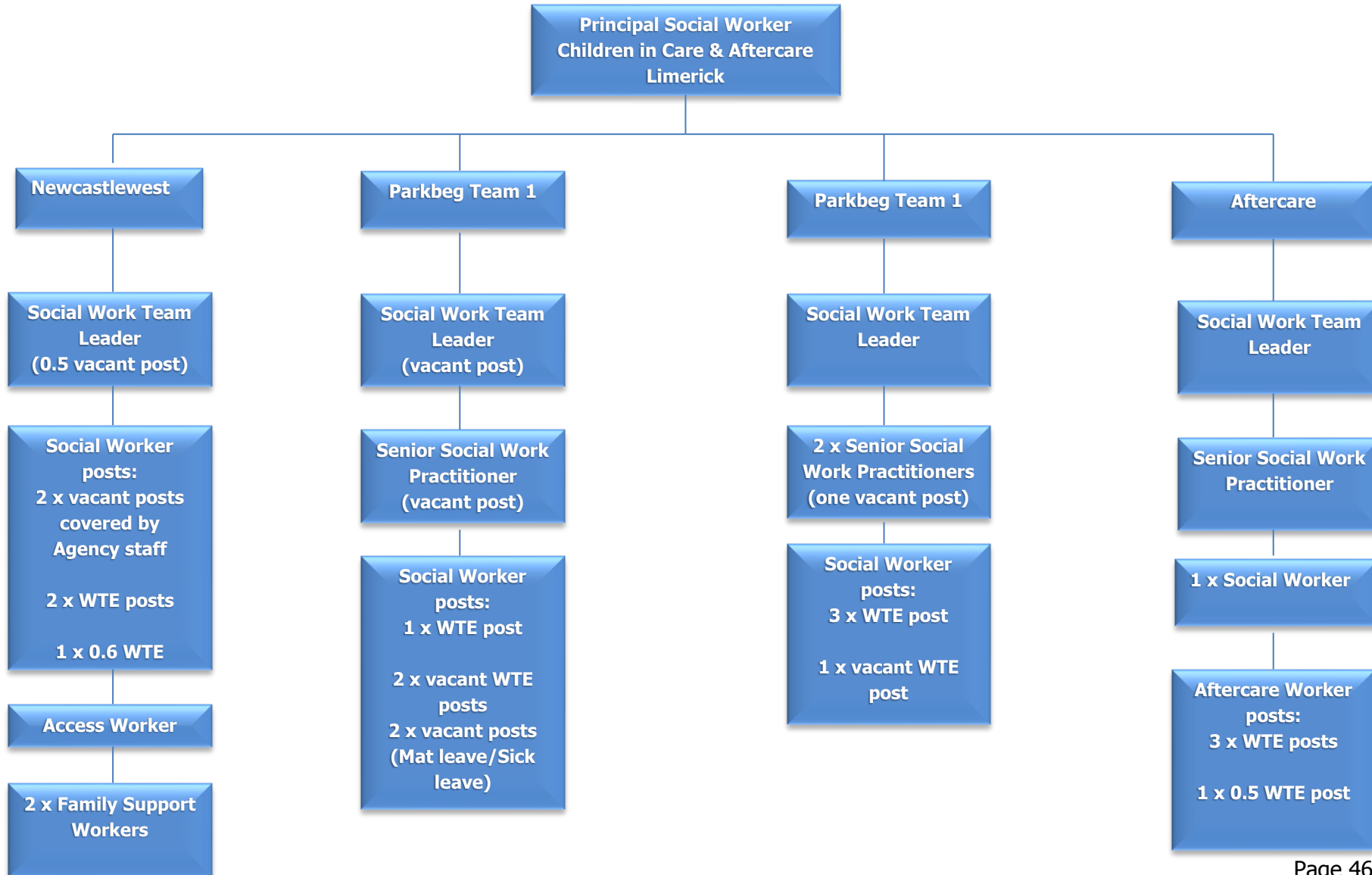
Appendix 2: Organisational structure of Statutory Alternative Care Services, in the Mid West Service Area *

(i) Management Structure

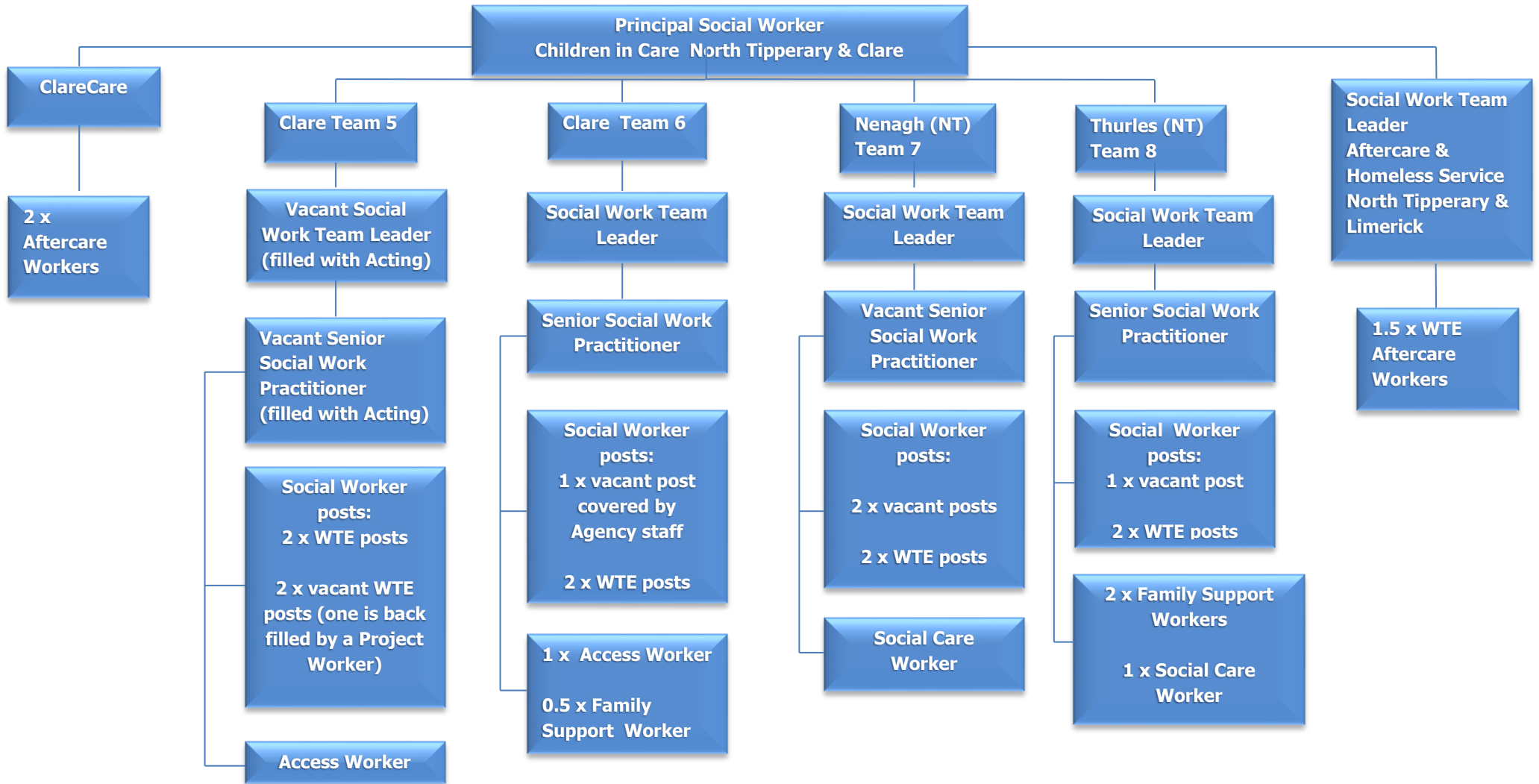


* Source: The Child and Family Agency

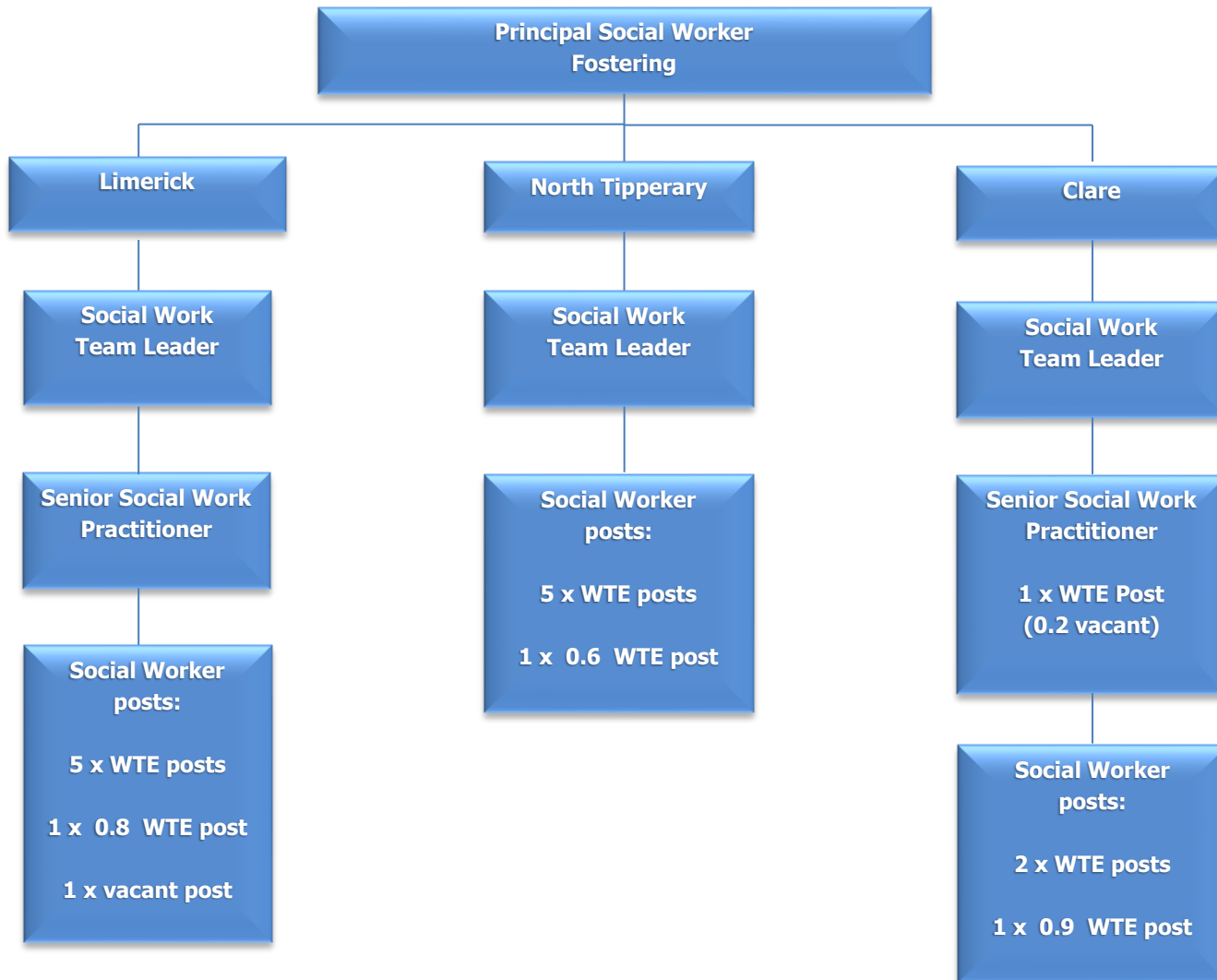
(ii) Children in Care & Aftercare Limerick



(iii) Children in Care North Tipperary & Clare



(iv) Foster Care service



Action Plan

This Action Plan has been completed by the Provider and the Authority has not made any amendments to the returned Action Plan.

Provider's response to Report Fieldwork ID:	MON 0026597
Name of Service Area:	Mid West
Date of inspection:	29 April – 2 May 2019
Date of response:	01 July 2019

These requirements set out the actions that should be taken to meet the identified child care regulations and *National Standards for Foster Care*.

Theme 2: Safe and Effective Services

Standard 5 – The child and family social worker

Non-compliant Moderate

The provider is failing to meet the National Standards in the following respect:

Not all children had an allocated social worker.

There was no system of oversight for ensuring statutory visits to children were carried out in line with the timeframes set out in the regulations.

The quality of records pertaining to home visits was of mixed quality and were not consistently uploaded to the child's file.

Case chronologies on children's files were not a consistent practice.

Action required:

Under **Standard 5** you are required to ensure that:

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

Please state the actions you have taken or are planning to take:

1) HR Task Group:

The area has a monthly HR Task Group established since January 2019, which is chaired by the area manager and attended by the regional HR manager. This group have agreed improved mechanisms to process all posts as quickly and efficiently as possible and to provide oversight of same. There is a priority to process children in care vacancies during these meetings. The area is also working on retention strategies to ensure that recruitment issues are sustained for the longer term. A significant number of agency and permanent staff have come into post in children in care teams since inspection in all three counties in the area.

2) Recruitment:

All required HR actions are tracked to ensure that staff recruitment is progressed in the minimum amount of time. Interviews for permanent PQSW staff were held in Limerick during May 2019 as part of a national recruitment campaign and vacancies are currently in the process of being filled.

3) Duty System:

A duty system is being progressed for the area and will be fully in place by July 2019.

4) Tracker:

A fully populated tracker is currently being developed to incorporate details of statutory visits and their due date using NCCIS. This will be reviewed by social work team leaders on a monthly basis.

5) Training:

Training on record-keeping will be provided by the NCCIS Lead and Workforce Learning and Development in relation to

- records pertaining to home visits and uploading to child's file

<ul style="list-style-type: none"> recording case chronologies. 	
Proposed timescale:	Person responsible:
Monthly	Principal Social Workers
1) Complete (May 2019)	
2) July 2019	Principal Social Workers and Social Work Team Leaders
3) Q3 2019	NCCIS Lead & General Manager, Alternative Care
4) Initial meeting to design the training 10 th July 2019	Principal Social Workers NCCIS Lead WLD Training Officer General Manager, Alternative Care

Standard 7 – Care planning and review

Non-compliant Moderate

The provider is failing to meet the National Standards in the following respect:

It was not always evident that decisions arising from a child in care review were discussed with children or shared with those not in attendance.

Deficits in statutory requirements were not consistently discussed or recorded in case supervision records.

Placement plans were not consistently completed.

Voluntary consent provided by parents at the time of the child's admission to care was not adequately reviewed.

Action required:

Under **Standard 7** you are required to ensure that:

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

Please state the actions you have taken or are planning to take:

1) Reviews:

The chair of the review will identify necessary parties, within the care plan, with whom care plans should be shared. A checklist will identify the date the care plan was shared

and each child in care review will identify who shares the plan with the child and by when.

2) Case Supervision Records:

Deficits in statutory requirements will be discussed in case supervision records where the case is allocated. Whereby the case is unallocated, this will be reviewed on the tracker system and by using the local managing unallocated cases policy.

3) Placement Plans

From end of quarter 3 placement plans will be completed for all newly received children in care going forward. For all current children in care placement plans to be completed following the next child in care review and to be updated at each subsequent review. All placement plans will be completed by end of quarter 3 2020.

4) Voluntary Consent: Voluntary care will be discussed at any child in care review where there is voluntary care in place. By the end of quarter 3 an audit will be carried out on all cases where the care status is voluntary care and where absent a review date for all voluntary care arranged.

Proposed timescale:	Person responsible:
1) July 2019	Principal Social Workers Social Work Team Leaders
2) Ongoing from July 2019	Social Work Team Leaders
3) Q3 2020	Social Work Team Leaders
4) Q4 2019	Social Work Team Leaders

Standard 8 – Matching carers with children and young people**Substantially compliant****The provider is failing to meet the National Standards in the following respect:**

The recording of the matching process was not evident on children's files.

There was a backlog in the completion of long-term matches in the area.

Information provided to foster carers prior to a child's placement was not consistently evident on a child's file.

Action required:

Under **Standard 8** you are required to ensure that:

Children and young people are placed with carers who are chosen for their capacity to meet the assessed needs of the children or young people.

Please state the actions you have taken or are planning to take:**1) Matching Process:**

Minutes of the matching process will be forwarded by the fostering team leader to the children in care social worker

2) Foster Care Committees:

Additional foster care committees will be convened to hear the long term matching reports in the area

3) Training:

A copy of the written information provided to foster carers will be uploaded on the child's file. This will be part of the joint training to be provided by NCCIS lead and workforce learning and training development officer.

Proposed timescale:	Person responsible:
1) July 2019	Fostering Social Work Team Leader Children in Care Social Worker
2) Q3 and Q4 2019	General Manager, Alternative Care Principal Social Worker, Fostering
3) Initial meeting to design training on 10 th July 2019	General Manager, Alternative Care NCCIS Lead WLD Training Officer Principal Social Worker

Standard 10 – Safeguarding and Child Protection**Non-compliant Major****The provider is failing to meet the National Standards in the following respect:**

Not all allegations made by children were assessed and investigated in line with Children First (2017).

Formal safety plans were not always in place when specific risk to children were identified and in some cases, safety plans were not adequate.

Action required:

Under **Standard 10** you are required to ensure that:
Children and young people in foster care are protected from abuse and neglect.

Please state the actions you have taken or are planning to take:**1) Tracker:**

The tracker, which is currently being developed, will track all allegations made by children. A bi monthly governance meeting will oversee these allegations in relation to children in foster care. A flow chart which is based on the Tusla national policy "Interim policy for managing concerns and allegations of abuse against foster carers or relative carers, 2017" is in use in the area. This was developed from Regional Task and Finish 2019. Part of this policy is to ensure that all allegations are investigated in line with Children First (2017). Standard 10 will further be reviewed at Regional Task and Finish for Children in Care.

2) Training:

The tracker will be part of the joint training to be provided by NCCIS Lead and Workforce Learning and Training Development Officer.

3) Safety Plan:

An agreed safety plan template has been agreed by managers in the area for alternative care. This will be part of the joint training to be provided by NCCIS lead and workforce learning and training development office

Proposed timescale:	Person responsible:
1) Q3 2019	Task and Finish
2) Initial meeting to design training on 10 th July 2019	General Manager, Alternative Care NCCIS Lead WLD Training Officer Principal Social Worker
3) Initial meeting to design training on 10 th July 2019	General Manager, Alternative Care NCCIS Lead WLD Training Officer Principal Social Worker

