Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Child Protection and Welfare Service

Name of service area:	Dublin North
Name of provider:	Tusla
Type of inspection:	Focused CPNS
Date of inspection:	14 - 17 September 2021
Lead inspector:	Erin Byrne
Support inspector(s):	Grace Lynam Tom Flanagan Una Coloe
Fieldwork ID	MON-0033834

About monitoring of child protection and welfare services

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

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

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

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

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

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

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

How we inspect

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

The key activities of this inspection involved:

- the analysis of data
- interview with the area manager,
- focus group with five principal social workers
- focus group with 9 social work team leaders
- focus group with 15 social workers
- the review of local policies and procedures, minutes of various meetings, supervision files, audits and service plans
- observation of a child protection conference
- the review of 25 children's case files
- phone conversations with 10 parents
- phone conversations with 4 children

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

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

Profile of the child protection and welfare service

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

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

- child welfare and protection services, including family support services
- existing Family Support Agency responsibilities

- existing National Educational Welfare Board responsibilities
- pre-school inspection services
- domestic, sexual and gender-based violence services.

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

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

Service area

North Dublin is one of the 17 national service areas across Ireland and is part of the Dublin North East (DNE) Region. North Dublin local health area encompasses two geographical local authority catchment areas, namely Fingal County Council and Dublin City Council. The North Dublin area stretches from Raheny and Sutton on the east side, inland to Oldtown and the Meath border to Stamullen. In October 2013 the boundary of North Dublin was extended to include all of Dublin 15 resulting in the Fingal part of the area becoming co-terminus with Fingal County Council boundaries. Fingal is the youngest and most ethnically diverse county in the state, with a birth rate that exceeds the national average. The area also encompasses Howth, Coolock, Raheny, Darndale, Edenmore, Kilbarrack, Donaghmede and newly developed areas such as Clongriffen and the Racecourse in Baldoyle. With this realignment, an additional 101,032 population came under North Dublin's remit. This added significant pressures on an already under resourced Area and continues to present significant challenge to the present time.

The area is under the direction of the service director for Tusla, Dublin North East region, and is managed by an area manager. Dublin North child protection and welfare services was delivered through nine social work teams based in three office sites. They are located at Swords (Airside), Coolock Primary Care Centre and Blanchardstown Primary Care Centre (Grove Court). These teams reported to three principal social workers for child protection and welfare in the area. The child protection conferencing service was delivered by two principal social workers and administration staff were employed to assist them. There were 67 children listed on the CPNS at the time of the inspection and all children on the CPNS were allocated a social worker. While the majority of children listed on the CPNS were allocated to social workers on the child protection and welfare teams, there were a small number of cases allocated to social workers on the children in care teams in the area.

At the time of the inspection, there were 10 whole time equivalent social work vacancies, and 4 key frontline social care and family support practitioner vacancies across the child protection and welfare service. Seven social work posts were being filled by agency staff. In addition, there were 18 new staff employed in the weeks preceding the inspection.

Compliance classifications

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

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

This inspection was carried out during the following times:

Date	Times of inspection	Inspector	Role
14/09/2021	09:00 – 17:00	Erin Byrne Grace Lynam Una Coloe Tom Flanagan	Lead Inspector Support Inspector Support Inspector Remote Inspector
15/09/2021	09.00 – 17.00	Erin Byrne Grace Lynam Una Coloe Tom Flanagan	Lead Inspector Support Inspector Support Inspector Remote Inspector
16/09/2021	09.00 – 16:00 09.00 – 17.30	Erin Byrne Grace Lynam Una Coloe Tom Flanagan	Lead Inspector Support Inspector Support Inspector Remote Inspector
17/09/2021	10.30 – 12.00 (interview with area manager - Remote)	Erin Byrne	Lead Inspector

Views of people who use the service

As part of this inspection, inspectors spoke with four children and 10 parents of children who were subject to a child protection conference and or listed on the child protection notification system. This section of the report will provide an overview of the views of parents and children shared with inspectors, about their experience of the service and the child protection conference process.

Inspectors spoke with four children individually over the phone. Three children who spoke with inspectors had attended their child protection conference (CPC) and their social worker had explained the reasons for the CPC. Each was aware of their safety plan and felt that it had brought about change for the better and they felt safer as a result. The children described good experiences of their social workers and, for two children, being allocated a support worker in the community made a big difference in their lives. Some of their comments are as follows:

"It has been a good experience – I feel safer now".
"The social worker explained a lot of things to me and told me I could contact her anytime".
"We had a safety plan and it worked".
"The social worker got me a worker – he was amazing. We went places and talked about personal things."
"The social worker had a discussion with me and explained everything – why we had to have the big meeting and what was going to happen".
"We have a safety plan – we all know what we have to do if anything happens".
"I didn't feel listened to … but things are moving now okay".
"My worker is brilliant. We go out for food, go bowling and do other stuff"
"The safety meetings have helped keep me out of trouble"
"The social worker visits a lot & talks to me on my own. She is nice. She wants me to be safe".

Inspectors spoke with 10 parents all of whom had attended their Child Protection Conference. The purpose of the meetings and how they would be conducted were explained to them. All confirmed to inspectors that they received copies of the CPC minutes and the child protection safety plans. All 10 parents spoke about having safety network meetings and about the social worker visiting them, the frequency of which depended of their family circumstances.

Seven of the 10 parents expressed satisfaction with their experience of the service. While almost all parents had positive things to say with the overall CPC process. "The whole thing has been quite good and it has helped me look after my children better".

"Overall it's positive at the moment and the social worker is good". "The CPC system was very helpful – it opened my eyes to what needs to be done". "At first, it felt they were at me for this and that – then I realised it was all about safeguarding". "I felt the whole process to be objective, enlightening and eye-opening".

Some commented on positive experiences of the CPC meeting itself. "The chair of the meeting explained everything to me and I felt more relaxed". "I felt very nervous going into the meeting but the chair made me feel relaxed and gave me lots of information". Three parents were not happy with some aspects of the service. One felt they were not listened to: "The social worker kept talking over me". Another parent said that "The CPC process is very slow" and "feels like they're blaming us and there's no evidence". While one parent expressed frustration "we don't know where it's all going – we never know the end goal".

All parents who spoke with inspectors experienced some good outcomes in regard to the safety of their children. Some of the comments are as follows: "The children are safe and happy". "My son is doing great – they've been helping him. There were big problems but things are settled now". "They got him a support worker and that was really good for him".

Almost all parents spoke very positively about the social workers they worked with. "Social workers have really improved things". "The social worker visits me and the kids every week – she keeps me informed". "Trust is the most important thing for me and I trust the social worker". "The social worker visits regularly – I get on well with her – she is open and transparent". "I've been blessed with all the social workers and if you work with them they work with you".

Capacity and capability

In the Dublin North child protection and welfare service children identified as being at ongoing risk of significant harm were provided with a good quality, consistent and safe service. The service functioned in accordance with required legislation, regulation and national policy. There were effective governance and management arrangements in place and qualified and experienced managers provided strong leadership. There were well established mechanisms to review and assess the effectiveness and safety of the child protection and welfare service. However, records of review and oversight by managers required improvement.

Staff's approach to working with families was child-centred and there was a common approach amongst all staff who met with inspectors which indicated a culture of learning in the service, where questions were encouraged and challenges were used as learning opportunities. Data and information was routinely used to ensure a good quality and safe service for children and families.

This inspection took place in what had been a challenging time nationally for social work teams and children and families engaging in the services due to the risks and public health restrictions associated with the COVID-19 pandemic. In addition, in May 2021, Tusla was the target of a major cyber-attack which had compromised their national child care information system (NCCIS) for several weeks. In this context, HIQA acknowledges that services needed to adapt how they worked with children and families to ensure essential supports were delivered as required. These issues, and how they were managed, were reviewed within the overall assessment of local governance. They were found to have been well managed and had minimal impact on the service provided to children and families subject of child protection conference or child protection safety plans.

As cited above, the aim of the inspection was to assess compliance with national standards the service delivered to children who are subject to a child protection case conference and whose names are entered onto the child protection notification system.

Children First National Guidance for the Protection and Welfare of Children (2017), states; "where serious concerns of ongoing risk of significant harm are identified during the assessment and interventions, or where a social worker has concerns that progress is not being made under the Child Welfare Plan/Family Support Plan, a plan of action is prepared. This is done by consulting with the parents and appropriate professionals to protect the welfare and safety of the child. A Child Protection Conference (CPC) will be held to decide whether it is necessary to put the child's name on the Child Protection Notification System (CPNS) and if so, to agree a Child Protection Plan." "The Child Protection Notification System (CPNS) is a secure database that contains a national record of all children who have reached the threshold of being at ongoing risk of significant harm and for whom there is an ongoing child protection concern. The list is there to help a small group of relevant professionals make decisions about the safety of a child."

Tusla National Guidelines on Child Protection Conference and The Child Protection Notification System was developed in 2018, at the time of inspection this document remained an interim guideline and required updating as a means of assurance of quality and consistent practice. However, inspectors found the areas management team were proactive in their response to address gaps in national policy or guidance. Locally produced guidance documents were available to staff which ensured consistency in practice that was aligned with the service approach to child protection. This guidance had been devised in consultation with senior managers including; the child protection conference chair persons and principal social workers and clearly outlined the expectations of staff in the management of these cases included; requesting a CPC, provision of reports for CPC, pre-consultation with families and CPC chairpersons and the requirement to ensure appropriate immediate safety plans were agreed as required following CPC's. In addition, the guidance outlined for social workers the steps needed to be taken to ensure appropriate oversight of plans through network meetings and practically the steps taken to make a child 'active' on the CPNS as appropriate.

There were effective governance arrangements within the service and clearly defined lines of accountability. There were clear reporting procedures and well-established lines of communication. The service was well-led and there was a culture of team work. Leaders in the service had an expectation that children subject to child protection conference and therefore at the highest level of risk, received prompt, considered and supportive interventions which were monitored closely for their effectiveness. The areas management team were assured of the quality of service to children subject to CPC through well-established systems of oversight which included governance meetings, senior management meetings, complex case forums, staff supervision, staff learning and development initiatives and an active presence within

the team on a day to day basis.

Strategic objectives of the service were in line with required standards and expectations of a well governed service. The area service plan, as it related to this inspection, reflected a focus on ensuring compliance with legislation, regulations and national policies and on promoting child-centred practice with active participation from families and external stakeholders as appropriate. There was clear evidence of the service acting to ensure learning from previous inspections. Internal audits and review processes were incorporated into service improvement plans. Principal social workers and the Area Manger were clear that decisions about children and their care or supportive interventions were made based on risks and identified needs therefore, children and families at the highest risk or in greatest need of supports were prioritised for their service.

Inspectors met with 32 staff members with varying levels of responsibility for delivering a service to children requiring a child protection conference and or child protection safety plan. All staff demonstrated knowledge of relevant legislation, policy and standards as they related to the management of children listed on the CPNS. There was effective oversight of the management of CPC's for children on the CPNS. Children on the CPNS were all allocated a social worker and their cases closely overseen by social work team leaders (SWTL). Principal social workers (PSW) received regular updates from their social work team leaders on progress in these cases and closely monitored risks associated with children subject to CPC's. Responsibility for chairing child protection conferences was held by two independent principal social workers, neither of whom had direct involvement in the management of cases. The area manager met regularly with managers with responsibility for oversight of the CPC process. Quality assurance mechanisms formed part of routine management procedures of the service. The area manager provided regular supervision to all principal social workers and both child protection conference chair persons during which data and information pertaining to children on the CPNS as well as referrals for CPC were routinely discussed.

The area manager received data relating to children subject to the CPC processes on a monthly basis, which provided specific details for each child including, duration listed on the CPNS, whether or not they were overdue a review CPC's and listing the principal social workers as well as chair person responsible for each child. This information in turn informed the area managers supervision of the PSW's with regard to ensuring appropriate response to address delays in review CPC's, referral to complex case forum for children listed for prolonged periods and generally keeping up to date on progress in addressing risks relating to children listed on the CPNS.

Inspectors reviewed records of management meetings and decision-making forums and found that these were well recorded. Actions were clearly identified and there was good follow through on decisions. Regular management and governance meetings included; CPC governance meetings, CPW governance meetings and area management meetings.

There were six weekly governance meetings attended by all senior managers in the service, the agenda for which included the CPNS and CPC process. Inspectors found that where trends had been identified, these were highlighted within management team meetings and appropriate measures put in place to address same. For example, an audit conducted by the CPC chair persons, on cases of children who were received into care and de-listed from the CPNS without review, identified deficits in the timeliness of issuing of letters to relevant stakeholders including families, schools, general practitioners and Gardaí, informing them of the decision to remove a child from the CPNS. This was highlighted by the CPC chair persons and relevant procedures agreed amongst the management team to address these delays, ensuring all relevant stakeholders are routinely and promptly notified of changes in circumstances leading to the de-listing of children from the CPNS.

There were good systems for monitoring and evaluating quality of service also in place. There was system for auditing case records and quality of social work reports by PSW's who regularly reviewed case records through NCCIS and discussed their findings through supervision with their SWTL's. Inspectors found evidence of audits of children's case files as well as records entitled 'governance notes' which were produced by PSW's detailing discussion or direction to SWTL's to address deficits identified through routine review of children's records. In addition, there were audits of records for children on the CPNS completed monthly by the area manager's business support team and findings of these were disseminated directly to PSW's by the area manager's office. These audits had only begun to be implemented in the area therefore only a small sample was reviewed. They were found to be comprehensive and detailed, they included details of safeguarding visits, oversight and governance of each case, including case supervision and examined social work judgements and quality of analysis of harm for children listed as 'active' on the CPNS.

The chair persons for CPC told inspectors that they provided regular feedback to managers on quality of social work practice, including feedback on report prepared for CPC or quality of communication with parents by social workers, which informed learning and development of staff within the service. Principal social workers told inspectors about initiatives introduced following internal audits and findings of other oversight mechanisms, which lead to presentations by CPC chair persons to all staff, as well as, the inclusion of training on CPC's and CPNS as part of new staff induction. In addition, learning from experiences and review of practice in the area had led to joint training initiatives with external stakeholders to promote learning on the purpose and process of child protection conferencing as well as the remit and role of all of those invited to attend.

Staff supervision was identified as an assurance mechanism by all managers who met with inspectors. Cases related to children subject of CPC's were routinely discussed through supervision and SWTL's as well as PSW's, where relevant, received regular updates on persistent or escalating risks related to these children. However, inspectors found that written records of case supervision were not available on all children's files. Records evidencing managerial oversight, case discussions and detailing how or why certain decision were reached were not routinely and promptly uploaded on children's case files in all cases.

The area manager provided supervision to all principal social workers and both child protection conference chair persons in the area and a review of supervision records found that this was frequent, in line with policy and relevant. Records demonstrated regular discussion of high risk cases both referred for CPC, with potential for future referral and those listed on the CPNS. Complex cases were routinely discussed and decisions to refer cases for complex case forum were agreed and documented.

The complex case forum was used in the area to discuss referred cases in detail and examine interventions, progress and risks as appropriate. The forum was attended by senior managers throughout the service who reviewed cases and offered support, advice and additional oversight to social workers with challenging and complex cases. This forum was used to promote a culture of shared responsibility and sharing of ideas. Cases were referred to complex case forum on a monthly basis and it was routine practice in the area to refer any case of a child listed on the CPNS longer than 18 months for review within this forum. Principal social workers, child protection conference chairpersons and the area manager all told inspectors that this process had been revised with the intention of referring cases on the CPNS longer than 12 months to the complex case forum however, this decision had only just been implemented at the time of inspection. Inspectors reviewed minutes of complex case meetings and found that they reflected open and transparent discussion, social

workers were asked to account for their decisions and suggested interventions to improve progress or alternative actions were offered. Principal social workers and social work team leaders identified this process as a valuable tool within the service to evaluate interventions and decisions in relation to complex cases and assisted in generating ideas for intervention to promote better outcomes for children and families.

There were clearly defined structures within the service to ensure that escalating risks were identified quickly, reported and responded to as required. Structures and governance arrangements in place ensured risks were well managed in line with Tusla's risk management framework. Progress in addressing risk was appropriately monitored and there were clear mechanisms for reporting on progress and risks externally to the regional service director as required. There was a process in place to escalate individual risks within the service through 'Need to Knows' which were reported to the area manager and regional service director as required, inspectors reviewed 'Need to Knows' related to the focus of the inspection and found that these were relevant, appropriate and escalated in line with Tusla policy.

The service had a risk register which was reviewed and updated regularly as required. The service effectively managed risks which presented throughout 2020 and 2021 as a result of Covid-19 as well as the cyber-attack on Tusla in May of 2021. Neither risk impacted adversely on the provision of service to children subject to CPC's as alternative arrangements were agreed promptly and efficiently. Creative solutions were identified for ensuring families were supported and risks continued to be managed. Delays in review CPC's which were postponed during the summer months were considered and rationale for decisions clearly documented.

Managers responded appropriately and promptly to complaints about the child protection service as well as appeals of decisions of child protection conferences. Inspectors reviewed one complaint relating to the CPC process and one appeal of a decision of a CPC and found that both were addressed as required. There was a delay in responding to the appeal of the decision of the CPC however this was directly related to the cyber-attack and an inability by the service to access records for a number of weeks. The reasons for this delay were clearly communicated to the relevant people and prompt action was taken to resolve the matter effectively.

Inspectors reviewed the CPNS and found that the information was accurate and reflective of data provided by the area. The system was promptly updated following decision to list and de-list a child and responsibility for this process was clearly defined. In addition, child protection conference chair persons conducted regular audits of the CPNS to ensure there was no unauthorised persons accessing the system.

There was a culture of continuous learning and development promoted amongst the managers within the service and social work told inspectors that they were supported and encouraged by all managers throughout the service. There were clear mechanisms in place for notification and review of serious incidents and learning from such events was shared with all staff within their established communication structures. Staff told inspectors that they were supported to develop their practice. Parents and children consistently reported standard practice in line with requirements in particular relating to their inclusion, provision of information and opportunities to participate meaningfully in the CPC process.

All parents received feedback forms following their involvement in a CPC, providing them with the opportunity to relay their opinion on the CPC process. In addition, the views of external stakeholders were sought and considered as required to inform decision making as well as overall learning and service development. There was evidence of good working relationships with a wide variety of local external service providers including; Gardaí, schools, public health nurses, hospitals and crèche services, and joint learning and development initiatives were in progress.

Standard 3.1

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

There were governance structures in place which supported the delivery of the CPNS service in line with relevant legislation and national standards. Staff and managers were knowledgeable and committed. Where required local guidance, policies and procedures were developed to support staff to effectively protect children and promote their welfare.

Tusla National guidelines on child protection case conferencing and the child protection notification systems that had not been subject to review and required updating to ensure consistent delivery of service to children subject to child protection conferencing process.

Judgment

Substantially compliant

Standard 3.2 Children receive a child protection and welfare service, which has effective leadership, governance, and management arrangements with clear lines of accountability.
Children and families received a service which had effective leadership, governance and management arrangements in place. Managers provided strong leadership and the service promoted a culture of continuous learning and development amongst their staff where questions were encouraged and opportunities for learning were drawn from challenges. There were strong assurance mechanisms and risks were appropriately managed. Records were not always in place promptly as required and improvement was required to ensure that managerial oversight of decision making was appropriately recorded and evidenced on all children's case records.
Judgment Substantially Compliant
Standard 3.3 The service has a system to review and assess the effectiveness and safety of child protection and welfare service provision and delivery.
There were effective systems in place for review and assessment of risks associated with the delivery of a child protection conferencing and child protection notification system. Risks were appropriately notified to the regional and national office as required. There were appropriate systems in place to ensure learning from monitoring and evaluation systems was shared and actions implemented as required.
Judgment Compliant

Quality and safety

Children who were assessed as being at ongoing risk of significant harm or neglect were subject of a multi-disciplinary child protection conference promptly. Quick action was taken which ensured children were protected from harm. Initial child protection conferences was convened promptly in the majority but improvements were required to ensure consistency in the timeliness of convening CPC's. Reviews of child protection plans were timely. Where there were delays in convening review CPC's, the reasons for these delays were clearly recorded and safety plans were closely monitored by allocated social workers to ensure children's continued safety. Child protection plans were good quality and detailed a clear list of actions aimed at reducing the risk of harm to the child however, improvements were required in ensuring arrangements for monitoring of safety plans by allocated social workers were detailed within plans. There were good interagency and inter-professional working relationships and interagency practice in the area promoted the protection and safety of children.

All cases referred for a CPC were appropriately referred and the majority of CPC's were convened promptly but there was inconsistency in timeliness. While improvements were required to ensure consistency of convening CPC, the area implemented actions to address this in the months prior to inspection and the majority of very recent CPC's were scheduled within two weeks of referral. Inspectors reviewed 13 records relating to initial CPC's, convened in the 12 months prior to inspection for timeliness. Two of 13 records examined indicated delays in convening the initial CPC while 11 of 13 occurred within one month, seven of which took place within two weeks of referral. In the remaining two cases, initial CPC's took place within 8 weeks after referral. Inspectors found that there were appropriate safety mechanisms in place for children and families while they waiting for CPC and risks were appropriately managed. Where delays occurred these were uncommon. Reasons for delays were clearly recorded within children's records and progress on addressing delays monitored effectively.

Child protection conferences were found to be well planned and inclusive of all relevant family members and children where appropriate. Child protection conferences were well attended by all relevant professionals as required to ensure needs of children were appropriately represented and plans to address risks included all relevant people. Conferences were chaired by independent professionals who had no direct involvement in the assessment or management of the case. Inspectors found that child protection conferences were well chaired and facilitated ensuring, every aspect of risk, as well as children's needs were discussed and plans agreed where required. Participation of all attendees was encouraged and each person's views sought, considered and recorded within conference records.

Children and their families attended and participated in child protection conferences wherever possible. Families played a central role in child protection conferences and children's own views were sought and well represented whether they were present or not. Children were encouraged to attend and provided with opportunities to complete preparatory reports. Parents were facilitated to attend as a priority and where necessary they were provided with supports and additional resources, such as transportation, to aid them in attending.

Inspectors observed an initial CPC which demonstrated all of the above. Risks to children were openly discussed and the impact of these risks clearly named. Multi-agency input was encouraged and discussion amongst all in attendance at the conference was facilitated. The CPC concluded with clear decisions on actions to address identified risks and expectations of all people present were named and documented as part of the CPC record. The decision to list a child on the CPNS was discussed openly and opinion of all present was sought and recorded in considering the final decision. The service ensured where there were unresolved child protection concerns and a decision was reached that the risks to a child were so great as to warrant their inclusion on the CPNS these risks were clearly communicated and plans to address and minimise the risks were discussed and agreed.

Following every CPC, a child protection safety plan (CPSP) was put in place. Child protection safety plans clearly listed the risks and or concerns as discussed during CPC and identified actions to protect children subject of the CPSP against these risks. The purpose of CPSP was to clearly set out the agreed plans and each person's responsibility in ensuring the plan to keep children safe, were effective in doing so.

Generally, CPSP were found to be comprehensive, detailed, updated as required and monitored closely. CPSP were recorded on a standard template and provided a detailed, easy to follow record of each element of the safety plan. It was clearly explained to all persons with responsibility for monitoring of as part of a safety plan including, family network and professionals, that they were required to attend regular network meetings, but the frequency of these varied in line with needs of children and families subject of a child protection safety plan. However, details of arrangements for monitoring of safety plans by social workers were not always clearly documented. Child protection safety plans did not specify arrangements for visits to children by social workers or frequency of updates to be provided to social workers by the safety network through network meetings or indeed by other means such as written reports, assessments or daily updates. While inspectors found that there was appropriate monitoring of all child protection safety plans, in the absence of recorded detailed monitoring arrangements, it was not possible to assess if social workers were monitoring safety plans consistently in line with arrangements. In addition, when

changes to monitoring arrangements such as, frequency of social work visits moving from weekly to fortnightly, were agreed, rationale for these decisions as well as evidence of decisions being clearly communicated to the child and family were difficult to track in the absence detailed plans.

Inspectors found that social work response to risk was timely and proportionate. Children were regularly visited by their social workers and where required social workers directly monitored children's progress to ensure the effectiveness of safety arrangements agreed as part of CPSP. Inspectors examined cases where frequency of social work visits increased to multiple times per week in response to escalation in risk to a child. Equally social workers told inspectors and it was found through review of children's case records that where progress was evident and safety arrangements adequately reducing risks to children, social workers adapted their monitoring accordingly, maintaining regular contact with the safety network and reducing the frequency of social work visits. When risks presented these were identified and managed effectively. Social workers were responsive in their duty to safeguard children from harm and managers were involved in all decisions relating to children listed on the CPNS.

Children and families were an integral part of their own safety network and all staff within the service were clear on their responsibility to ensure that children in particular fully understood the plans in place to ensure their safety. Inspectors saw through examination of case records that child-centred practice was at the core of social work in the area. Inspectors found several examples of age appropriate and child friendly versions of child protection safety plans and records detailing interactions with children to ensure they fully understood the plan for their safety and their options should they find themselves in a position of risk or danger. Parents received copies of child protection plans and were fully involved in the developments as well of review of these.

In all 25 cases examined by inspectors children's protection plans and interventions were reviewed as required. Inspectors examined nine cases which had been subject of a review child protection conference (RCPC), in line with Children First (2017). As with initial child protection conferences, review child protection conferences were chaired by an independent professional who ensured these RCPC's were multi-disciplinary, inclusive of all relevant people, involved active participation from all present including parents and family and that the views of children were discussed and considered.

Inspectors reviewed nine records of RCPC's and found that the content was relevant, detailed and clear. Risks to children were documented in full and opinions as well as

suggestions for limiting impact of risks on children were all considered and recorded. Decisions of RCPC's were clear and the reasons for decisions were outlined. When the decision to keep a child on the CPNS was reached the reasons for this were clear. The goals to be achieve to reduce risks and remove a child from the CPNS were recorded and the bottom lines on expectations from all adults involved in keeping children safe were specified. Equally, when the decision to remove a child from the CPNS was made this was with agreements from all relevant people that appropriate safety measures were in place for the child which were sustainable. Inspectors reviewed eight files for children who's review CPC was scheduled outside of the specified six month timeframe, in all cases examined it was found that rationale for delays were clearly documented, made in consultation with social work team leaders and principal social workers and communicated to families, external professionals and child protection conference chair persons as required. At the time of inspection review CPC's were overdue for three families, each were scheduled in the coming weeks and rational for delaying reviews were considered, proportionate and appropriate to the needs of each individual family. Inspectors found that when decisions were made to postpone reviews of child protection plans monitoring arrangements were maintained and oversight of cases effectively ensured children remained safe and families supported as required.

Inspectors reviewed 11 cases of children who had been removed from the CPNS in the six months prior to inspection for the purpose of examining the practice in reaching decisions to remove a child. Of 11 such cases reviewed, five related to children who had been received into care and six related to children who remained in their families but for whom risks had sufficiently reduced and progress had been sustained in keeping children safe. Inspectors found that in all cases examined the decision to remove or de-list a child from the CPNS was appropriate. Decisions were discussed and agreed with all professionals and family members involved in the child's care and planned effectively to ensure sustained safety for the child or children concerned.

The service area had clear procedures in place for de-listing a child who had been received into care, which included approval by principal social worker and area manager prior to de-listing. Social workers, team leaders and principal social workers as well as the chair persons of the child protection conferences who held responsibility for managing and updating the CPNS were all clear on the procedures in place. Inspectors examined the CPNS for evidence of appropriate management of the system and found that children were listed and de-listed promptly as appropriate and in line with decisions reached through CPC procedures in place in the area. There were locally agreed timeframes for removing a child from the CPNS once they were received into care. For example, where a child was in care on a voluntary care

agreement, signed by their parents, then they remained on the CPNS for a period of up to three months. However, where a full court order was granted in relation to a child, they were removed from the CPNS immediately. Inspectors found through examination of records that these procedures were consistently implemented.

The service had clear and effective procedures in place to support inter-agency and inter-professional cooperation in the management of cases related to children on the CPNS. There was evidenced in all files examined of cooperation between agencies in ensuring children were safe. External professionals were routinely invited and attended child protection conferences. Principal social workers told inspectors that there was an expectation of cooperation between agencies to improve outcomes for children which had been fostered and promoted in the area and resulted in a multi-agency approach to maintaining children's safety in all cases that required it. Staff told inspectors that they had very close working relationships with their partner agencies including schools, An Gardaí Síochána, public health nurses, therapeutic services and family and community support services. Child protection conference chair persons told inspectors that from their experience, professionals were well informed and up to date on progress for children and families when they attended CPC's or RCPC's. External professionals were prepared and practiced at providing relevant opinion in their given area of expertise as to the safety of the child or children concerned. Professionals were confident in engaging in discussion risks to children and their input was sought and valued. Equally, it was reported to inspectors that input in relation to progress and development on the part of the family was sought and valued from all as appropriate.

Inspectors found through review of records, consistently good inter-agency consultation amongst social workers and external service providers with responsibilities for children's safety including, general practitioners, schools, public health nurse and or family support services including child care workers, addiction services and community support services. The roles and responsibilities of each professional were clearly documented and decisions relating to direct work or interventions were specifically recorded. Parents said that they were aware of everyone's role in supporting their family and there was evidence of good child-centred work directly with children explaining the role of all professionals in their lives. The service used network meetings as a means of monitoring progress and seeking updates from professionals on their interactions and progress of their interventions to promote safety within families. There was a very high level of attendance by professionals at regular network meetings throughout files examined.

Child protection conferencing administration team had responsibility for ensuring information packs were provided to professionals in advance of attendance at CPC's.

Where required, chair persons would make contact with professionals seeking reports in advance of CPC's and making them aware of their role and responsibilities as part of a CPC. There was an ethos in the area whereby support networks consisted of natural family members as well as all professionals involved in ensuring a child's safety. Actions to address risks clearly delegated to each individual member of a child's safety network. Responsibilities associated with keeping children safe were clearly explained including; the requirements to provide regular and timely updates on progress of interventions through contact with social workers and attendance at network meetings.

There were good mechanisms in place for sharing information and learning was well as for building cooperative relationships with other agencies in the service area. There were regular meetings between Tusla and An Garda Síochána as well as Tusla and the HSE, in line with relevant joint working protocols, during which children on the CPNS were discussed and reviewed as required. There were agreements in place for representative attendance at all CPC's by An Garda Síochána and their attendance was noted in all 25 cases reviewed by inspectors. Tusla managers told inspectors about their efforts to ensure good relationships were maintained with schools, general practitioners, public health nurses and addiction services, they spoke about cooperative and effective input from all sectors and highlighted creative measures put in place to facilitate attendance by already stretched service providers.
Child protection conference chair persons were clear on their responsibility to ensure professionals were afforded the opportunity to share their expertise to support assessments of risk and planning of interventions for children at risk. Inspectors found through examination of records that input from professionals was sought and considered appropriately.

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

Child protection conferences were requested appropriately but improvement were required to ensure that all were convened within consistent timeframes. They were appropriately facilitated by independent persons who ensured that children and their families were central to the conference proceedings. The views of children and families were appropriately sought and records demonstrated clear consideration of the view of all participants in reaching decisions on children's need for safety. Child protection safety plans were developed quickly following the decision to list a child as active on the CPNS. Child protection safety plans were detailed, clearly explained to all relevant people with responsibility for ensuring the plan was implemented and were updated and monitored closely by social workers. However, details of arrangements for monitoring of safety plans by social workers were not always clearly documented.

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

Judgment
Substantially Compliant

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

Review child protection conferences were held at regular intervals and reviewed progress in addressing risks to children and families in line with the requirements of Children First 2017. Information agreed at CPC's was clearly documented and decisions recorded and provided in writing to families. Decisions to delay review CPC's were considered and rationale for decisions were clearly recorded and found to be appropriate to the individual needs of children and families. Decisions to delist children from the CPNS were appropriate, planned and agreed with senior managers, families and professions involved as appropriate.

Judgment
Compliant

Standard 2.9 Interagency and inter-professional cooperation supports and promotes the protection and welfare of children.
The service ensured cooperatives relationship with other professionals were promoted and fostered strong partnerships with local agencies. Inspectors found evidence of interagency working in all cases examined as part of this inspection. There were clearly defined mechanisms and procedures for sharing of information and joint training initiatives in place. Professionals were clear on their responsibilities as part of child protection safety plans and the role and function of each agency was explained to children and families.
Judgment Compliant

Compliance Plan for Dublin North Child Protection and Welfare Service OSV – 0004413

Inspection ID: MON-0033834

Date of inspection: 14 – 17 September 2021

Introduction and instruction

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

The provider is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Standard Heading	Judgment
Standard 3.1	Substantially Compliant

Outline how you are going to come into compliance with Standard 3.1: The service performs its functions in accordance with relevant legislation, regulations, national policies and standards to protect children and promote their welfare.

Tusla National Guidelines on Child Protection Conference and the Child Protection Notification System requires updating. This issue was raised at a meeting between Tusla National and HIQA on 18/10/21. An agreed plan has been set out by National Office to amend the CPC Guidelines and further embed effective safety planning across all areas. This will ensure the service performs its functions in accordance with relevant legislation, regulations, national policies and standards to protect children and promote their welfare.
The plan includes Tusla's approach to further enhance local area governance and oversight of same.

Standard 3.2	Substantially Compliant

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

1: Office of the Area Manager to amend the CPNS Audit Tool to incorporate oversight of case recording. All children on CPNS will be audited by Q1 2022 (using the CPNS audit tool) to ensure all records are in place.

2: CPNS will form part of supervision template for all managers from Q4 2021.

Standard 2.6	Substantially Compliant

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

1: Dublin North shall amend the Local Area CPNS Practice Matter to include adherence to timeframes for convening CPC. A clear rationale shall be documented on NCCIS where this is not possible.

2: Dublin North shall amend the Local Area CPNS Practice Matter to document on Safety Plans:

- Details of Social Work monitoring of safety plans
- Arrangements for Social Work home visits

- Updates regarding frequency of visits to be provided at Network Meetings by Social Worker and Safety Network

Section 2:

Standards to be complied with

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

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

Standard	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Standard 3.1	The service performs its functions in accordance with relevant legislation, regulations, national policies and standards to protect children and promote their welfare.	Substantially Compliant	Yellow	08/11/2021
Standard 3.2	Children receive a child protection and welfare service, which has effective leadership, governance and management arrangements with clear lines of accountability.	Substantially Compliant	Yellow	31/03/2022
Standard 2.6	Children's who are at risk of harm and neglect have child protection plans in place to protect and promote their welfare.	Substantially Compliant	Yellow	31/12/2021