

Service Area Inspection

Health Information and Quality Authority
Regulation Directorate monitoring inspection on
the progress of the service area's implementation
of their child protection and welfare and foster
care services actions



Name of service area:	Dublin South Central
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Lead inspectors:	Erin Byrne Niamh Greevy
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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.

1. Introduction and inspection methodology

This is the third inspection of Dublin South Central (DSC) Service Area in eight months and was undertaken due to the on-going risks within both the Foster Care and Child Protection and Welfare services in the area. Inspections of the foster care service in July 2018 and the child protection and welfare service in September 2018 identified major non-compliances and serious risks to the protection and welfare of children in the area.

This inspection was a combined foster care and child protection and welfare inspection aimed at assessing the progress within the area with respect to actions agreed by the area manager in response to previous inspections. The inspection team endeavored to evaluate progress within the area in the management of identified risks and engaged with the social work teams and management with respect to the systems and governance issues which were acknowledged by the area following the previous inspections of the services.

Dublin South Central Service Area monitoring and inspection activity

Below is a brief overview of inspection activity and engagement with the Dublin South Central service area, including engagement with Tusla's chief operations officer in relation to the risks identified during 2018 within this service area.

July 2018

In October 2017 a foster care inspection of DSC judged six out of eight standards related to the assessment, approval, review, supervision, training and support of foster carers, including safeguarding practices, to be non-compliant-major. These non-compliances related to the management of allegations and serious welfare concerns against foster carers, and practice in relation to foster carer reviews and assessments of relative carers. The purpose of the follow up inspection in July 2018 was to assess progress against standards previously identified as having major and moderate non-compliances.

The July 2018 inspection found similar findings to that of the previous foster care inspection in October 2017. A decision was taken to schedule a child protection and welfare service inspection within the area due to the risks identified associated with the management of allegations by the service area.

HIQA's Head of Programme for children's services wrote to the chief operations officer seeking assurances in relation to the reoccurring risks relating to Dublin South Central's foster care service including, delays in management of allegations against foster carers and increasing numbers of unallocated foster carers.

September 2018

A risk based inspection of DSC's child protection and welfare Services was conducted in September 2018. Such risks included the poor management of child protection and welfare allegations relating to children in foster care, an indication of increased risks within the service area as reflected in Tusla's published quarterly performance and activity data, and receipt of unsolicited information relating to risks within the service.

The September 2018 child protection and welfare inspection found major non-compliances in five of six National Standards which were inspected against. Risks identified included absence of appropriate and timely screening and preliminary enquiry completed in relation to child protection referrals, waiting lists at all stages of the referral process, poor quality completed assessments and inadequate or absent safety planning arrangements. Management structures were ineffective and systems for monitoring and oversight of practice and waiting lists were chaotic and did not ensure a safe service to children and families in the area. Sixteen cases were escalated as part of this inspection seeking assurances in relation to the safety and welfare of the children concerned. In addition, assurances were sought in relation to case files which could not be located during inspection fieldwork.

October 2018

Due to these ongoing risks, HIQA's Head of Programme for children's services, a Regional Manager and the Lead Inspector from the child protection and inspection met with the Tusla chief operations officer and regional service director for Dublin South Central. A presentation outlining overall risks both within foster care and child protection and welfare services in the area was provided to them at this meeting.

These risks included:

- on-going delays in the management of allegations against foster carers
- a lack of timely assessment of relative foster carers
- an increase in the number of unallocated foster carers
- a lack of timely screening and preliminary enquiries of child protection and welfare referrals
- an absence of safety planning
- delays in the commencement and completion of initial assessments and
- poor quality assessments including inadequate analysis of risks in further assessments.

The chief operations officer was requested to submit a plan which identified measures to be implemented and actions to be taken to address the risks presented.

The response outlined the following actions to be undertaken within the service area:

- an organisational review and restructuring of the CPW service to include a new intake team in the area with a dedicated principal social worker
- development of performance and accountability framework in the area
- a project management plan to address all recommendations and implementation of service improvement plans, to be produced and implemented
- a new principal social worker with specific responsibility for managing allegations against foster carers and to improve practice and quality of screening and preliminary enquiries in the area to be introduced
- a review of the auditing, quality assurance and monitoring systems to be undertaken
- an increase in resources for intake, screening and preliminary enquiry, fostering, service improvement, and prevention, partnership and family support services across the service area.

November 2018

The area manager provided satisfactory responses on all individual cases escalated following the child protection and welfare inspection in the area.

HIQA Head of Programme for children's services requested a copy of Tusla's project plan as outlined within the chief operations officer's response detailed above. In addition, the chief operations officer was notified of HIQA's intention to monitor progress including the implementation of the project plan, as it incorporated major risks within both services, as part of HIQA's monitoring activity for 2019.

January 2019

A progress report on the implementation of Tusla's Dublin South Central service area project plan was sought from the chief operations officer.

February 2019

A combined foster care and child protection and welfare inspection was announced, detailing the intention to focus the inspection on an assessment of the progress within the area with respect to actions agreed to address significant risks in the area.

March 2019

The area manager and Senior Management team of Dublin South Central, including five principal social workers, met with HIQA Regional Managers and foster care and child protection and welfare lead inspectors prior to inspection fieldwork in March 2019, during which a brief update on progress in the area was provided and logistics for facilitating inspection fieldwork was agreed.

The intention to produce a combined service area report focusing on progress in implementation of actions to address areas of significant risks identified by HIQA during 2018 monitoring inspections was notified to the Areas Management Team.

The inspection was undertaken on 4-8th March 2019 and was conducted over five days.

2. Profile of the service area

The Child and Family Agency

Dublin South Central is one of 17 service areas in the Child and Family Agency. Forming part of the Dublin Mid-Leinster region, it encompasses two geographical local authority catchment areas, namely South Dublin County Council and Dublin City Council. The Dublin South Central Area provides services to areas in Dublin South City and Dublin South West, including Dublin South Inner City, Rialto, Inchicore, Ringsend, Rathmines, Rathfarnham and areas to the south west of the city including Ballyfermot, Cherry Orchard, Clondalkin, Rowlagh, Palmerstown and Lucan.

The total population of the area is 305,278. Of that figure, 65,564 (21.5%) are children under the age of 18 years of age. Please see (Figure 1) breakdown of age profiles and totals:

Figure 1 - Age profile of children under 18 in Dublin South Central area Age:	Total
Under 1 years	4,016
0-4	19,949
5-12	29,358
13-17	16,257

(Data taken from 2016 census)

The Pobal 2016 deprivation index cited some areas within the catchment as being 'very disadvantaged' and 'extremely disadvantaged'.

The area is under the direction of the regional service director for the Child and Family Agency Dublin Mid-Leinster region and is managed by the area manager.

At the time of inspection, the Dublin South Central child protection & welfare service comprises of three child protection teams, two intake teams and one Section 3 team.¹

The child protection teams were line managed by five social work team leaders who reported to two principal social workers. The Section 3 team reported directly into a principal social worker.

¹ As part of Tusla's action plan in response to the HIQA statutory investigation into the management of allegations of child sexual abuse against adults of concern by Tusla (2018), Tusla have implemented a service improvement project for the management of retrospective referrals of abuse within Dublin South Central Service Area, the Section 3 team are responsible for the review and management of all retrospective referrals in the area.

In addition, the intake principal social worker line manages a quality assurance team leader who is conducting a series of audits informed by the 2018 child protection & welfare HIQA inspection. The team had offices in two parts of the area Lord Edward Street and Cherry Orchard Hospital.

The Dublin South Central fostering service comprises of three fostering teams line managed by three team leaders across three locations, Lord Edward Street, Cherry Orchard Hospital & Inchicore Primary Care Centre, who report to a principal social worker. In addition, one part time team leader oversees foster care reviews for the area.

3. Summary of inspection findings

This inspection of Dublin South Central Service Area was undertaken with the purpose of examining progress within the area in implementing actions identified to address risks to children in both the child protection and welfare and foster care services.

Since 2018 additional resources had been made available within the services in Dublin South Central and there had been a restructuring of both the foster care and child protection and welfare teams. The service continued to be led by an area manager with oversight of both the fostering and child protection services who reported directly to the regional service director. There were however changes to the line management structure within both services.

Since the last foster care inspection, an additional third fostering team had been set up. At the time of this inspection, three fostering social work teams, managed by three social work team leaders for fostering, reported to a principal social worker. However, despite the improved capacity of the service since the last inspection, significant risks remained due to poor governance and management within the fostering service.

The area had undergone a period of change and improvements were evident within the governance and management of the child protection and welfare service including, clear decision making procedures, clear referral processes between intake and child protection teams and defined lines of accountability including the introduction of a new principal social worker with responsibility for the intake (screening and preliminary enquiry) teams, working alongside a newly appointed principal social worker for child protection and welfare (initial assessment and duty) teams across the area.

Social work team leaders and social workers were more confident in the lines of accountability and responsibility within the child protection and welfare service and were clear on the process for managing cases as well as waiting lists. Nevertheless, significant risk remained.

At the time of this inspection, as with the previous inspection of the areas child protection and welfare service, the area continued to operate waiting lists for children and families at all stages of the referral process, including significant waiting lists for preliminary enquiries. Children and families whom in many cases waited lengthy periods for the completion of preliminary enquiries which concluded that assessment of protection concerns was required, waited again after this stage of the process to be allocated to a social worker for required work / assessment to commence. In addition, the quality of safety planning remained a significant risk across both services.

Foster Care

Improvements were found in some areas during this inspection. Specifically all foster carers with children placed were now allocated a link social worker, which was a significant improvement from previous inspections. In addition, significant progress had been made in clearing the backlog of foster carer reviews, and the area was on target to clear their backlog of reviews, with the remaining 29 reviews scheduled.

While some progress was noted in the oversight and governance of the management of allegations and serious concerns against foster carers, improvements were still required in relation to the appropriate categorisation of allegations and serious concerns, the timely completion of assessments, and the notification of allegations and concerns to both the monitoring office and the foster care committee. In addition, the safety planning process remained inadequate.

Progress in relation to relative assessments and placements of children with relatives in an emergency was still inadequate. Of the nine outstanding relative assessments, only one had been presented to the Foster Care Committee (FCC) in the timeframe indicated previously to HIQA by the chief operations officer of Tusla. One had been withdrawn; however there remained seven that were still outstanding by the time of this inspection. In addition the process to ensure the completion of checks in relation to placements with relatives in an emergency had not been progressed, and this was yet to be addressed. The continued lack of progress in this area of risk is unacceptable.

Child Protection and Welfare

This inspection found similar risks as the September 2018 inspection and there continued to be a risk of harm to children from on-going delays in receiving services due to the back log of intake records and initial assessments. Data provided by the area indicated 1001 referrals on a waiting list for a child protection and welfare service, 714 awaiting preliminary enquiries, 269 awaiting initial assessment and 18 awaiting further assessment.

Screening and preliminary enquiries were not being completed in line with the Child and Family Agency's Standard Business Processes. Due to the nature of referrals which are identified as requiring a child protection service any delays in completion of preliminary enquiries poses a potential risk to children concerned and in the majority of cases examined these enquiries were not completed within five days, the timeframe identified within Tusla's child protection and welfare standard business processes.

Analysis of potential risks through screening of referral information had improved since October 2018. This was evident through improved application of risk ratings,

prioritisation of cases and identification of tasks to be completed but, screening was not adequate in all cases and services were not effectively delivered within safe timeframes resulting in delays and inadequate responses to some children at risk.

Cases which were examined and were awaiting interventions as identified through screening and/ or preliminary enquiry were not being addressed in a timely way. The backlog of cases which required basic preliminary enquiry constitutes a significant risk and there was no clear, timely plan to address this.

The principal social workers and area manager told inspectors that this backlog will be addressed over coming months by continuing to allocate cases when the capacity to do so becomes available, while also citing capacity issues due to vacant posts as a significant contributing factor for the unacceptable number of cases awaiting preliminary enquiry.

As with the previous inspection of the area there were waiting lists operating at all stages of the referral process. Improvements had been made in the management of these waiting lists and there was an increased confidence within the area that all child protection and welfare referrals were being monitored. The areas management team, while aware of the risks associated with large waiting lists for services, were confident in their oversight and management of waiting lists and felt assured that no child/children at immediate risk was waiting for a service.

Data provided by the area prior to inspection indicated that there were 206 high priority cases awaiting allocation within the service area. Sixty one of these were awaiting preliminary enquiry, 135 were on a waiting list for initial assessment and ten waiting commencement of a further assessment.

The restructuring as well as practice improvement initiatives implemented within the area such as; the introduction of a full time principal social worker with responsibility for service improvement and the implementation of a number of auditing and quality assurance measures aimed at effecting long term sustainable improvements, had improved confidence amongst the child protection and welfare social work teams to a degree. The system for managing cases awaiting allocation within the area had improved in that all waitlisted cases were being monitored by social work team leaders with oversight from principal social workers. The system for screening all referrals had improved and a consistent approach to reviewing waitlisted cases was in place. However, inspectors found that these improvements, while there was an increased awareness of children at risk actions to address these risks were not sufficient. Issues with capacity within the area to deal with the significant backlog meant that not all interventions to ensure children's safety were implemented in a timely way.

Children who were allocated a social worker received a better service than was previously provided as social workers were afforded the time and offered support in the form of guidance and oversight on assessment and interventions. The quality of initial assessments had improved and children had been seen during the assessment process in all cases examined by inspectors. However, protective measures such as home visits, school checks, multi-disciplinary consultation and meeting with children were delayed and implementation of appropriate safety plans remained an issue.

Safety planning remained a significant risk across both the foster care and child protection and welfare services. Significant improvements in the timely implementation of safety plans as well as quality of safety plans were required, particularly when such safety measures are the only mechanisms available to direct the safety of children while they are awaiting delayed social work interventions. Despite being aware of the issues that arose during this inspection, such as concerns regarding the management of allegations and serious welfare concerns and the quality of safety planning, the area management team for foster care had not implemented effective systems of oversight to address these issues at the time of inspection and poor practice was not consistently addressed by team leaders.

The previous inspection of the service area found that all suspected incidents of abuse were not notified to An Garda Síochána (AGS). While there was evidence that some actions to address this issue had been implemented, progress was not sufficient.

On completion of this inspection, HIQA met with the chief operations officer of Tusla and the regional service director for Dublin Mid-Leinster. The chief operations officer outlined that improvement initiatives were on-going within the service area aimed at targeting the identified risks, these included:

- increasing resources within the intake service
- bespoke recruitment campaigns
- the approval of overtime for staff in order to reduce waiting lists of cases awaiting preliminary enquiries
- intensive workshops relating to intake case prioritisation, thresholds and practice issues such as safety planning,
- further development of National Child Care Information System (NCCIS) to improve timeliness and accuracy of recorded referral information on the system and
- strengthening interface between intake and PPFS

Additional information relating to the improvement initiatives within DSC service area will be addressed throughout this report.

4. Foster care service

Management of allegations and serious concerns against foster carers

At the time of the foster care inspection in July 2018, inspectors found that allegations and serious concerns:

- were not categorised appropriately and therefore did not receive the appropriate response
- foster carers were not always interviewed as part of the assessment of concerns or allegations
- foster carers about whom there had been an allegation or serious concern did not always have an allocated link worker
- similar to the 2017 inspection, the governance and oversight remained ineffective.

Following the previous foster care inspection the chief operations officer informed HIQA:

- that all new allegations would be notified to the principal social worker and area manager
- the area intended to allocate all foster carers where there was an open serious concern or allegation
- that the principal social worker for Service Improvement would review allegations, their categorisation and track them through to reaching an outcome, in addition to reviewing safety plans in place.

During this 2019 foster care inspection, the PSW for Service Improvement told inspectors that she was involved in the review of all allegations and serious concerns that was conducted by four PSWs in the area. Minutes also showed that the PSW for Service Improvement attended a number of management meetings where allegations and serious welfare concerns were discussed. However, the PSW for Service Improvement did not track allegations through to reaching an outcome, contrary to the assurances provided to HIQA. Instead, they had conducted an audit of safety planning, with the plan to continue to do this on a quarterly basis. While auditing is good practice and is a good quality assurance mechanism, and ongoing auditing is a positive step, continued auditing without first taking action to address the issues already identified from numerous previous inspections and previous audits, will not lead to improved outcomes and improvements in practice.

Inspectors found during this foster care inspection that the service followed through on the action of ensuring that all foster carers with an open allegation or serious welfare concern had an allocated link worker. The area manager and PSW for fostering also told inspectors that they were notified of all new allegations.

On this inspection, inspectors reviewed:

- allegations and serious welfare concerns reported before July 2018 that remained open at the time of this inspection
- new allegations and serious welfare concerns that were reported since the last inspection
- allegations and serious welfare concerns that were closed since July 2018.

Allegations and serious welfare concerns reported before July 2018 that remained open at the time of this inspection

Following the review of allegations or concerns that had been reported prior to the inspection in July 2018, inspectors found that children were not at risk but there was significant drift in the management of these concerns. Inspectors sampled two of these allegations and one serious welfare concern. All three cases showed delays in the management of the concerns or allegations which meant that concerns and allegations were open and unassessed for prolonged periods without being resolved. While there were no children in these placements at the time of inspection, the conclusions in relation to these concerns had taken between 13 months and over two years to be reached on two cases that had recently been concluded, while the third case was awaiting assessment for 15 months at the time of inspection.

New allegations and serious welfare concerns that were reported since the last inspection

The intake social work team was responsible for the assessment of allegations. The PSW for child protection and welfare told inspectors that allegations against foster carers were now prioritised for assessment. Inspectors reviewed one allegation that was referred two months earlier and found that it was assessed by the intake team in a timely way, showing evidence that more recent practice had improved.

Inspectors reviewed five allegations and concerns that were referred since the last inspection and found there was evidence of some improvement in how they were managed. A strategy meeting was held promptly in four out of five cases but for one case, the meeting did not take place until a month after the reported concern. In addition, appropriate action was taken to safeguard children in three of the five cases, but safety planning for two cases was inadequate. A safety plan had not been developed as needed on one case and the oversight of the implementation of another safety plan was poor.

Despite generally convening strategy meetings in a timely way to categorise the concerns, two cases relating to allegations of physical chastisement of children were inappropriately categorised as serious welfare concerns which was not in line with

the National Guidance for the Protection and Welfare of Children 2017². The principal social worker told inspectors of a third case that was deemed to not meet the threshold of serious welfare concern, despite the serious nature of the concern. This indicated that the area continued to inappropriately classify concerns and allegations made by children in care. Children First (2017) outlines that physical abuse can include physical punishment. As a result, inspectors identified that the threshold applied by the area for allegations to be assessed as a potential child protection concern were too high.

Notification of serious concerns and allegations to the foster care committee (FCC) and the Monitoring officers remained inadequate. Notifications to the FCC were outside the five-day timeframe for three (of four) cases and in one case it took as long as six months before the notification was sent. The notification of serious welfare concerns and allegations to the monitoring office was inconsistent. Practice varied between offices, as one office was consistently sending notifications to the monitoring officer as required, while the other office was not.

Allegations and serious welfare concerns that were closed since July 2018

Inspectors reviewed four assessments of allegations or concerns that had been closed since the last inspection and found the quality was poor due to a lack of child-centered practice. For example, social workers failed to talk to children about the allegation in one case and in another, interviewed them in the presence of the foster carer against whom the allegation was made. In the two other cases the serious welfare concern was deemed “unfounded” despite the foster carer admitting the incident occurred or without adequately assessing the allegation. This meant that the service did not ensure children were supported to share their views on the concern or allegation, or that their views were given adequate weight as part of the assessment. As a result, the assessments did not identify the potential risks to children placed with these carers.

The foster care committee (FCC) has a role in overseeing the management of allegations and serious concerns but this was outside the scope of this inspection. As a result, inspectors did not review the committee’s records in full or interview their chairperson. However, due to the questions raised regarding their acceptance of outcome reports following assessments of allegations and serious concerns related to the cases outlined in the previous paragraph, inspectors sought and received assurances following this inspection from the regional service director regarding the oversight of the work of the FCC.

² The Children First Act 2015 included a provision that abolished the common law defence of reasonable chastisement in court proceedings. This defence could previously be invoked by a parent or other person in authority who physically disciplined a child. The result of this is that the protections in law relating to assault now apply to a child in the same way as they do to an adult.

The area had commenced quarterly governance meetings from November 2017 to improve oversight of allegations and serious concerns, particularly related to safety planning. Inspectors reviewed minutes of the meetings that took place since the last inspection, which will be further discussed under the heading safety planning³.

Unallocated foster carers

At the time of the July 2018 foster care inspection, there were 76 unallocated foster carers. Three of four cases without an allocated social worker reviewed by inspectors had been visited by a link social worker in the nine months since the previous inspection. However, the quality of support and supervision varied.

The chief operations officer of Tusla advised following that inspection that a third fostering team was created and remaining positions would be filled in order to increase the capacity of the service. The action plan from the previous foster care inspection in October 2017 also outlined that the area would provide training to its staff in relation to support and supervision.

At the time of this inspection, all foster carers with children placed had an allocated link worker which was a significant improvement since the last inspection. The area had created a third fostering team to increase the capacity of the fostering service, in line with the commitments given in October 2018. The area had also held a pre-scheduled half-day workshop on support and supervision the week before this inspection. Inspectors reviewed five cases for support and supervision of foster carers and found the quality had improved since the last inspection. Two of the five cases reviewed by inspectors had been unallocated previously and during this time there was a gap of ten months between support and supervision visits to one foster carer, and a six month gap between visits to a second foster carer. However, there was evidence of more regular visits on the remaining three cases, and visits had taken place in recent months on all five cases.

Assessments of relative carers

Thirty relative carer assessments were outstanding at the time of the 2017 foster care inspection, and as outlined in the published report of the follow-up inspection in July 2018 it was unclear at the time what progress had been made in relation to these assessments, as Tusla were unable to provide an update on the status of each of these assessments during the July 2018 inspection. An update was subsequently provided to HIQA immediately following the July 2018 inspection.

³ Safety planning is reported on in detail for both foster care and child protection services under the child protection section of this report.

HIQA was informed by the chief operations officer in October 2018 that the 30 assessments had been reduced to nine long-term outstanding assessments, which would be approved by the FCC by December 2018.

While there was improved oversight of the progress of outstanding assessments, there were still considerable delays in completing these relative assessments. The PSW for fostering met the independent assessing agencies on a regular basis to review progress made in relation to assessments. However, progress remained slow and the area had not completed them by December 2018, with only one of the nine long-term outstanding relative assessments completed since the July 2018 inspection. A further assessment was withdrawn during the inspection, leaving seven assessments still ongoing at the time of this inspection. Inspectors reviewed records of meetings with the assessing agencies and found that it was not always clear what action would be taken to address the causes of delay, and there was a lack of follow-up on issues causing delays, reflecting poor governance of assessments. Some of the delays were due to documentation such as updated care plans not being provided to the assessing agencies. However, inspectors did not see any evidence that delays that were within the control of Tusla were adequately addressed in a timely manner.

All new relative carers were allocated for assessment after the application was made by the referring social worker to the fostering team. This should have an impact on the stability for children within their placements and provide assurances that carers have the capacity to care for the children placed with them. These assessments were being completed by external agencies but the PSW told inspectors they hoped to begin to allocate these assessments to link social workers after the backlog of foster carer reviews was cleared.

The area conducted an audit of support and supervision of foster carers in February 2019 that identified significant issues relating to the quality of support and supervision of unapproved relative foster carers. In response to this the area held a half-day workshop for link social workers facilitated by a team leader.

Placement of children with relatives in an emergency

The action plan for the 2017 foster care inspection identified that the PSW for foster care would monitor the tracker for emergency placements on a monthly basis.

During the July 2018 foster care inspection, inspectors found significant delays in the completion of emergency checks on relatives carers.

Two of three emergency placements sampled during this inspection were of poor quality. Inspectors found that there were delays of more than five weeks from when

the child was placed to when fostering social workers conducted a home visit and emergency checks being completed. In the third case sampled, emergency checks were completed in a timely way and the emergency placement was signed off by the team leader within 10 days of placement. However, a clear process had not been developed since the last inspection, in order to address the inconsistencies and the delays found. Despite being aware of the need to “radically speed up” the process the principal social worker told inspectors that no changes were made to the emergency placement process since the inspection in October 2017. At the time of this inspection a draft standard operating procedure for emergency checks was with the PSW for foster care and area manager for approval. However the lack of timely progress in this area remained a concern.

Reviews of foster carers

At the time of the last foster care inspection, 157 foster carers reviews needed to be completed in order to clear the backlog. The action plan for the inspection in October 2017 indicated that this would be completed by December 2018, but inspectors found in July 2018 that only 34 of 155 planned reviews had taken place.

The action plan from 2017 outlined that the service had introduced a prioritisation tool in order to help staff prioritise reviews for completion. This plan also indicated that reviews following the closure of allegations and concerns would be a priority. The area also intended to appoint a team leader to act as a reviewing officer until the backlog was addressed.

The PSW for foster care told inspectors there was a significant reduction in the number of carers on the panel since the last inspection as people who were no longer fostering had since been removed from the list of foster carers. Notwithstanding this, inspectors found significant progress had been made since the July 2018 inspection. The reviewing officer had taken up their role and was responsible for scheduling and chairing foster carer reviews. Fifty four reviews were held since the last foster care inspection, 29 reviews were scheduled in order to clear the backlog and a further 15 were scheduled as part of cases that needed an updated review.

The team leader responsible for chairing reviews had a schedule in place for reviews for the remainder of the year and told inspectors that there were very few carers long overdue for review.

The July 2018 inspection found that reviews were not consistently held following closure of an allegation. This inspection showed some evidence of improvement in the area of holding reviews following serious concerns and allegations. Data for the area showed that 11 serious welfare concerns and allegations were closed since the

last inspection but only two reviews were held following a concern or allegation in the same period. However, of three files reviewed where the assessments of serious concerns or allegations were recently concluded, two had a review scheduled and the assessment had been concluded the week of the inspection on the third.

Inspectors reviewed the two reviews that took place following an allegation or serious welfare concern. While the review reports referenced the serious concerns in both cases, the review records did not adequately demonstrate that the concerns were fully considered as part of the review.

5. Child Protection and Welfare Service

Screening and Preliminary Enquiry

The last inspection of the child protection and welfare service in September 2018 found that the service had an inadequate system in place for managing referrals coming into the service as:

- It was not possible to establish that child protection and welfare referrals were screened by a social worker in a timely manner
- Inspectors found 232 cases that were awaiting allocation at this initial stage of the child protection and welfare process
- Information recorded was minimal. Records of actions taken at screening and preliminary enquiry were poor or absent in the majority of files examined, intake records were not routinely completed and where they were used, did not contain all required information or prompt all necessary action to ensure the safety of children concerned
- Risks existed with respect to the quality of screening and preliminary enquiries when they were completed including, failure to complete internal checks, failure to clarify details with the referrer and/or failure to consider all information relating to a child such as previous referrals, when reaching a decision in relation to action required to ensure the child's safety
- The duration of time between receipt of referral information and completion of preliminary enquiries varied with 90% of those examined during inspection found to have been completed outside of the defined timeframe as set out in Tusla's standard business process for completion of preliminary enquiry.

Since the previous inspection (Sept 2018) of the child protection and welfare service, significant changes in the management team and restructuring of the child protection and welfare service had occurred. Three new principal social workers had been appointed, and the service had been re-structured to ensure more effective and sustainable service delivery into the future. The division of the child protection and welfare teams into two pillars in January 2019 and the introduction of a new principal social worker with responsibility for the intake (screening and preliminary enquiry) teams, working alongside a newly appointed principal social worker for child protection and welfare (initial assessment and duty) teams across the area, had led to a greater level of oversight and clearer management structures.

There was an improved level of management oversight and greater opportunity to support practice improvement within the service. A number of staff vacancies which had been filled in the first quarter of 2019 supported improvements in timeliness and practice.

However, despite some progress the key areas of significant risk had not been prioritised and changes within the management structure while necessary to ensure long term stability and sustainability, did not address the immediate risks in the area. Responses to significant risks were inadequate and did not effectively ensure a timely, safe service for children subject of child protection and welfare referrals.

The area manager at the time of the last inspection was not assured that the systems in place for screening and preliminary enquiry were adequate. In response, HIQA were advised that a re-structuring of the child protection service would be undertaken in order to implement a more efficient and robust screening of referrals. Alongside this restructuring, a review of all referrals awaiting completion of screening and preliminary enquiries / or all open cases was due to be completed by November 2018. The purpose of the review was to provide assurances that all children at immediate and serious risk had been responded to.

Prior to this inspection fieldwork in March 2019, the service area's management team told inspectors that the review of all open cases was not completed by November 2018 as indicated within the action plan following the previous inspection however, was near completion. The management team said that this review had identified additional shortcomings in individual cases, which included a significant number of cases requiring appropriate screening and preliminary enquiry. Inspectors were told that it was necessary to prioritise screening of all referrals as they were not in a position to complete screening and preliminary enquiries including the timely completion of intake records, in line with standard business processes. The management team told inspectors that a screening sheet had been introduced, the purpose of which was to record required actions identified through screening of a referral. These sheets were then placed on each child's file and informed the preliminary enquiry process.

At the time of this inspection, inspectors reviewed 75 files for evidence of screening as outlined above and found that some improvements were evident, in that the majority of referrals examined had evidence of screening on file. Of 75 referrals reviewed for evidence of progress, 50 (66.6%) had evidence of screening on file. Records which had been screened more recently indicated an improvement in the quality of screening including, appropriate application of thresholds as well as prioritisation of each referral. Next steps were appropriately identified and immediate or urgent steps were recorded where these were required. However, while there were improvements in screening, gaps remained. Screening was not timely in the all cases and evidence of appropriate screening as described above was not recorded in all cases.

In addition, the quality of screening required further improvement. In 29 of 50 (58%) screening records reviewed there were issues identified with regard to the

quality of the screening undertaken, which included: significant time delays in completing screening, incomplete records and/or failure to consider all relevant information and risks during the screening process. However, of the 21 referrals which had evidence of good quality screening on file, 16 (76%) were received in 2019 indicating a significant improvement in screening since the establishment of the new intake pillar within the area.

This inspection found that while some improvements were evident in the quality of screening significant delays remained in the commencement and completion of preliminary enquiries within the area. Children First: National guidance for the protection and welfare of children (2017) outlines that initial checks are aimed at helping a social worker to understand a child's history and circumstances, identify unmet needs and determine if there is a risk of harm to the child. While referrals were found to be appropriately prioritised to ensure that the children at greatest risk of harm were given the highest priority, the risk associated with cases on waiting lists for completion of these initial checks meant that children at risk may not be identified for appropriate interventions in a timely manner.

The purpose of the preliminary enquiry process is to bring together all information gathered on a completed intake record and use this information to inform their analysis and decision making in relation to referrals. Intake records should clearly detail the outcomes of preliminary enquiries, detail next steps to be taken and have clear evidence of oversight by a social work team leader.

Data provided by the area prior to inspection indicated that preliminary enquiries were not completed within the required five day period as defined by Tusla's standard business processes. Inspectors reviewed 74 referrals for the purpose of examining the preliminary enquiry process and found that of these 39 (52%) had intake records on file, 35 did not. Of 39 intake records on file 32 had been completed and seven were on-going at the time of inspection. Of 32 referrals where screening and preliminary enquiries had been completed, improvements in the quality of intake records were evident however, progress was limited as 8 of 32 (25%) were found to be of poor quality. Reasons for the judgements of poor quality on completed intake records included: inappropriately classified, inappropriately prioritised, failure to carry out internal checks, i.e. identify and consider previous referrals, failure to clarify details with the referrer.

As was found during the previous inspection of the area re-referrals were received in relation to open cases which were awaiting intervention by a social worker. Inspectors found during this inspection however, that some improvements were evident.

Re-referrals were identified as such and original information was considered along with any new information received in reaching a decision to prioritise or action the case for social work intervention. While this is a welcome improvement it does not mitigate the risks associated with referrals identified as high priority awaiting preliminary enquiries.

Dependency on re-referrals or external parties to identify and report increase or continued risks to children is unsafe. The absence of re-referrals is not an indication of reduced or absent risk, nor does this account for potential cumulative harm, particularly with regard to non-school aged children.

While improvements in screening of referral information is welcomed, it was insufficient and the delays in proceeding to preliminary enquiries meant that, tasks identified through the screening process, which in some cases included the need to make contact with referred families and to see children, were delayed.

This represented a significant risk to children about whom the referrals were made, as basic checks including contacting the referrer, checking internal systems for previous known concerns or risks and identified urgent tasks was not within the capacity of the team to complete safely due to the significant back log which existed. Inspectors found four examples of referrals received in 2019 which had been screened, identified as high priority, and where a determination had been made that a home visit was required to ensure the safety of child/children concerned. However these visits were delayed, one for more than a week, one for more than three weeks, one for five weeks and one for more than six weeks, and no further action had been taken in the intervening period.

During the course of this inspection, as with the previous inspection it was necessary to seek assurances from staff that actions had been taken to protect a child, where evidence or records of actions were absent from files reviewed by inspectors. Where verbal assurances could not be provided by social workers and/or social work team leaders these were escalated for further action. Twelve cases which required further action at the screening and preliminary enquiry stage, to ensure the safety of children were escalated to the principal social worker for intake both during fieldwork and post inspection and assurances were received in relation to all cases escalated.

Initial Assessments

The last inspection in Sept 2018 of the service identified serious concerns in relation to the management of referrals where an initial assessment was required. These concerns related to shortcomings within the service including:

- poor management and oversight of waiting lists for children awaiting allocation to a social worker for completion of an initial assessment and
- lengthy delay in the commencement of initial assessments
- the procedure for allocating social workers to complete initial assessments was not consistent and
- the quality of completed initial assessments was poor with the majority of those examined falling short of appropriate and safe practice.

During this follow up inspection improvements in the management and quality of initial assessment were evident. Restructuring and reassignment of the management team within the area had led to a greater level of oversight and clearer management structures. There was a dedicated child protection and welfare team with responsibility for completing assessments, which included duty social workers and better decision making with respect to prioritisation of cases for allocation.

Inspectors examined 12 completed initial assessments and found improvements in practice and quality of the assessments. There was evidence of analysis of risks, consultation with other professionals, involvements of parents, and children had been seen in all assessments reviewed. Initial assessment were reviewed and signed off by social work team leaders and outcomes were clearly recorded. Social workers and their managers made definite progress in improving the quality of initial assessments in a short period of time and this is to be commended.

Wait lists

As with the previous inspection of the area there were waiting lists operating at all stages of the referral process. Improvements had been made in the oversight and management of these waiting lists and there was an increase in confidence within the area that all child protection and welfare referrals on wait lists were being monitored. The area management team while aware of the risks associated with large waiting lists for services were confident in their oversight and management of waiting lists and felt assured that no child / children at immediate risk of harm was waiting for a service.

Data provided by the area indicated that at the time of inspection there was a total of 1001 cases on a waiting list for child protection and welfare services, 714 of which were awaiting a preliminary enquiry, 269 awaiting initial assessment and 18 cases awaiting further assessment.

As cited above inspectors reviewed samples of cases awaiting allocation for preliminary enquiry and initial assessments and found that while improvements were evident in the tracking of cases, through an improvement in screening of referrals,

significant risk existed due to the delays for children and families accessing child protection services.

Data provided by the area prior to inspection indicated that there were a total of 206 high priority cases awaiting allocation within the service area. Sixty one of these were awaiting preliminary enquiry, 135 were on a waiting list for initial assessment and ten waiting commencement of a further assessment.

The restructuring of the child protection and welfare teams included implementation of a consistent approach to reviewing waitlisted cases. However, inspectors found that these improvements, while evidently increasing awareness of children at risk and actions required to address these risks, were not sufficient. Issues with capacity within the area to deal with the significant backlog meant that not all interventions to ensure children's safety were implemented in a timely way.

Principal social workers told inspectors that the process for reviewing and monitoring all open cases informed their decision making with respect to prioritising cases for allocation. However, they also acknowledged that it was necessary, due to the backlog, to make judgments on a daily basis on high priority cases which remained on waiting lists and which were allocated. In addition, the team acknowledged the risks associated with the number of medium priority cases, of which there were 400 (293 awaiting preliminary enquiry, 99 awaiting initial assessment and 8 awaiting further assessment) that had the potential to increase in priority due to inability to respond in a timely way.

Despite an acute awareness within the area of a significant number of high and medium priority cases awaiting social work intervention there was no concrete plan to address this risk in a timely way. Social workers, social work team leaders, principal social workers and the area manager all told inspectors that these high risk referrals were being prioritised where capacity allowed.

The principal social worker from intake (screening and preliminary enquiry), as well as the area manager, told inspectors that the risks associated with delays in completion of preliminary enquiries was a priority within the area.

The improvements in screening were identified by the areas management team as a safety mechanism as they meant that managers within the area were aware of all risks, despite acknowledging an inability due to capacity within the area, to address these risks appropriately and within safe timeframes.

Social workers told inspectors that they were more confident than was reported during previous inspection that the cases awaiting allocation were being monitored and appropriately prioritised for allocation and more assured that risks to children were identified appropriately. They told inspectors that while they did not have

responsibility for managing cases on waiting lists the whole team within the area was working to reduce the backlog of cases where capacity to do so arose. In addition, social workers had accepted an offer by the area manager to work overtime during the evenings and weekends in an effort to reduce the backlog of cases awaiting allocation within the area.

The strategy for reducing the backlog that existed within the intake team, i.e. cases awaiting preliminary enquiries, as outlined by the area manager, was to continue to allocate cases beginning with high priority cases to social workers when capacity arose and to continue to offer overtime.

The regional service director for Dublin mid-Leinster region informed inspectors that the offer of overtime had also been extended to social workers within the wider region and that this had been taken up by a number of colleagues outside of Dublin south central service area. In addition, the regional service director was receiving fortnightly updates relating to the intake service and this risk remained an agenda item at all governance and oversight meetings for the area.

This significant risk was escalated to the national office of Tusla following the inspection of the area. HIQA wrote to the chief operations officer following inspection fieldwork, seeking assurances in relation to a number of areas of risk, including:

- the measures available to the service area to action cases prioritised as high following screening, to ensure they receive a timely response,
- the plan to address the backlog in regard to preliminary enquiries and the timescale required

In response, HIQA was informed of a reduction from 61 to 33 high priority cases awaiting preliminary enquiry in the time since data was returned to HIQA prior to inspection in February 2019. The chief operations officers noted that at the time of submitting the data set, there were vacancies within the intake service, two of which had been filled in late February / March. In addition, the approval of new senior practitioner posts for intake which were in the process of being recruited would further increase capacity of the intake service to respond to risks.

Two immediate actions were identified to address the backlog of cases awaiting preliminary enquiry: provision of overtime and the diversion of referrals identified at screening as being of low priority to staff within the prevention, partnership and family support service, enabling the intake service to prioritise referrals of a high and medium priority.

The chief operations officer identified that the plan was to significantly reduce the number of referrals by June 2019 (with high priority referrals reduced by May 2019).

However, as a demand led service, this would be dependent on there being no significant increase in new referrals and that staffing levels remained relatively consistent. Additional measures were also outlined by the chief operations officer, a summary of which will be provided under leadership, governance and management section of this report.

Notification of suspected abuse to An Garda Síochána

At the time of the previous inspection of the service in September 2018 the system for notifying An Garda Síochána of suspected abuse was not adequate and not all allegations of suspected abuse were notified as required. A system in place for monitoring notifications to and from Gardaí was not effective and the area manager in his response to the previous report identified several measures to be implemented with the view to ensuring all allegations of suspected abuse were reported as required.

These measures included:

- issuing a memo to all staff in November 2018 to state that all allegations of suspected abuse are to be notified to An Garda Síochána in line with statutory and mandated responsibilities and to reiterate this responsibility through team meetings.
- the project team with responsibility for review of all open cases, being led by the PSW for child protection and welfare, would ensure that all notifications of suspected abuse had been made and
- monthly sample audits of intake/child protection cases by the social work team leader for quality assurance within the area would ensure compliance with this action
- in addition, the newly appointed PSW would chair Garda Liaison meeting and have robust oversight of all notifications to and from the Gardaí.

During this inspection, improvements in the notification to Gardaí were evident however, the improvements in processes and procedures were in the early stages of implementation and further work was required to ensure a consistent understanding of the notification requirements. Improvements with respect to awareness of the need to consider whether or not a notification was required was evident through discussions with social workers, social work team leaders and all members of the management team.

Direction from the area manager's office had been received and implementation of these directions was being monitored by social work team leaders. The areas review of all open cases included an examination of the need to notify Gardaí and direction to complete garda notifications were routinely recorded on file review action sheets examined by inspectors during the course of this inspection.

Confusion existed with respect to the need to validate or ground allegations prior to reporting to An Garda Síochána versus notifying Gardaí of all allegations of abuse against a child. It was evident through supervision records and team meeting minutes that clarification was being sought and efforts to ensure consistency throughout the service area were being implemented. However, of 21 referrals reviewed for the purpose of examining progress in this regard, where a garda notification was required only eight (38%) had been sent as required, and of the 13 outstanding referrals, five were awaiting notification since 2018.

The area manager told inspectors that a new system/ process for monitoring notifications to An Garda Síochána was recently put in place which would provide clarification and improve monitoring and oversight of notification to and from An Garda Síochána. In addition, liaison meetings with An Garda Síochána, in line with the Joint Protocol for An Garda Síochána / Tusla – Child and Family Agency Liaison (2017) had been occurring regularly under the direction of the newly appointed principal social worker for child protection allowing for more frequent and consistent communication in relation to referrals between both services.

Closed Cases

Inspectors reviewed a sample of 11 cases which had been closed since January 2019 and found that all had been appropriately closed. Inspectors observed improvements in practice, in particular oversight and guidance by the PSWs in relation to practice in the area since the previous inspection. This progress was evidenced by inspectors within the sample of closed cases reviewed during this inspection.

A concern remained however in relation to cases closed in 2018. One case identified by inspectors during a review of open cases, had been re-referred to the service after being inappropriately closed in 2018. A review of this case identified poor practice and premature closure of the case despite oversight by the social work team leader within the area.

Data provided by the area identified that 709 cases had been closed within the area since 1st October 2018 and 450 cases had been re-referred following closure. No analysis of these figures had been completed by the area and it is unclear if re-referrals related to inappropriate or premature closure of cases. However, the number of re-referrals following closure within such a short period requires further examination within the area to ensure that cases closed prior to implementation of improved practices were done so appropriately.

Safety Planning

Inspectors reviewed the measures in place to safeguard children against harm where there were reported child protection and welfare concerns, including those made against foster carers. Previous inspections of both the fostering and child protection and welfare service identified that inadequate measures were put in place to safeguard children from potential harm.

The foster care inspection in July 2018 found that safety plans put in place in response to allegations or serious concerns against foster carers did not address all identified risks. At the time of the child protection and welfare inspection in Sept 2018, inspectors reviewed cases where social workers did not identify children at risk of harm in a timely manner and necessary safety plans were not put in place. In addition, of those safety plans that were in place the quality and oversight of these was poor and they were not effective at keeping children safe.

Following the previous inspections the chief operations officer indicated that the area would conduct quarterly audits of safety plans, the findings of which would be fed back to staff and additional training would be provided.

During this inspection (March 2019), inspectors found that some progress had been made with respect to training and instructing staff on the need for safety plans; the circumstances in which a safety plan may be required; and on the quality of content of a safety plan. However, progress was slow and good quality safety plans were not yet being routinely implemented within the area. Despite the poor quality of safety planning being identified as a significant risk by HIQA in the previous inspection reports, efforts to engage with staff to improve the quality of safety planning was still in development at the time of this follow-up inspection.

Safety planning- Foster Care

During this inspection of the foster care service, inspectors found that governance arrangements were not effective in ensuring that adequate safety plans were in place to safeguard children in foster care placements where there was an allegation or serious concern against a foster carer. Inspectors reviewed eight cases where safety plans were required. Good quality plans were in place in three cases reviewed by inspectors. However, three safety plans reviewed did not address the identified risks, one of which had been escalated at the time of the last inspection in July 2018. A further two cases had no safety plan in place where it was required.

While an audit of safety planning for children in care was conducted since the last inspection, this did not have a substantive impact on practice by the time of this inspection. The PSW for service improvement was aware that further work was

needed to improve the quality of safety planning. Fostering social workers told inspectors that they attended a half day of training on the national model for child protection and welfare but felt that they needed further guidance on safety planning. At the time of inspection, feedback from the audit had been shared with team leaders for implementation on individual cases only, but there had been no collective analysis of the issues found from the audit, in order to inform learning.

The PSW for service improvement told inspectors that they had scheduled two half days per month to conduct workshops with child protection and welfare and fostering staff to improve practice in key areas, including safety planning. In the intervening period, children remained in placements with inadequate measures in place to protect them from potential harm. The repeated auditing of safety plans, despite not having taken any action to address the issues already identified to the area in the first instance, demonstrated poor governance.

The allegations and serious welfare concerns governance group met twice since the last inspection to improve oversight of safety planning in cases where there are open allegations or concerns reported against foster carers. This group considered if safety plans were needed but did not review the quality of plans. Inspectors found that these meetings were not effective due to inaccurate information being provided at this meeting in relation to three cases and poor recording and tracking of decisions.

Safety Planning - Child Protection and Welfare

Inspectors reviewed 23 child protection and welfare referrals where it was determined that a safety plan was required and found that 14 had safety plans in place. Of the nine cases where safety plans were required but were not yet in place all cases were escalated as part of this inspection and appropriate assurances were received. Responses which provided assurances received by inspectors included, prompt plans for review and monitoring of safety plans where required, further assessment of parental capacity and social work intervention to update safety plans.

In eight of nine cases safety plans were agreed and/or implemented as required, one case upon further enquiry was identified as not requiring a safety plan at that time. In one case escalated for assurances by the inspection team a decision had been made due to the on-going risk of significant harm to the children concerned, to refer the case for child protection conference. This decision had been made in November 2018 however, no referral had been made and no social work intervention or safety planning had taken place since this time. Immediate action was taken during the inspection fieldwork by the principal social worker for child protection and welfare to address the risks associated with this delay.

Of the 14 safety plans in place inspectors judged the quality of the majority (8 of 14) of these to be poor. The six that were considered of good quality were adequately monitored for implementation, considered all presenting risks and they contained evidence of effective assessment of the capacity of the identified adult to protect the child/children concerned.

Following the inspection HIQA sought further assurances from the chief operations officer as to how Tusla intended to ensure that good quality safety planning was embedded in child protection practice in the service. The measures outlined included the following:

- to build greater capacity and support social work team leaders with safety planning through regular service pillar meetings with a key agenda being to embed safety planning across the team
- a request was to be made to the training and development office to assist in service pillar meetings to embed safety planning across the team
- sample safety plans would be reviewed in supervision and / or as part of scheduled audits by principal social workers throughout the service
- the principal social worker for service improvement would provide feedback on learning and strengths as well as themes requiring improvement at area pillar meetings as identified through audits of safety plans and
- in line with the National Child Protection and Welfare strategy the area implementation plans for group supervision would support embedding of safety planning also.

6. Governance of service area

At the time of the previous inspections of Dublin South Central Service Area, senior management within the area were aware of significant shortcomings in the management of both foster care and child protection and welfare Services. However, systems implemented throughout 2018, including the implementation of a service improvement plan to address these shortcomings had not been timely or effective.

In 2017 the area manager along with the regional service director created a service improvement governance group within the area to address non-compliances within their foster care service identified through HIQA inspections. In September 2017 a decision was made to include child protection and welfare services as part of this service improvement plan due to the identification of significant risks within this service. This plan detailed many of the risks identified during the previous inspections of both services. However, progress in implementing the plan remained

slow and actions were not effective at ensuring risks to children referred to the service were managed in a timely and safe way. Actions to address major non-compliances identified in two foster care inspections during 2017 had not been adequately progressed and risks were not being effectively managed.

Throughout 2018 there was a defined management structure which included clear reporting procedures, risk management processes and quality assurance systems but, these had not adequately ensured consistent implementation of national frameworks, policies and procedures or appropriate managerial oversight of social work practice and accountability within the area.

In October 2018, the chief operations officer provided assurances to HIQA on measures to address the risks identified during both fostering and child protection inspections. These included the development of a Dublin South Central service area project plan which would detail the co-ordination of all improvement initiatives and actions to address known risks in the area. A progress report on the implementation of this project plan was sought from the chief operations officer in January 2019.

In response, a list of tasks / actions, incorporating actions to be implemented from previous inspections and actions required as part of the service areas improvement plan was provided. Of 44 (36 relating to CPW and eight relating to foster care) actions identified in 2018, 22 were noted to have been completed and 21 were past due.

Since 2018 additional resources had been made available within the services in Dublin South Central and there had been a restructuring of both foster care and child protection and welfare teams. The service continued to be led by an area manager with oversight of both the fostering and child protection service who reported directly to the regional service director. However there were changes to the line management structure within both services.

Since the last foster care inspection, an additional third fostering team had been set up so at the time of this inspection, three fostering social work teams, managed by three social work team leaders for fostering reported to a principal social worker.

Restructuring and reassignment of the management team within the child protection and welfare service including the appointment of three new principal social workers, to address governance issues identified previously, had led to a greater level of oversight and clearer management structures. Decision making with respect to allocation of cases, more defined roles for each team within the area and greater accountability was evident at the time of this inspection.

There was a dedicated child protection and welfare team with responsibility for completing assessments, which included duty social workers with responsibility for responding to cases requiring immediate or urgent intervention.

The division of the Intake and Child protection teams and introduction of a second principal social worker to this service meant that there was an improved level of management oversight and greater opportunity to support practice improvement within the service.

In addition, a reviewing officer was appointed to schedule and chair foster carer reviews and a principal social worker for service improvement had taken up post in January 2019.

Increased resources within the foster care services had led to improvements in the level of allocation of foster carers, in particular for foster carers where there was an open allegation or serious welfare concern. The allocation of cases and appointment of a reviewing officer also had an impact on the number of foster carer reviews completed and the increased capacity of the fostering service had a positive impact on foster carer reviews, support and supervision and allocation of foster carers.

Restructuring as well as increased resources in the child protection and welfare service was at a very early stage of implementation however, some improvements in screening, the oversight of wait listed cases and the quality of initial assessments were evident. There was an increasing confidence amongst social workers to manage their own caseloads and there was adequate supports and guidance to support practice improvements, in place. However, staff vacancies at both social worker and social work team leader level within the child protection and welfare Service had significantly impacted on service delivery.

Despite the improved capacity of the service and some progress since the last inspection, significant risks remained. Progress to address risks within the child protection and welfare service was inadequate and did not effectively ensure a timely, safe service for children who were the subject of child protection and welfare referrals, and concerns remained in relation to the governance and management of the fostering service.

One of the initiatives implemented within the area as part of the service improvement plan was the introduction of a full time principal social worker with responsibility for service improvement. Inspectors spoke with the principal social worker for service improvement who had taken up a full time post in the area in January 2019 and was initially focused on targeting improvements within the foster care service. This PSW told inspectors that priorities had been agreed with the area manager upon starting in the role and initially they were targeting their work at the level of team leaders within the foster care service, due to their important role in

quality assuring the work of link social workers. The PSW for service improvement had not begun direct work with the child protection and welfare teams at the time of this inspection.

The PSW for service improvement had conducted audits in two areas relating to the foster care team since the last inspection. At the time of inspection, the findings on individual safety plans had been shared with team leaders for implementation and the PSW for service improvement advised of their plan to do workshops with staff to address the issues identified in audits. However, these quality assurance mechanisms had not resulted in improvements in practice during this 2019 follow up inspection, for example in relation to safety planning, because the training had not yet been completed.

Their plan was to conduct two half-day workshops each month with foster care social work team leaders, and subsequently conduct workshops with link social workers. However, since the last inspection senior managers in the area had not taken effective action to address known risks to children relating to quality management issues, with the result that there continued to be poor quality assessments of concerns and allegations, and inadequate safeguarding measures in place for children who lived in placements where there were open allegations or serious welfare concerns.

A number of auditing and quality assurance initiatives including a review of case files, quality of intake records, and initial assessments, were planned or had begun, aimed at improving practice, ensuring compliance with national policies, processes and frameworks and improving oversight and monitoring of progress. However, inspectors found, as with previous inspection of the area, records were not up-to-date, case notes were not always completed in a timely way and social workers repeatedly told inspectors that they did not have capacity to address these risks promptly. In addition, there had been delays in implementing the National Child Care Information System (NCCIS) and this remained the case as it had not been fully implemented at the time of this inspection and the majority of information was still kept on paper files within social work offices.

The provision of supervision across all roles was a priority within the area and frequency of supervision was appropriate in the majority of records examined. Supervision of social work team leaders by the PSW's within the child protection and welfare teams had improved since the restructuring of the CPW service. Records showed good discussion in relation to management of change in the area including the need to provide guidance and training to address practice issues and support progress amongst the social work teams. Although supervision was the main reporting mechanism through the line management structure, supervision records of social workers and team leaders did not have clearly identified actions that were

tracked for implementation. This meant that managers could not be assured that action had been taken to respond to the issues that arose in supervision.

Supervision records by managers showed inconsistent oversight. Progress in relation to areas of risk was not routinely discussed and delayed reports on some risks not followed up in a timely way. Gaps in supervision, in addition to poor systems for tracking and oversight meant that it was difficult to see how some managers were held to account and how poor performance was identified and addressed.

An external leadership and management consultant had been commissioned by Tusla to provide support to managers in the service area through the change process. This external consultant began a leadership development programme with the Dublin South Central senior management team in February 2019 and all managers told inspectors that this was a welcome support.

Standardised systems for screening and oversight of cases awaiting allocation were being put in place across the area with the view to achieving, consistent, safe and effective practice. Social workers within the child protection and welfare teams were receiving increased supports by the management team including increased monitoring of caseloads to ensure they were appropriate, manageable and reviewed as required, timely supervision and the active presence of principal social workers providing daily oversight and guidance as required. In addition, there was a pilot of a new caseload management tool being undertaken within the intake teams of child protection and welfare service.

Inspectors reviewed management meeting minutes that took place since the last inspection such as team meetings, fostering management meetings, intake and child protection individual team meetings, child protection and welfare service management team meetings and meetings with external agencies including assessment agencies and community/family support services.

Appropriate information was shared in meetings with social workers, team leaders or external agencies. However, actions agreed were not always clearly outlined, or persons responsible for completion of the actions or expected timeframes for completion were not identified. In addition, it was not evident that actions were followed up from meeting to meeting. The impact of this was that the system to monitor progress was not adequate. Where issues or concerns were raised through management meetings there was an absence of clear direction and decision making from management to address the issues.

Similarly, in the 'Allegations and Serious Concerns Governance Group' meetings referred to earlier, members considered if safety plans were needed in the majority of foster care cases discussed. However, decisions, person responsible and timeframes were not clearly recorded for the cases discussed. In addition the tracker

for allegations and serious concerns had not been updated at the time of inspection to include decisions and actions from the last meeting. This meant that the systems in place to provide oversight of safety planning were not being used effectively and it was not possible to monitor progress or ensure accountability through actions agreed at management and governance meetings. As a result, it was not evident that timely action was taken to address the issues identified.

Despite being aware of the issues that arose during this inspection, such as concerns regarding the management of allegations and serious welfare concerns and the quality of safety planning, the area management team for foster care had not implemented effective systems of oversight to address these issues at the time of inspection and poor practice was not consistently addressed by team leaders.

The management team for child protection and welfare were acutely aware of the risks relating to waiting lists within the area and management of these was a key priority. However, progress with respect to the management of these risks was insufficient and escalating risks were not effectively addressed in the period between September 2018 and March 2019. There was continued lack of adherence with standard operating procedures and practice improvements were slow to be embedded.

The review of all open cases within the service initiated by the Area Manager following the previous inspection with the view to being completed in November 2018 was not completed until March 2019. While the outcome of the review provided assurances to the area manager that all open cases had been appropriately screened, categorised and prioritised, it had not led to improved or timelier service for the majority of children. Despite an increase in figures relating to cases awaiting allocation at all stages of the referral process throughout the course of the review, there was no systematic analysis of the deficits leading to these increases. This opportunity to collate findings which could then inform decision making such as allocation of resources, training and supports or performance management priorities was missed. In addition, data related to closed cases and re-referrals had not been questioned or analysed to ensure that cases closed prior to implementation of improved practices was done so appropriately.

Risk management systems did not ensure that reported or identified risks were acted upon or appropriate measures taken to mitigate risks and the biggest risk within the area was not effectively prioritised by the management team. As cited previously the management team within the area was acutely aware of the risks associated with a significant waiting list for preliminary enquiries and initial assessments and these had been escalated to the regional service director through internal escalation processes on two occasions since December 2018. However, actions to address this increasing risk were not prompt or adequate.

During the course of this inspection, as with the previous inspection it was necessary to seek assurances from staff that actions had been taken to protect a child, where evidence or records of actions were absent from files reviewed by inspectors. In twenty eight cases examined by inspectors assurances were provided verbally by social workers and/or social work team leaders. An additional twenty one cases which required further action to ensure the safety of children were escalated to the service area both during fieldwork and post inspection, and assurances were received in relation to all cases escalated.

In addition to approving overtime and allocation of wait listed cases, when capacity arose, the following measures were cited by Tusla in response to assurances sought in relation to risks identified in DSC service area:

- Improvements in timeliness and efficiency of management of Review Evaluate and Direct (action) RED meetings, RED meetings involve engagement between the areas child protection teams and community support and commissioned services during which children and families requiring community and family supports, typically low priority cases, are diverted to these services for intervention - this is intended to support the intake service in prioritising referrals of a high and medium priority.
- A commissioning plan, which would lead to a more strategic view of what the priority service pressures and how commissioned services could support the social work department in responding to these, was in the process of being developed.
- Due to the high level of referrals relating to domestic abuse, work had commenced on developing a model whereby a project worker with experience in domestic abuse, would be assigned to the intake team for the purpose of responding to referrals where domestic abuse was the primary reported referral reason.

HIQA met with the chief operations officer of Tusla and the regional service director of Dublin Mid-Leinster in April 2019 to discuss the above information. They outlined that Dublin South Central Service Area had been identified as one of five service areas across Tusla requiring a specific service improvement initiative to reduce the number of unallocated cases.

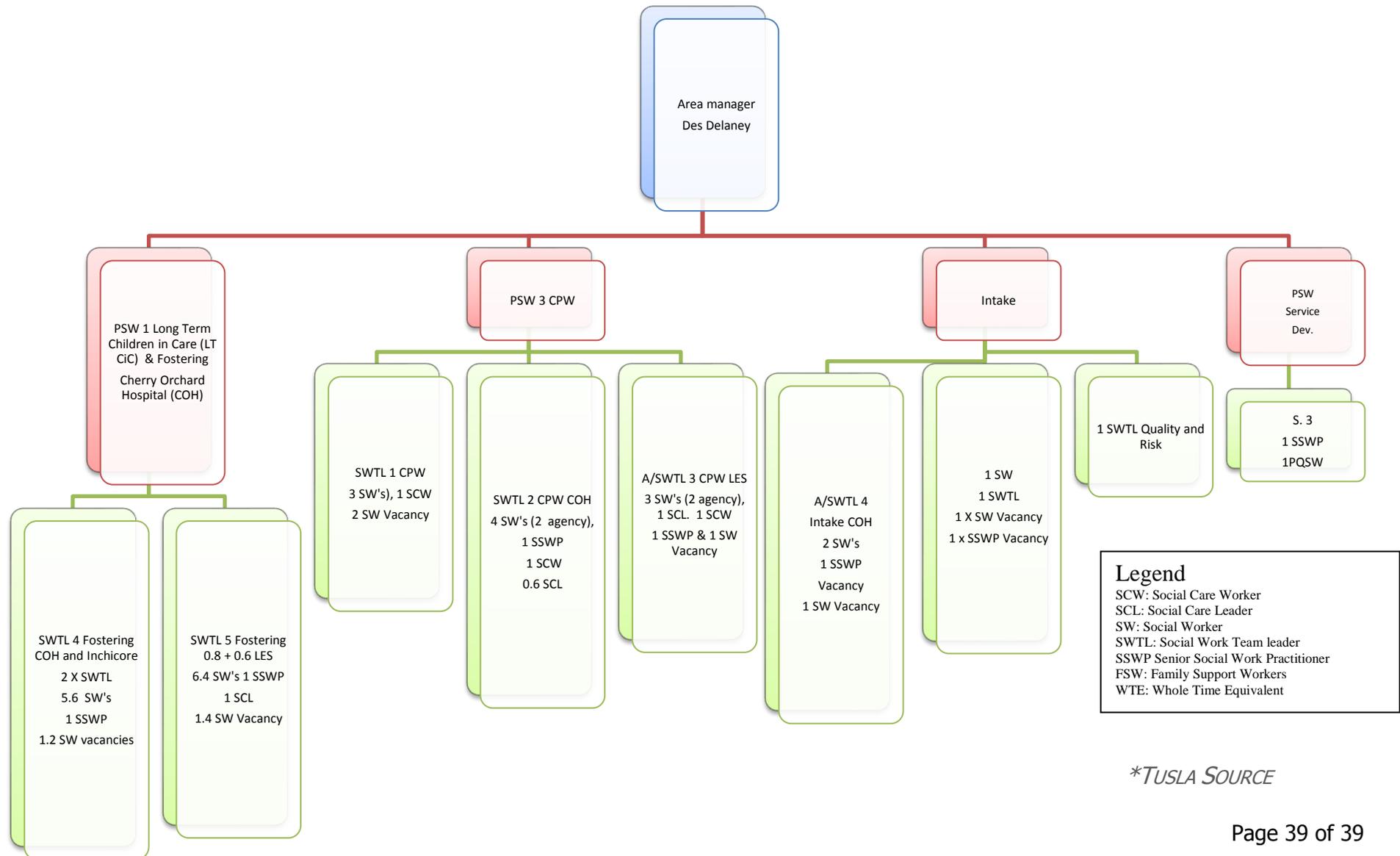
The chief operations officer outlined the initiatives that were on-going in the service area as have been referred to above. In addition, he outlined the following:

- A bespoke recruitment campaign to fill existing vacancies - Measures relating to vacancies within DSC, including recruitment for vacant senior practitioner posts and an open evening for new graduates had been undertaken during April 2019.

- A pilot workforce plan creating area level multi-disciplinary teams and strengthening existing administrative and business supports was proposed.
- A review of all retrospective referrals by the PSW for service improvement had begun in DSC.
- An audit / review of notifications of child protection and welfare concerns sent by An Garda Síochána into Tusla was scheduled to be undertaken in DSC on 13th-15th May 2019.
- As part of the Tusla child protection and welfare strategy, practice improvement initiatives including workshops relating to intake case prioritisation, application of thresholds and safety planning would continue. In addition, learning from audits and reviews will be shared during meetings of staff within the child protection and intake pillars.
- DSC have commenced a process of reviewing the current service deliver model and geographical boundaries, structures and reporting relationships and the level of information available relating to the profile and needs of the area with the view to informing engagement with funded/commissioning agencies to ensure that all resources available to Tusla are being used in the most effective way possible.

HIQA will seek bi-monthly updates on the progress within Dublin South Central Service Area beginning 1 June 2019 as well as a plan to complete further inspection fieldwork within the area by the end of 2019 to review reported progress.

Appendix 1—Service Area Organisation Chart – Dublin South Central



*TUSLA SOURCE