

Child protection and welfare inspection report

Health Information and Quality Authority
Regulation Directorate monitoring
inspection report on child protection and
welfare services under the *National
Standards for the Protection and Welfare of
Children*, and Section 8(1)(c) of the Health
Act 2007



Name of Service Area:	Child and Family Agency Midlands.	
Dates of inspection:	12-14 January 2016 19-21 January 2016 9-11 March 2016.	
Number of fieldwork days:	9	
Lead inspector:	Eva Boyle	
Support inspector(s):	Grace Lynam Bronagh Gibson	Tom Flanagan Ann Delany
Type of inspection:	<input checked="" type="checkbox"/> Announced <input type="checkbox"/> Unannounced <input checked="" type="checkbox"/> Full <input type="checkbox"/> Themed	
Inspection ID:	713	

About monitoring of child protection and welfare services

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

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

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

1. Inspection methodology

As part of this inspection, inspectors met with children, parents and or guardians, other agencies and professionals. Inspectors observed practices and reviewed documentation such as child protection plans, policies and procedures, children's files and staff files.

The aim of on-site inspection fieldwork is to gather further evidence of performance against the *National Standards for the Protection and Welfare of Children*.

During this part of the inspection, the inspectors evaluated the:

- timeliness and management of referrals
- effectiveness of assessment and risk management processes
- provision of immediate help where required
- effectiveness of inter-agency and multidisciplinary work
- outcomes for children.

The key activities of the January 2016 fieldwork involved:

- the analysis of data
- the review of local policies and procedures, minutes of various meetings, 24 staff files, audits and service plans
- reviewing 228 children/adult case files
- meeting with 12 children and eight parents or guardians.
- meeting with the area manager, two principal social workers, two chairpersons of child protection conferences, one area senior child care official, one information officer and one training officer
- focus groups were held with six social care leaders/workers, eight family support workers, 22 social workers and team leaders
- questionnaires from five external stakeholders and meetings or telephone interviews with 17 external professionals including, members of An Garda Síochána (the Irish police force), health services and educators
- observing staff in their day-to-day work
- observing practice in three review child protection conferences, one complex case meeting, one governance review group meeting and one garda-liaison meeting

The key activities of the follow up fieldwork in March 2016 involved:

- the analysis of data
- the review of minutes of various meetings
- review of garda notification backlog audits
- review of 51 children/adult files

- meeting with the area manager, interim principal social worker duty intake, interim social work team leader duty intake, senior social worker responsible for managing the adult retrospective social work team and five social workers.

Acknowledgements

HIQA wishes to thank the children, parents, staff and managers of the service for their cooperation with this inspection.

2. Profile of the child protection and welfare service

2.1 The Child and Family Agency

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

The Child and Family Agency 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
- service response to domestic, sexual and gender-based violence.

Child and family services are organised into 17 service areas and are managed by area managers. These service areas are grouped into four regions, managed by 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 areas.

2.2 The Midlands Area

The Midlands Area comprises the counties of Laois, Offaly, Westmeath and Longford. The area is predominantly rural in nature and has five main urban areas, Portlaoise, Tullamore, Athlone, Mullingar and Longford.

Based on the 2011 census of population, the area had a population of 282,410 of whom 77,726 (6.8%) were between 0-17 years. The Pobal HP deprivation index classified the Midlands as disadvantaged.

The area is under the direction of the Service Director for the Child and Family Agency, Dublin Mid Leinster (DML) and is managed by the Area Manager. The service comprises of;

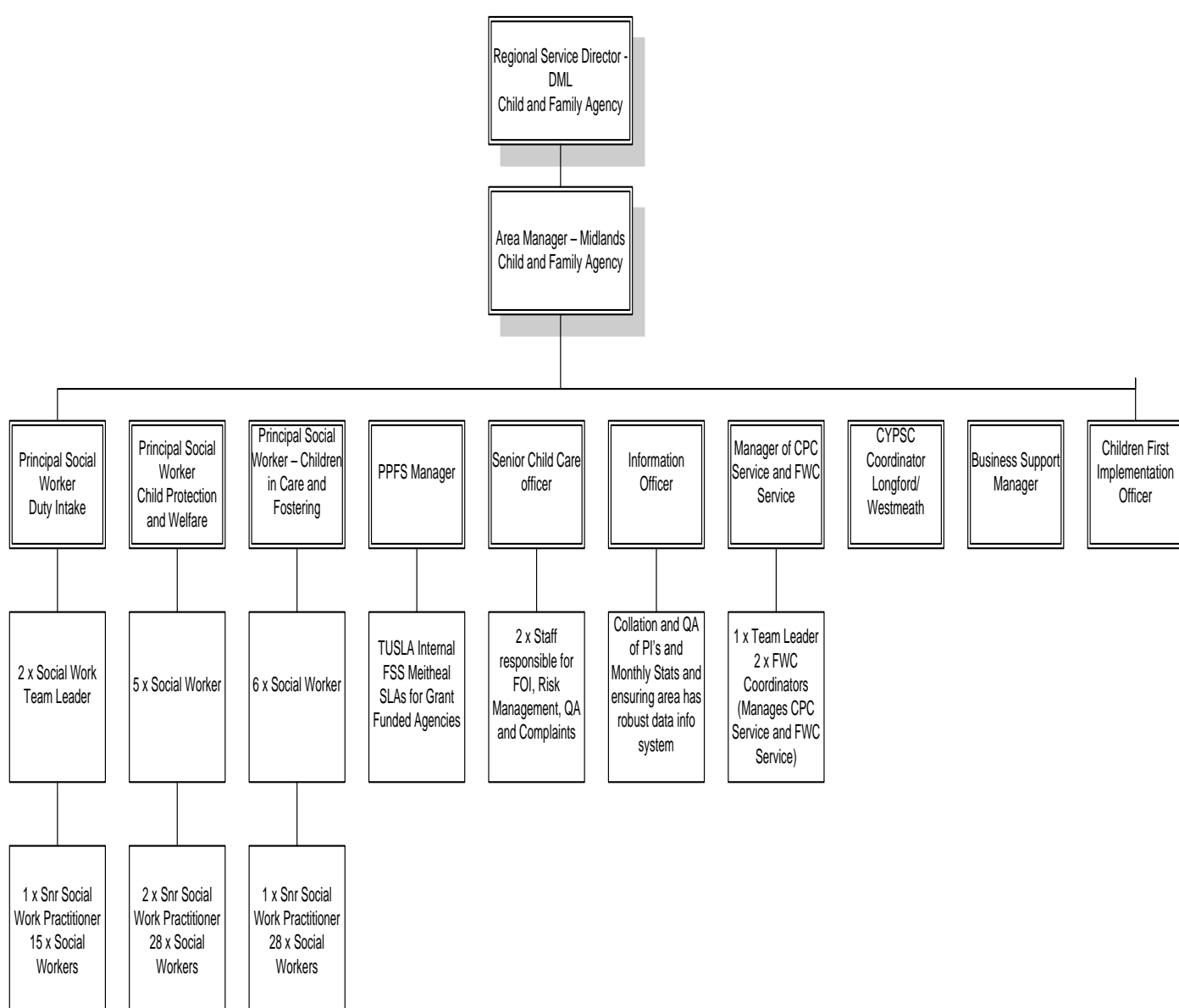
- three Principal Social Workers – one with responsibility for duty intake, one for child protection and welfare and one for children in care and foster care
- a manager for partnership, prevention and family support (PPFS) and

- two chairs of child protection conferences/management of the family welfare conference service. Services are based within the five main urban areas.

In the 12 months prior to the January 2016 inspection the area reported 4439 referrals to the services and there were 1277 open cases.

The organisational chart in Figure 1 describes the management and team structure of the child protection and welfare service, as provided by the Service Area.

Figure 1: Organisational structure of the Child Protection and Welfare Service, Midlands Area*



* Source: The Child and Family Agency

3. Summary of inspection findings

The Child and Family Agency has legal responsibility to promote the welfare of children and protect those who are deemed to be at risk of harm. These children require a proactive service which acts decisively to assess and meet their needs in order to promote their safety and welfare. As much as possible, children and families require a targeted service aimed at supporting families. However, there will always be some children who will need to be protected from the immediate risk of serious harm.

This report reflects the findings of the inspection, which are set out in Section 5. The provider is required to address a number of recommendations in an action plan which is published separately to this report.

During the combined inspections HIQA found that of the 27 standards assessed:

- one standard was met
- 22 standards required improvement
- four standards were identified as a significant risk.

An inspection of the Midlands service area was scheduled for April 2015. However, in April 2015 the Child and Family Agency (Tusla) advised HIQA of on a high number of unallocated child protection cases and, notifications of alleged abuse received from An Garda Síochána to which no response had been made by the Midlands service area. As Tusla had reported the risk, they were given an opportunity to put corrective actions in place and provided regular progress reports to HIQA. The Midlands service area was subsequently inspected in January 2016.

This report sets out the findings of the inspection of the Midlands child protection and welfare service. The initial fieldwork took place in January 2016. Inspectors identified a number of serious risks over the course of the inspection and the following was escalated at the end of the fieldwork:

- The number of high priority cases, including adult retrospective cases identified for immediate allocation in November 2015 by the Area Manager, which had not been allocated and were known to the department for a number of years.
- One in five of 53 cases sampled in one duty office were escalated by the inspection team to the duty intake principal social worker for review due to their assigned prioritisation and lack of timeliness of and/or appropriate action.
- One duty team that was predominantly resourced with agency staff with under two years experience, who had no direct line manager and with a principal social worker who was due to leave on the day after the initial fieldwork.

Due to risks that were escalated at the end of the fieldwork, HIQA carried out follow up fieldwork over two and a half days in March 2016 to assess the implementation of the assurances provided by Tusla. The follow up fieldwork specifically reviewed the following areas; duty intake system in one duty intake office, adult retrospective cases and backlog garda notifications. As a result of the follow up and systems implemented, four standards that were previously assessed as significant risk were reduced to requires improvement.

Overall, once children were allocated to a member of staff in the service, the majority of children and their families received an adequate service. However, children experienced delays in being allocated to a social worker and in their needs being assessed. The majority of children who were identified as being at serious and immediate risk received a timely service and emergency action was instigated when required. Following the fieldwork in January 2016, HIQA sought assurances in relation to a number of high risk adult cases which were not actively receiving a service, including three that had been assigned for immediate allocation to a social worker. In addition, some cases on the duty/intake system were also escalated to the area manager as there were concerns in relation to their prioritisation and timely/appropriate action.

Follow up fieldwork was conducted in March 2016, and inspectors confirmed that escalated cases were actively receiving a service. During the follow up fieldwork in March 2016, duty intake social workers had access to an assigned team leader in the Portlaoise office, an interim principal social worker had been recently appointed with responsibility for duty intake service and a manager had been assigned responsibility for the management of adult retrospective cases. While these structures were very new, it was evident that they were making a positive impact into the overall management of the service. The management team had put in place some strategies to reduce the number of children and adults waiting to be allocated to a social worker.

Staff endeavoured to be child-centred in their practice. The majority of parents and children who spoke to inspectors were positive about their experience of the service. There was good communication with children. However, not all children were aware of all of their rights. There was a complaints process in place but the management team had identified that improvements were required in its operation.

The area was not fully compliant with Children First (2011). Concerns regarding children were screened effectively with the vulnerability and strengths of children and families informing the decisions of social workers, but there had been delays in this process in the recent past. The area was completing an on-going audit of historical garda notifications to establish whether concerns made to the Laois/Offaly area during 2007-2013 had been assessed and an appropriate intervention implemented if required. This was not in line with best practice or Children First (2011), as the area was not clear whether these children were receiving or had received adequate care and protection.

The child protection conference system was well managed, and comprehensive child protection plans were formulated and implemented. The Child Protection Notification System (CPNS) was available 24 hours a day.

There were systems in place to identify serious incidents. However, there was no consistent system in place to review, manage and implement the findings of serious incident reviews.

The service had experienced significant changes in the structure, management team and systems over the last 12 months. An area manager had been appointed and was endeavouring to put systems in place to support the service towards better outcomes by implementing a management improvement plan.

There was insufficient planning in relation to the use of resources and services. Information systems were not fit for purpose for the service. However, a new system was due to be operational by end of April 2016. The quality of record keeping in the service was varied and not all children had their own individual records.

In January 2016, there were key management roles vacant or about to become vacant and a significant number of staff were employed by a recruitment agency. There was a significant number of inexperienced staff in one duty office who worked at the first point of children's entry into the service and were dealing with unassessed risk on a daily basis. These staff did not have a direct line manager in place. In March 2016, an interim team leader was in place to manage this team and the majority of staff were employed directly by the Child and Family Agency.

4. Summary of judgments under each standard

During the inspection, inspectors made judgments against the National Standards. They used four categories that describe how the Standards were met as follows:

- **Exceeds standard** – services are proactive and ambitious for children and there are examples of excellent practice supported by strong and reliable systems.
- **Meets standard** – services are safe and of good quality.
- **Requires improvement** – there are deficits in the quality of services and systems. Some risks to children may be identified.
- **Significant risk identified** – children have been harmed or there is a high possibility that they will experience harm due to poor practice or weak systems.

<i>National Standards for the Protection and Welfare of Children</i>	Judgment
Theme 1: Child-centred Services	
Standard 1:1 Children's rights and diversity are respected and promoted.	Requires improvement
Standard 1:2 Children are listened to and their concerns and complaints are responded to openly and effectively.	Requires improvement
Standard 1:3 Children are communicated with effectively and are provided with information in an accessible format.	Requires improvement
Theme 2: Safe and Effective Services	
Standard 2:1 Children are protected and their welfare is promoted through the consistent implementation of Children First (2011).	Significant risk
Standard 2:2 All concerns in relation to children are screened and directed to the appropriate service.	Requires improvement
Standard 2:3 Timely and effective actions are taken to protect children.	Requires improvement

<i>National Standards for the Protection and Welfare of Children</i>	Judgment
Standard 2:4 Children and families have timely access to child protection and welfare services that support the family and protect the child.	Requires improvement
Standard 2:5 All reports of child protection concerns are assessed in line with Children First (2011) and best available evidence.	Requires improvement
Standard 2:6 Children who are at risk of harm or neglect have child protection plans in place to protect and promote their welfare.	Requires improvement
Standard 2:7 Child protection plans and interventions are reviewed in line with requirements in Children First (2011).	Meets the Standard
Standard 2:8 Child protection and welfare interventions achieve the best outcomes for the child.	Requires improvement
Standard 2:9 Interagency and inter-professional cooperation supports and promotes the protection and welfare of children.	Requires improvement
Standard 2:10 Child protection and welfare case planning is managed and monitored to improve practice and outcomes for children.	Requires improvement
Standard 2:11 Serious incidents are notified and reviewed in a timely manner and all recommendations and actions are implemented to ensure that outcomes effectively inform practice at all levels.	Significant risk
Standard 2:12 The specific circumstances and needs of children subjected to organisational and or institutional abuse and children who are deemed to be especially vulnerable are identified and responded to.	Requires improvement.

<i>National Standards for the Protection and Welfare of Children</i>	Judgment
Theme 3: Leadership, Governance and Management	
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.	Requires improvement
Standard 3:2 Children receive a child protection and welfare service, which has effective leadership, governance, and management arrangements with clear lines of accountability.	Requires improvement
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.	Requires improvement
Standard 3:4 Child protection and welfare services provided on behalf of statutory service providers are monitored for compliance with legislation, regulations, national child protection and welfare policy standards.	Requires improvement
Theme 4: Use of Resources	
Standard 4:1 Resources are effectively planned, deployed and managed to protect children and promote their welfare.	Requires improvement
Theme 5: Workforce	
Standard 5:1 Safe recruitment practices are in place to recruit staff with the required competencies to protect children and promote their welfare.	Requires improvement
Standard 5:2 Staff have the required skills and experience to manage and deliver effective services to children.	Requires improvement

<i>National Standards for the Protection and Welfare of Children</i>	Judgment
Standard 5:3 All staff are supported and receive supervision in their work to protect children and promote their welfare.	Requires improvement
Standard 5:4 Child protection and welfare training is provided to staff working in the service to improve outcomes for children.	Requires improvement
Theme 6: Use of Information	
Standard 6:1 All relevant information is used to plan and deliver effective child protection and welfare services.	Significant risk
Standard 6:2 The service has a robust and secure information system to record and manage child protection and welfare concerns.	Significant risk
Standard 6:3 Secure record-keeping and file management systems are in place to manage child protection and welfare concerns.	Requires improvement

5. Findings and judgments

Theme 1: Child-centred Services

Services for children are centred on the individual child, their care and support needs. Child-centred services provide the right support at the right time to enable children to lead their lives in as fulfilling a way as possible. A child-centred approach to service provision is one where services are planned and delivered with the active involvement and participation of the children who use the services.

Summary of inspection findings under Theme 1

The team endeavoured to be child-centred at all times, but improvements were required in order to achieve this. The service had information leaflets for families, had information on children's rights displayed in the offices and some children had good quality rights based work completed with them. Communication was good with children and families who had an allocated social worker. However, this was not the situation for children who were waiting for a service. The complaints process was not transparent as an independent complaints officer did not investigate each complaint. The area had not completed any formal awareness initiatives to inform the public about how to access the service.

Children's rights

Children and parents were not fully aware of their rights and were not consistently informed of their rights. Some children had a good understanding of their right to be heard, to be safe, to be listened to and to privacy, but other children were not clear on their rights. However, the service had information on children's rights on display in the reception area of their offices and had information leaflets on the service for parents. In some files, it was clear that staff had discussed rights with parents and children and provided information but it was not evident on others.

Some children exercised their rights, but others did not. It was evident that children met individually with their social workers and gave their opinions. Social workers told inspectors that they encouraged children to participate in meetings and, if a child chose not to attend or it was inappropriate for them to do so, then they reflected the children's views at these meetings. However, it was not always recorded that children had been given the option to attend meetings. One child told inspectors that they had attended meetings with social workers and had felt better afterwards as they were listened to and got help with school as a result. Inspectors found that when children were allocated to a worker and their cases were being actively worked by staff, their rights were respected and promoted. Children were made aware of their right to be

protected from abuse and some children benefited from working directly with staff members around their safety. However, there were children who did not have an allocated social worker and therefore, their right to safety may have been compromised by this situation.

In general, children's rights to dignity, respect, privacy and confidentiality were respected, but this required improvement in some areas and is discussed throughout the report. Inspectors found that consent was requested from parents prior to services gathering information on the child and consent forms were on records. Inspectors observed staff being respectful to children during the inspection. Children told inspectors that social workers were nice to them and were good at talking and listening to them.

Diversity

Children's differences were generally acknowledged in relation to their diversity, gender, sexuality, religion, age, or membership of the travelling community. However, the service had not provided formal training for staff on working with children from diverse backgrounds. A sample of some files showed good practice in this area, where staff had consulted members of new communities, engaged with professionals who had expertise on working with ethnic groups, such as a public health nurse, who worked directly with members of the Travelling community. However, in other files, the family's ethnicity and how it may have related to family functioning was not referenced. The majority of cases that were reviewed by inspectors in relation to working with children who had a disability showed good practice, but there were some challenges in regard to meeting the needs of children who had limited verbal skills.

Children had access to advocacy. A small number of children had a court appointed guardian ad litem, whose role was to advocate on behalf of the child and represent their views in court proceedings. A child told inspectors how they had benefited from the input of an advocacy programme that was arranged through the social work department. In addition, staff members strongly advocated on behalf of children and their families on issues such as accommodation, access to services such as psychology services, and financial assistance when required.

Communication

There was good quality and regular communication with children and families who were allocated to a social worker but there were no formal consultation processes with children to ascertain their views of the service. Children were regularly met on their own by social workers and or social care leaders. Their views were reflected in their records. However, for those families who were waiting for a service, the primary means of communicating with them was by letter, and this did not consider that some service-users may have literacy issues. The service had information leaflets for parents on the service, on case conferences and on the roles of family support workers and social care

leaders. Some parents were familiar with this information while others were unsure whether they had received them.

Interpreters were available to staff when required both for meeting with parents and children, which was in line with national procedures around the use of interpreters. Inspectors viewed correspondence translated into a range of languages in order to ensure that families were kept fully informed.

Inspectors found that there was some good quality child centred work completed with children. Various tools were used to work with children in order to communicate with them. Children told inspectors that they thought that social workers, family support workers and social care leaders communicated well with them, not only verbally but through the use of art.

Complaints

Not all children and parents who engaged with inspectors were aware of how to formally complain. No children had made complaints. Information on making a complaint through the 'Your Service Your Say' was on display in offices, and some had locked boxes where members of the public could submit their complaint or comment.

The system in place to record, manage and resolve formal complaints was not entirely robust. There was a nominated complaints officer for the area. Inspectors found that complaints were made directly to staff members, the complaints officer, local service area office or national office. Twenty six complaints were received by the area in 2015, and 23 of these were closed. Complaints related to a range of matters ranging from poor communication, dissatisfaction with the service or lack of intervention by the service. Complaints were generally responded to in a timely manner.

However, individual complaints were investigated by the principal social workers or the area manager. This was not an independent process, as a manager could potentially be reviewing their own decision-making while dealing with the complaint. In addition, not all of the investigators had received training in the management of complaints.

Complaints were recorded on a complaints log that was in line with national policy, but the log did not outline the investigation undertaken or whether the complainant was satisfied with the outcome of the complaint. Inspectors found one complaint that was not logged. In addition, all information in relation to complaints was not held centrally by the complaints officer. The area manager and complaints manager told inspectors that the management of complaints was an area that was identified for review and this was documented in the minutes of a recent senior management meeting.

The service had no supports in place for children with communication difficulties so they could raise concerns or make a complaint in regard to their experience of the service. There were no communication systems such as a Loop system within the service in order to assist children with sensory disabilities. This meant that there may be barriers for some children and families in raising concerns.

Raising awareness in the community

The service had not taken any formal awareness initiatives to inform the public about its services and how to access them in the local area. However, Tusla operated a website that contained information in relation to the service area. The area manager told inspectors that raising awareness in the community was a priority objective of the service for the coming months, and this was outlined in management meeting minutes.

Inspectors found that not all external agencies in the community knew how the service decided on what families/children would be provided with a service. Therefore, inappropriate referrals may have been sent to the service by such agencies.

Theme 2: Safe and Effective Services

Services promote the safety of children through the assessment of risk, learning from adverse events and the implementation of policies and procedures designed to protect children. Safe services protect children from abuse and neglect and follow policy and procedure in reporting any concerns of abuse and/or neglect to the relevant authorities. Effective services ensure that the proper support mechanisms are in place to protect children and promote their welfare. Assessment and planning is central to the identification of children's needs, the risks to which they are exposed and the supports which need to be put in place for each individual child to keep them safe and maintain their wellbeing.

Summary of inspection findings under Theme 2

Once children were allocated a worker they generally received a consistent service. The majority of children who were at serious and immediate risk were appropriately prioritised by managers. However, there were children and adults of concern that were awaiting the allocation of a social worker, mainly at the duty intake stage of the service. This meant some risks to children could not be identified and assessed for long periods of time and this potentially placed them at risk. Inspectors escalated a number of cases at the end of the initial fieldwork in relation to high risk adult retrospective cases and inappropriate prioritisation, lack of timely action and/or appropriate intervention in relation to a further 12 cases. On the follow up fieldwork in March 2016, inspectors found that some improvements were made in regard to the prioritisation of cases and there were processes in place that were implemented to try and reduce the number of children and adults waiting for a service.

Protecting children

Children First (2011) was not fully and consistently implemented throughout the service. Not all children were safeguarded and protected as there were delays in elements of service delivery. There were delays in children being allocated a social worker and having their needs assessed and the system in place to review lists of children awaiting allocation of services was not consistently effective. The service had, over the three months prior to the initial fieldwork, over 400 cases awaiting allocation to a social worker. Data provided to HIQA outlined that there were 435 cases awaiting allocation in the service at the end of December 2015, which was a reduction on 35 cases on the previous month.

Inspectors found that the review and tracking process of unallocated cases was not transparent, as the name and dates of the person who reviewed cases awaiting allocation were not consistently recorded on risk estimation system forms. This was not

safe practice as it did not evidence that unallocated cases were consistently reviewed in line with the area's protocol for cases awaiting allocation, nor was it an accountable practice by the managers involved in ensuring that risks to children were routinely reviewed and updated. This was evident mainly in the duty and intake part of the service and inspectors found improvements in this practice on the follow up fieldwork.

There were variations in the quality of service delivery. During 2015, a backlog of cases dating back a number of years was brought to the attention of Tusla's national office in relation to children, adults of concern and garda notifications. The staff team had worked through the majority of the children's cases and a small number of cases remained. However, there had been significant delays in assessing and managing these cases. The backlog cases in relation to garda notifications and adult retrospective cases are discussed later in this section.

During the initial fieldwork, 12 out of 53 cases that were sampled by inspectors in one of the duty intake offices were escalated due to concerns in regard to their prioritisation level, and timely and or appropriate intervention. Practice in this area had improved by the follow up fieldwork. Overall, these practices were not in line with Children First (2011) or good practice.

The service was not consistent in identifying patterns of cumulative harm, long-term harm and neglect in children's lives. Inspectors found that practice in some neglect cases was good and children benefited from improved outcomes due to the input of staff. Some children told inspectors that they believed that their lives had changed for the better as a result of the involvement of the service. A neglect group had been established in the area, to review research on neglect and to impart updated knowledge and research to the staff team. This was a positive development. However, inspectors found a significant number of cases where there were re-referrals of neglect over a number of years and there was limited analysis of cumulative harm in these cases. Inspectors found in some cases that social workers completed initial assessments on individual referrals to the service and it was not always evident that previous referrals were actively considered when making a judgement in regard to whether a child was at on-going significant risk or their welfare was being affected. Therefore, workers were not consistently taking into account the long term impact on children of being subjected to neglect.

Referrals and assessments

Screening and carrying out of preliminary enquiries were generally completed in a timely manner. Screening involves the social worker reviewing the referral information and establishing whether it is appropriate to the service. Data returned from the area outlined that 1100 out of 4439 referrals received in the 12 months prior to the inspection were not screened within the service's own timeframes. Inspectors observed the timely screening of child protection and welfare concerns on inspection. Staff acknowledged that this was an area that had improved over recent months.

After the screening process, a social worker's next task is to carry out preliminary enquiries, which includes checking whether the child or family are currently or were previously known to the service. This may involve contact with other professionals or services. There were some delays in preliminary screening. For example, in one case, a family was known to the service and the case was recently closed. However, inspectors found that recent referrals had come into the duty intake office in advance of the case being closed but the social worker had not been made aware. This case was subsequently re-opened. Inspectors found that the internal information system in place did not lend itself to efficient preliminary enquiries, as the information system was not integrated.

The majority of referrals were correctly classified as welfare or protection cases.

There were standard frameworks in place to determine thresholds of harm, levels of risk and prioritisation of cases. However, thresholds were not routinely recorded on children's records. Staff and managers referenced that the service had implemented 'Thresholds for referral to Tusla Social Work Services'. However, inspectors found no record in cases sampled of what threshold was assigned. Despite this, staff demonstrated an awareness of the thresholds.

There was a prioritisation system in place, but its use was not robust throughout the area and this risk was escalated to the area manager. The service used a tool to estimate risk and also to prioritise cases awaiting allocation, as high, medium or low. Inspectors reviewed a number of these cases and found that not all cases had been appropriately prioritised. HIQA escalated seven cases from one duty office to the area manager where inappropriate prioritisation was identified following the initial fieldwork. The area manager responded and identified that four of the seven cases were re-prioritised as high and were allocated to a social worker, one was re-categorised from low to medium, another was re-categorised from medium to low and one remained the same. In addition the area manager undertook a review of all unallocated cases (totalling 277) held in the identified duty office and provided the findings of the review to HIQA. The outcome of this review was one case without a rating was prioritised as high and a second case was re-rated from medium to high. All other cases were deemed by the review team to be appropriately prioritised. The review also indicated that 81 cases may, following an initial assessment, be closed or referred to other services. Staff from both duty intake and the child protection and welfare teams were assigned to complete work on duty intake cases and this work was ongoing during the follow up field work.

During the follow up fieldwork in March 2016, a sample of case files in the duty system were reviewed and found to be appropriately prioritised.

There was a system in place to review unallocated cases but it was not consistently implemented. Team leaders reviewed unallocated cases and recorded this on a specific risk estimation form. Inspectors reviewed a sample of these forms in the duty offices

and found that not all of these were signed and dated. Therefore, it was not always clear when cases awaiting allocation were reviewed or how regularly they were reviewed by team leaders in order to establish if the risk to children had changed.

Social workers complete initial assessments based on new concerns that come into the service. The quality of initial assessments varied. Some initial assessments were thorough and were completed in a timely manner, while others were scant in information, delayed in their completion and were not signed off by managers. Children were routinely met with as part of the process. Data provided to HIQA showed that of the 2997 referrals which required an initial assessment, 41% (1241) were completed in the 12 months prior to inspection. Therefore, this impacted on children as their needs and safety were unassessed and may have caused delays in the children receiving services.

Some initial assessments were completed on each referral. Inspectors reviewed files where a number of referrals related to the same child received over the course of a few days and an initial assessment was completed on each referral. Inspectors also found examples of up to 12 initial assessments being completed for individual children during a six year period of time, but there was no consideration made of the previous information, and the potential for cumulative harm. This did not indicate the best use of resources or good management oversight of the case.

Further assessments are completed when a social worker makes a recommendation after an initial assessment that a more indepth focus is required into a child's life and their safety. Overall the quality of further assessments was good, but they were not always recorded on the standard template. Data provided to HIQA indicated that 97 further assessments were completed in the 12 months prior to inspection. This figure was relatively low based on the number of completed initial assessments and inspectors found that further assessments were recommended in a number of cases but had not been completed. Staff told inspectors that further assessments were comprehensive assessments and validation assessments of sexual abuse. Nine assessments were sampled and inspectors found that seven were of good quality. They were completed in a timely manner, clearly outlined the child's needs, parent's functioning and made findings and clear recommendations in order to safeguard the child. However, the other two assessments were not sufficiently detailed and had not been completed in a timely manner. Both had been signed off by a team leader.

Under Children First (2011), social workers have to report allegations of abuse of children to An Garda Síochána. In turn, An Garda Síochána must notify Tusla of child protection and welfare concerns that come to their attention and both services should agree a joint course of action to address these concerns. In the majority of current cases, social workers were appropriately completing these notifications. However, there were a small number of files at the time of the initial fieldwork and one file at the time of the follow up fieldwork, where Garda notifications had not been completed. These

were brought to the attention of team leaders and principal social workers and notifications were completed prior to the end of the fieldwork.

The service had a backlog of notifications of suspected abuse or welfare concerns made by the Gardai to the service from 2007-2013 where it was not known if the welfare of children referenced in these notifications had been assessed by social workers. The area had recognised the need to address the backlog and had put a system in place during 2015 to do so. However, the area had struggled to establish in a timely manner the exact number of backlog garda notifications there were, whether the children or adults were known to the service already, whether work had already been completed or whether there was outstanding work to be completed. Data provided to HIQA in regard to the total number of backlog garda notifications that required review varied over the course of the inspection.

In March 2016, inspectors reviewed data relating to Garda notifications that documented a total of 932 backlog garda notifications relating to the period 2007-2013 in the Laois/Offaly area. Almost 50% of these notifications had been reviewed and closed off to the service. An audit was ongoing of the remaining garda notifications and this work was scheduled to be completed by the end of March 2016. The interim principal social worker for duty intake had reviewed garda notifications received by the service for 2014-2015 relating to the Laois Offaly area and had identified a small number that required further follow up. In addition, a new system had been recently implemented for the tracking of garda notifications and was being managed by the principal social workers.

Planning for children at risk

There were good systems in place for children assessed as being at ongoing risk of significant harm and/or neglect. The area had a manager of the case conference service who was responsible for chairing case conferences (along with a second independent chairperson) , and had responsibilities around maintaining the Child Protection Notification System (CPNS). The service had a local policy in relation to child protection conferences and review, including the role of the independent chair and this was generally adhered to. The manager of the child protection conference system reviewed requests for case conferences and accompanying reports. She then decided if a case met the criteria for a case conference in line with policy. The area manager could overturn decisions if she deemed that a case conference was warranted.

Children who were assessed by social workers of being at ongoing risk of significant harm and/or neglect had a child protection conference or it was scheduled. Children were involved in child protection conferences, where appropriate. On occasions, child protection conferences did not proceed as a quorum was not available, but appropriate safety plans were put in place in the interim by the social worker. Inspectors observed three review case conferences during the course of the inspection and found they were child-centred and well managed. Inspectors observed the chairs of conferences

explaining their role to participants. However, some parents told inspectors that they received information about case conference meetings but found it was still difficult to understand what was happening at the meetings.

Good quality child protection plans in line with Children First (2011) were developed at case conferences. However, inspectors found that there were delays in families receiving minutes and on occasions copies of child protection plans. Plans were clear and had identified persons responsible for actions along with defined timelines. The chairs of the case conference acknowledged that this had been an issue, and informed inspectors that one chairperson was completing two rather than three conferences a week in order to ensure that minutes and plans were completed in a timely manner.

Plans were actioned by professionals and social workers within agreed timeframes. Inspectors found that if parents did not engage in the child protection plan then social workers were pro-active in encouraging families to do so. This concern was also raised with line managers and at further conferences.

The effectiveness of plans were regularly reviewed and changes in circumstances and or level of risk to children were acted upon. The case conference forum made appropriate decisions in regard to increased monitoring of children such as supervision orders or decisions in relation to children coming into care. Inspectors observed three review case conferences during the course of the inspection. These were appropriately chaired, reviewed progress against the previous plan, were respectful of parents, reflected children's views and appropriate decisions were made regarding whether children required to remain on the Child Protection Notification System (CPNS).

Data provided to HIQA outlined that 15 children had three or more consecutive child protection plans. Inspectors reviewed a sample of these cases and found that for the majority of these children, decisions had been made in relation to making applications to the courts in regard to care proceedings.

The CPNS was well managed and was now available on a 24 hour basis to external agencies and professionals. The CPNS was part of a national CPNS operated by the Child and Family Agency and was new to the area. It was available to relevant external agencies. At the time of the inspection, not all senior members of staff had access to it but they were in the process of being linked to the system.

Each child in the area who was deemed to be at ongoing risk of significant harm was listed on the CPNS after a multi-disciplinary decision at a case conference. At the time of the January 2016 inspection there were 104 children listed as active on the CPNS and all had an allocated social worker. This enabled staff to monitor children's wellbeing, the level of risk involved and to co-ordinate the implementation of the child protection plan. The CPNS was updated by a designated member of the administration staff and the chair of case conferences had responsibility for ensuring that it was amended as required. Children were delisted from the CPNS in line with Children First (2011).

The service was generally proactive in taking actions to protect children who were at serious and immediate risk in a timely manner. An Garda Síochána removed 22 children from their homes under section 12 of the Childcare Act 1991. Five cases where children were removed by An Garda Síochána were reviewed by inspectors and the reasons for these removals were allegations of physical abuse against parents and challenging/threatening behaviours by adolescents. The majority of these children were already referred or known to the service for varying periods of time. Arrangements were in place for out of hours placements for children through a private fostering agency and staff told inspectors that on occasions they were challenged to find appropriate foster placements for adolescents.

Social workers sought emergency care orders on 20 children in the 12 months prior to inspection. No emergency case conferences were held, but inspectors found that some decisions in relation to emergency actions were made at case conferences and timely action was taken. Inspectors observed staff responding appropriately to situations that required immediate emergency action during the course of the inspection.

The area used supervision orders effectively to monitor children who lived with their families in the community. Data provided to HIQA outlined that there were 31 children subject to a supervision order. Inspectors reviewed the file for 20 children who were subject to supervision orders. Nine of these supervision orders related to children who had spent a brief period of time in care and were now back living with their families in the community. Inspectors found that social workers monitored these cases diligently and the majority of these children sampled were also on the CPNS.

Welfare services

The prevention, partnership and family support pillar (PPFS) of the service was in the early stages of its development. Meitheal is a national practice model designed to ensure that the needs and strengths of children and families are identified and responded to in a timely manner. It is an early intervention model and can involve one or more services as appropriate to the needs of the family. Staff training in relation to the Meitheal model was ongoing. Given that the implementation of Meitheal had been delayed, the service was in its infancy and only a small number of cases had been referred it was premature to judge its effectiveness as a service delivery model. In addition, the area manager informed inspectors that there was a need for further development of community services in order to facilitate the advancement of Meitheal.

Family support services were in place and they supported many families. At the time of the initial fieldwork there was an inequity in regard to accessing the family support service by the duty intake teams. However, this was resolved at the time of the follow up fieldwork. Data provided to HIQA outlined that there were 208 open family support cases and there were no families awaiting allocation to either a family support worker or a service. Family support services were provided by a combination of social workers,

social care workers and family support workers who worked with families at high, medium and low risk.

The quality of family support plans varied. Three hundred and forty nine family support plans were in place and these were mainly drawn up by social workers. The majority of family support plans outlined clear objectives, actions were reviewed regularly and families benefited from interventions provided by partner agencies. However, inspectors found in a small number of cases, some of which were backlog cases worked during 2015, where there were delays in completing family support plans and some families had not received services as a result.

Family welfare conferencing was well established in the area and led to good quality family focused plans. Inspectors found that positive work was achieved with families in safeguarding children by working with families through this model. Co-ordinators were clear about their responsibilities when child protection issues arose. However, six families were waiting family welfare conferences. This meant that there could have been delays in families availing of supports from within their own family and network of friends.

The area had not completed any formal analysis of the outcomes for children and their families who had received family support or welfare interventions. However, inspectors reviewed some of these cases and found that children and parents benefited positively from work such as parenting programmes, supports regarding housing, domestic violence, budgeting, advocacy and specific one to one work with children. Parents were very positive about parenting programmes and the support of social work, family support and social care workers.

Support and specialist services

Some support and specialist services were available to children, and many of these services were external to Tusla. Internally, the service operated a specialist team that completed sexual validation assessments for children. Data provided to HIQA outlined that 19 children were waiting for child sexual abuse validation assessments, this was reduced to 12 children at the end of the initial fieldwork. A sample of these cases were reviewed and the majority of cases were due to the fact that garda investigations were ongoing.

Children were referred to external services but the service did not maintain a record of these. Inspectors found in a small number of children's records that they had been referred for private forensic psychological assessments. Inspectors found that staff did refer children to community services such as psychological services. Children who required specialist medical examinations were referred to specialist medical professionals.

Some children in the community, who required additional supports were provided with input from the Youth Advocacy Programme or the Extern service.

Case planning and management

In the majority, allocated cases were well planned and managed but there were inconsistencies found in unallocated cases. The service had a caseload management system in place but it was not effective or consistently adhered to. Inspectors found that there were imbalances in relation to the quantity and risk level of cases that workers held. Some social workers carried a caseload in excess of 60 cases, while others carried a caseload of 20. New staff members, appropriately, had a protected caseload. Inspectors found that on some caseload management tools it recorded that social workers caseloads were unmanageable, but there were no recorded discussions in relation to how this would be addressed and so workers maintained these caseloads. In addition, it was not evident that team leaders and principal social workers consistently reviewed individual team's caseloads. Therefore, it was unclear how managers ensured that there was appropriate oversight of caseloads and that manageable caseloads were in place for staff.

Staff received regular formal case supervision and had regular informal consultation with their managers. However, copies of supervision records on individual cases were not always stored on the individual child's record. Therefore, it was not always possible to track how decisions were made or overseen on individual cases.

The majority of closed cases sampled by inspectors were appropriately closed, but inspectors found that some cases were closed prematurely without records being completed. Two cases closed in March and August 2015 respectively were escalated at the end of the fieldwork in January to the area manager as it was not clear that all work had been completed and or documented. The area manager acknowledged that further work was required and subsequently, the cases were reviewed and follow up work assigned. In March 2016, inspectors reviewed these two cases along with a sample of other closed cases, and found that all sampled cases had been appropriately closed. The service had recently introduced procedures for the identification and management of complex cases. These meetings occurred bi-monthly and had defined eligibility criteria that had to be met before cases could be presented. The area manager chaired this forum. Three principal social workers, one team leader and one senior practitioner were members of this group. Inspectors observed the second of these meetings and found that it was a robust forum. There was good discussion on high risk complex cases, fact finding and decision-making about specific cases. This provided staff with clear direction in regard to complex cases.

The criteria and procedure for the transfer of cases internally was bureaucratic and was not the best use of resources. Principal social workers wrote to one another when cases were due to be transferred from the duty intake team to the child protection team. (Cases transferred to the child protection team after a case conference was held and or when a family support plan was in place). Inspectors found that there were some minor

delays between the date of transfer and when a social worker was allocated to work the case.

Interagency cooperation.

The level of interagency co-operation varied. The service had well established links with some agencies and there was good interagency working, but this was not in place with all. Inspectors found that regular meetings were held with some community based organisations providing family support services in the community regarding referrals to their service and the priority of these referrals. Some staff in the area were involved in joint initiatives with the Health Service Executive (HSE) in regard to interventions for young people after a suicide in the community in one county. The area was also a pilot site for 'Hidden Harm' which related to the impact of drug and/or alcohol abuse on families. Some external agencies highlighted that they had good relationships with individual members of staff rather than there being a formal process in place.

There was adequate coordination of cases where multiple agencies were involved for those children who were allocated to a worker. However children who did not have an allocated staff member from the area did not have the same experience. The majority of files sampled of allocated work illustrated that once children had an assigned social worker they generally received integrated services. Meetings were held in relation to individual cases to ensure good communication with partner services. Professionals and agencies attended strategy meetings, professional meetings and family support meetings. Inspectors found that key professionals were invited to attend these meetings and minutes reflected good decision-making processes. Inspectors found examples where children benefited as a result of the input of a range of services, where professionals and families had agreed to work together on a clear plan. However, inspectors found that there were gaps in inter-agency working when cases were not allocated to a social worker. This meant that it was not evident that there was an on-going appropriate exchange of information or co-ordination of services for young people who were awaiting the allocation of a social worker.

There was good quality co-operation with An Garda Síochána. There were regular liason meetings between social work managers and An Garda Síochána. Inspectors observed one of these meetings and found that it was an effective forum for the exchange of information. On individual children's records, as appropriate, it was evident that staff had regular discussions with An Garda Síochána and strategy meetings were held when required, both formally or informally as per Children First (2011). Joint action sheets were completed on some files in relation to the decisions made in meetings between the Gardai and social workers. However, it was not always clear how social workers formally communicated the outcome of their assessment to An Garda Síochána when work was completed on Garda notifications. Inspectors observed that An Garda Síochána were one of the main referrers to the service.

There were established information sharing processes in place regarding alleged adult offenders of abuse who resided in the community and the service had regular meetings with An Garda Síochána and the probation service in relation to these offenders. This forum was an effective mechanism for the exchange of information between these agencies and contributed to the knowledge of the risk they may or may not pose.

Learning

There was no consistent system in place to review, manage and implement the findings of serious incident reviews. Five children had died who had varying levels of current or historical involvement with the service in the previous 24 months. In the 24 months prior to the inspection, ten serious incidents were notified to the national office. Inspectors were provided with a range of reviews including three national panel reviews of child deaths/serious incident, an Ombudsmans report, and two local/internal reviews. However, the recommendations and actions arising from local/internal reviews on specific children and national review panel reports were not effectively disseminated and implemented. Inspectors found that some staff were unaware of child deaths or their review. The quality of the three local/internal review reports varied; two made general recommendations in regard to service delivery but did not comment on the quality of decision making or oversight, while the third review was comprehensive. The area manager told inspectors that she planned to collate the recommendations from all review reports and track their implementation. However, opportunities for learnings both to emphasise good practice and areas for improvements had been missed as no system was in place to review, manage and implement the findings.

Organisational and institutional abuse

Significant risks were identified in the management and oversight of adult retrospective cases of abuse in January 2016. Data submitted to HIQA prior to the initial fieldwork identified that there were 134 cases of retrospective abuse reported to the service in the previous two years. No cases of institutional abuse were identified by the area on the dataset returned, but inspectors found one case of alleged institutional abuse that was awaiting allocation. At the time of the initial fieldwork in January 2016, a new governance group for the management of adult retrospective cases had its first meeting and it was planned that it would meet monthly. The purpose of the group was to implement standardisation of practice, address legal issues and identify training needs.

In January 2016, inspectors found there were significant delays in the service assessing risks in relation to retrospective abuse and there were immediate and high risks that were not dealt with in a timely manner. An internal audit in November 2015 had identified three retrospective cases as requiring the immediate intervention of a social worker, but this had not occurred by January 2016. As a result, inspectors escalated these immediate risks to the area manager. The area manager provided assurances in

early February 2016 that 21 high priority adult cases had also been allocated to social workers, and a new line management arrangement was put in place to provide oversight.

By March 2016, inspectors found some improvements in the management of adult retrospective cases, but further improvements were required. A senior social worker was managing three social workers who were assigned to work specifically with adult retrospective cases. There were improved systems in place to identify, screen, prioritise and review adult retrospective cases. All new referrals were being screened and prioritised by the adult retrospective team. The case lists had been reviewed and were in the process of being validated. Ninety five out of 199 cases were allocated to social workers, and all identified high priority cases were allocated. Inspectors reviewed a sample of these and found that these cases were being actively and appropriately dealt with. All unallocated retrospective cases had been recently reviewed by a senior social worker who was responsible for the ongoing review and management of this waiting list. However when inspectors looked at a sample of cases waiting for the allocation of a social worker that were of low and medium priority levels, they escalated one case to the senior social worker who following review re-prioritised the case from low to high. Inspectors found that these systems were very new and there remained cases, though of lower risk, that continued to be awaiting allocation for a significant period of time.

Theme 3: Leadership, Governance and Management

Effective governance is achieved by planning and directing activities, using good business practices, accountability and integrity. In an effective governance structure, there are clear lines of accountability at individual, team and service levels and all staff working in the service are aware of their responsibilities. Risks to the service as well as to individuals are well managed and the system is subject to a rigorous quality assurance system. Services provided on behalf of the area are robustly monitored.

Summary of inspection findings under Theme 3

Significant changes had occurred in the service's structure, management team and systems over the last 12 months. The service was assigned additional staffing and management resources by the national office of Tusla in 2015 for a defined time to address a large backlog of cases. With the assistance of an external consultant and consultation with staff and management, the service had devised an improvement plan with the objective of restructuring the service again in 2016. Key roles including that of area manager within the current management team were recently appointed on an interim basis and were given the responsibility to lead the service towards further restructuring. At the end of the initial fieldwork in January 2016, the management team faced ongoing challenges specifically in effectively managing their service to ensure that there was appropriate prioritisation and good management of cases awaiting allocation in order to ensure that risks posed to children were assessed in an appropriate and timely manner. By March 2016, the area manager was endeavouring to create stability in the management team and was implementing additional management systems. However, there remained significant challenges in managing cases awaiting allocation.

Statement of purpose

The service had no specific statement of purpose. The area provided a copy of their mission statement dated December 2015 which had a section on the purpose and functions of the service and legislation under which the service operated. However, it did not refer to the regulations or national policies or any specific model of service delivery that operated in the area. It outlined the services provided and the vision and goals of the service.

There was a significant divergence from the purpose and function identified and the day to day operations of the service as some children did not get timely access and therefore their needs were unassessed. Staff were aware of the contents of the mission statement.

Management structures and systems

Management structures in the area had been unstable due to changes in management and the interim filling of posts. There was a defined management structure in place with clear lines of accountability and responsibility. Inspectors found that the line management structure was clear to all staff, and staff across the service were aware of the roles and responsibilities of all grades of staff. Over the course of the previous nine months, the service had three different managers, including the chief operations officer of Tusla. The current interim area manager, who had previously worked as a principal social worker, was appointed in mid October 2015. The area manager was endeavouring to provide good leadership and direction.

A number of senior and middle managers within the area were in interim posts due to vacancies and long term leave. In addition, the principal social worker for duty intake had resigned her position and that position became vacant the day after the fieldwork in January ended. The area manager had identified an interim replacement for this role and also that of social work team leader for duty intake. The follow up fieldwork in March 2016 found that, although on an interim basis, management positions had been filled within a duty office and for the management and oversight of retrospective cases. While these appointments were recent, it was evident that the filling of these management posts or allocation of these responsibilities had impacted positively on the day to day operation of the duty intake and adult retrospective teams.

Staff described that they were accountable to managers in a range of ways, through supervision and performance development and within their day to day practice. Inspectors observed staff teams working diligently and told inspectors of their commitment to their work.

Management systems required further development and improvement. The area manager told inspectors that she attended a due diligence meeting on becoming appointed to her position with the chief operations officer and the regional service director. This had provided an overview of the service and the priorities.

Some new management initiatives had recently been introduced such as the complex management group and the governance of adult cases in the service. However, as they had only been recently implemented, it was premature to assess their overall effectiveness.

There were policies in place to guide practice, but their implementation required greater oversight. While audits had been completed on the implementation of the supervision and the records management policies, the implementation of other policies such as the thresholds policy or caseload management had not been audited. Inspectors found that staff and management were not clear in relation to whether the policy and procedures for responding to allegations of child abuse and neglect had been implemented. For example, one principal social worker told inspectors that there was no appeal process

operational under this policy, while the area manager said that there were currently a number of appeals ongoing.

Not all communication systems were effective. The principal social workers reported regularly to the area manager through informal day to day contact, supervision, management meetings, written communications, measuring the pressure reports and key performance indicators. However during the course of the initial fieldwork inspectors found that there was a breakdown in the accuracy of this reporting system as the area manager did not have accurate information regarding adult cases that were allocated and actively receiving a service by social work staff. As a result there was a discrepancy in the December 2015 figures that were returned to the national office.

The area manager communicated directly to all staff members in December 2015 and provided an overview of objectives for 2016. Staff told inspectors that this update was received positively. Team meetings were occurring regularly throughout the service. Minutes of meetings with the duty intake team showed that recurring issues were raised and that there was a lack of resolution.

Staff at different management grades were aware of their scope of decision-making, but the recording of decisions and their rationale was not always robust. Team leaders did not always sign off on key documents or recommendations, and decision-making was not consistently and clearly recorded on case records. Therefore, it was not always possible to track decision-making on case files. In some cases, inspectors found that managers had signed off cases which were escalated as part of the inspection.

Planning the service

There was a management improvement plan in place which had resulted from an acknowledgement at national level that the service required a comprehensive response in order to improve, but there was no local service plan. It was evident that progress was being made on key areas of the plan such as access to computers for staff, but there were some aspects of the plan that had not commenced and they were directly related to practices such as the differences in closure of cases at intake between the two duty offices.

The area manager had communicated a number of priority areas to staff in December 2015. They were; a reduction of wait lists, the continued development of locally based support services for children and families (through PPFS in partnership with external agencies), participation of children and parents, enhancing the understanding of and promoting child protection within the geographic area and finally to improve and further develop information and data collection systems within the area. These objectives were in line with the Child and Family Agency's corporate plan for 2015-2017 and business plan for 2016. Staff were aware of the service's objectives for 2016. Inspectors found during the initial fieldwork that these priorities had been recently discussed at

management meetings in order for principal social workers to consult with their teams to identify the steps needed to achieve these objectives.

In January 2016, minutes of the area management meeting referred to considering a blitz of low priority cases. At the time of the follow up fieldwork in March, staff from both the duty intake team and child protection teams were assessing selected unallocated cases in the duty intake system. Forty seven families consisting of 92 children were identified to be assessed by social workers during this period.

Risk management

Risk management systems were not robust. A number of significant risks were identified by the inspectors that had either not been identified by the service or were identified but the controls were not effective. Following the initial fieldwork, inspectors escalated a number of unallocated cases that had not been appropriately prioritised and/or had not received timely action, high risk adult retrospective cases that were not actively receiving a service and an inexperienced team of social workers in one duty office. While some of these risks were identified on the risk register, the identified controls had not been successful at reducing the risks.

A regional risk management forum had been recently re-established and the area manager was a member of this group. Inspectors reviewed the minutes of these meetings and found that the terms of reference for the group were in the process of being agreed. The service director told inspectors that one of the priority risks for the region was unallocated cases. Despite this priority area, inspectors found during the course of fieldwork of this inspection, that the monitoring of the risk of unallocated cases was not robust as risk estimation forms were not consistently dated and signed. Therefore, it was not clear that all unallocated cases had been adequately reviewed.

A system was in place in the area to alert national managers of concerns arising from the management of specific cases that may come to public attention. This system was called a 'need to know' procedure. Nineteen 'need to know' reports were escalated from the area to the service director in the 24 months prior to inspection, with six being in the 12 months prior to the inspection. All 'need to knows' fell within the remit of the process. The reports ranged from information regarding court actions to specific concerns in relation to cases. The service director told inspectors that he reviewed all of this information and then decided what was escalated to the national office.

Quality assurance and monitoring

Quality assurance and monitoring processes were evolving within the area. The quality and compliance section of the national office had implemented a number of audits in November and December 2015 to review the area's adherence to internal processes and national standards. Inspectors viewed audit reports of adult retrospective abuse cases, closed cases, a recently concluded CPNS and open cases audit. The audits highlighted some good practice but also raised concerns in relation to specific cases, information systems, and the recording and maintainance of records in the service. However, not all recommendations from the adult retrospective abuse, CPNS and open cases audits were followed up on at the time of the inspection. Inspectors found that some staff were working on identified deficits while other members of staff outlined that they had not received feedback on the audits. As referenced earlier in this report, inspectors escalated two closed cases to the area manager for assurances in relation to the appropriateness of their closures.

In early 2015, external consultants were commissioned by the previous area manager to review some neglect cases and also to review a sample of cases that were on a waiting list in one of the duty intake offices. As a direct response to the outcome of the second review and correspondance with the regional service director and the national office, a quality improvement team was established. This team comprised of social workers and social work managers who were assigned to work through a large backlog of work in one duty intake office during the summer of 2015. A quality improvement plan was developed in September 2015 and this was being used by the area manager and her management team to address a number of deficits. Local audits referenced earlier in this report were confined to record management and supervision audits.

The monitoring and review of service level agreements with procured services had not been robust during 2015. It was evident that the area manager had endeavoured to ensure that 2015 service level agreements were in an appropriate format. There was correspondance on records from the area manager to these procured services requesting performance reports from individual services. However inspectors found, that of the sample reviewed, no quarterly review meetings occurred with organisations as a means of monitoring their adherence to the agreement. In January 2016, inspectors sampled three out of 12 service level agreements and found that there was correspondence on file in regard to agreeing 2016 service level agreements, but they were not yet finalised.

Theme 4: Use of Resources

The effective management and use of available financial and human resources is fundamental to delivering child-centred safe and effective services and supports that meet the needs of children.

Summary of inspection findings under Theme 4

The system in place to plan, deploy and manage resources to protect children and promote their welfare was not entirely robust. The formal analysis of the needs of the entire service area had not been completed and there was no written service plan in place specific to the area. However, an improvement plan was in place that identified resource allocation in specific areas.

Resources

Resources were not always appropriately deployed to deliver on prioritised need and there was no formal needs assessment completed for the area. The service had an extensive improvement plan in place which prioritised actions in terms of resources, organisational design, communication, information systems, business processes and communication. The overall objective of this plan was to transition the service to a new delivery structure in 2016. Areas that required an immediate input in terms of resources were identified such as access to human resource input in the local area and information systems.

Staff told inspectors that when the service was restructured in early 2015 they were given the opportunity to indicate their preference in regards to where they worked in the service. The area manager confirmed this and outlined that most staff worked in their preferred area. However, this process did not ensure that there was a distribution of experienced staff deployed to meet the needs of the service where the need arose. For example, one of the duty intake offices which was responsible for taking in new referrals had a committed young team of social workers but they were the least experienced team throughout the service. The area manager informed inspectors that additional staffing resources and management capacity was approved for 2016 when the area would be re-structured.

A draft needs analysis around family support and prevention services had been completed for part of the area, but a comprehensive analysis for the entire area was not. As referenced earlier in the report, there were delays in developing the Meitheal programme in the area. The area manager told inspectors that there were a limited number of community based services and that the development of supports would take time. It was outlined that in the planned new delivery structure, as an interim measure, family support workers and social care leaders would be based within the PPFS pillar of

the service where they would be able to provide a service to low risk cases. This had commenced at the time of the follow up fieldwork.

The reporting mechanisms in place to manage resources in the area were defined. The area manager reported directly to the service director regarding finances. The area manager had responsibility for discretionary expenditure such as access to private therapy for service users and the creation and review of service level agreements with other agencies. In addition, they had to approve and recommend the provision of private foster or residential care placements to the service director. The principal social worker for duty intake and the principal social worker for child protection were responsible for the gatekeeping of referrals to two external agencies that had service level agreements with the service.

The physical condition of some offices used by the service were unsuitable. Some offices had recently been painted. However, not all offices were accessible to wheelchair users and facilities for meetings with children and families were not optimal throughout the service. The Health and Safety Authority had issued an action plan in regard to one specific office. The service director told inspectors that in his role as director of estates that he was aware of the challenges that existed in the service area and had been in discussions in relation to potential future accommodation options. However, no timeframe was available in regard to this.

Theme 5: Workforce

Each staff member has a key role to play in delivering child-centred, effective and safe services to support children. Children's services recruit and manage their workforce to ensure that staff have the required skills, experience and competencies to respond to the needs of children.

Summary of inspection findings under Theme 5

Generally, staff were recruited in line with best practice. There was a fragility within specific teams as there were inexperienced staff and in January 2016 there was impending staff turnover. Staff felt well supported by their line managers and were provided with regular supervision, but the quality of some supervision records needed to improve. Access to training had improved for staff over the previous 12 month period but not all staff were trained in Children First (2011).

Recruitment

The majority of staff were recruited in accordance with legislation, standards and policies, but not all staff files were up to date. Inspectors reviewed 24 staff files, most of which were paper files. All staff files sampled had appropriate an Garda Síochána vetting. The majority of the files had appropriate references, qualifications, job descriptions and evidence of a probation process. Interim appointments made in the three month period prior to inspection were not recorded on the three staff records. Inspectors found that none of the files sampled had copies of staff registration where appropriate and only some garda vetting had been updated. However, copies of CORU registration were maintained on most supervision records in the local area but there were some gaps. Therefore it was unclear how the service ensured that all social work staff had up to date professional registration which was required in order to work as a social worker.

In January 2016, the area was using 15 agency staff and copies of their registration and qualifications were held locally on their supervision files. The area manager told inspectors that agency staff were interviewed by managers in the service prior to being offered a position. Some of those 15 staff members were undergoing a recruitment process with the Child and Family Agency at the time of the initial fieldwork.

Induction and orientation processes were not consistently followed and/or documented in staff files. Staff told inspectors that they had mixed experiences of the induction process. Some staff said that they were given time to read policies, procedures, and case files prior to having contact with service users, while others told inspectors that they had no induction period. Inspectors reviewed an induction folder that contained key information for working in the service. A small number of new staff were scheduled to complete a formal national induction programme organised through the training

officer. Some more recent staff files had comprehensive induction checklists, while the majority of older files, recorded that staff received staff handbooks, but it was not clear how the majority of staff had been inducted into working in the service.

A comprehensive probation process was completed. In addition to supervision, newly appointed staff met formally with their manager twice in relation to their probation. Some staff files reflected that probation processes were extended on occasions and further training was recommended in others.

Sufficient staff and skill mix

Accessing sufficient experienced social work staff was an ongoing challenge for the service. There were staff vacancies in the area and the majority of these were filled with agency staff. At the time of the initial fieldwork there were imminent staff changes. The area manager told inspectors that the overall staff team had been stable but five social workers were due to leave their posts by the end of January 2016. In addition, the principal social worker for duty intake had resigned her position and was due to finish on the day after the inspection ended. The area manager outlined that there were suitability qualified and experienced staff being appointed on an interim basis for both a team leader and principal social worker position in the duty intake team.

All staff were appropriately qualified for their positions but not all teams had a mix of skilled and experienced staff. The service employed social workers, social care leaders and family support workers. However, inspectors found that one duty team was predominantly made up of inexperienced social workers who had qualified within the last two years. They worked at the first point of children's entry into the service and were dealing with unassessed risk on a daily basis. They reported directly to the principal social worker for duty intake as the interim social work team leader had not commenced in their post. This was the office where one in five of the 53 cases sampled were escalated to the area manager. The fragility and inexperience of this team was also escalated to the national office following the initial fieldwork. As part of the follow up fieldwork, while the general make up of the social work team in this office remained unchanged, an interim team leader had commenced in their post and was available to provide guidance and oversight to the team's work.

Support and supervision

Staff received regular supervision, but the quality of supervision varied. The majority of managers were trained in supervision. Supervision contracts, in line with the national supervision policy, were in place for most staff. A range of issues were discussed at supervision such as individual cases, annual leave, support required and some practice issues. As a result of the direction received at supervision by staff, some children experienced improvements in their lives as social workers completed specific tasks to enhance their situation. Staff told inspectors that they felt supported and that their managers also provided regular informal guidance and support. Managers spoke to inspectors about their commitment to providing regular supervision to their staff.

Professional development was discussed during supervision and the majority of staff had good quality professional development plans which were reviewed on a six monthly basis and training needs were identified for staff members.

Training

Access to training had improved. There was a national work plan in relation to training for 2016, but the 2016 local plan was yet to be finalised. The service area were in the process of completing a training needs analysis. In the interim, the training identified for the staff team for 2016 included attachment training, court skills, signs of safety, assessment framework and hidden harm. Inspectors found that individual training needs were identified for the majority of staff in their professional development plans.

Not all staff had received mandatory training, but staff were positive about the quality of the training that they had received. Data provided to HIQA outlined that approximately 70% of staff had up to date training in Children First (2011). The national training workplan for 2016 indicated that there would be further provision of Children First training throughout the service nationally. Some staff had received training in signs of safety, attachment, business processes, foetal alcohol syndrome and the management of aggression. There was further training in attachment, induction, neglect and Meitheal scheduled for individual staff members. Staff members who were assigned to work with specific service users such as adult perpetrators had attended specialist training abroad.

Theme 6: Use of Information

Quality information and effective information systems are central to improving the quality of services for children. Quality information, which is accurate, complete, legible, relevant, reliable, timely and valid, is an important resource for providers in planning, managing, delivering and monitoring children's services. An information governance framework enables services to ensure all information including personal information is handled securely, efficiently, effectively and in line with legislation. This supports the delivery of child-centred, safe and effective care to children.

Summary of inspection findings under Theme 6

The majority of information systems that operated in the area was poor and not fit for purpose. However, the area had recognised this and were working on having a new information system in place by the end of April 2016. The accessibility of the national CPNS information system on a 24 hour basis was a positive attribute to the service.

The information systems

The CPNS information system was a positive development. However, the other information systems in place were not fit for purpose to support the delivery of a child protection and welfare service. The availability of the national CPNS information system to relevant professionals on a 24 hour basis was identified as an improvement. However, other information was stored on multiple databases in operation throughout the service area, none of which were integrated.

The absence of an integrated information system led to delays in staff accessing information in a timely manner. Staff told inspectors that it could take 45 minutes to determine if a child was known or not to the service, as there were multiple databases that had to be checked. Both the information officer and the area manager were clear that the current information systems were not adequate and informed inspectors that a new information system would be in place by the end of April 2016, while they awaited the introduction of the national childcare information system.

In March 2016 a review of the database for retrospective cases was underway. However, inspectors found a reference in a case file to an alleged perpetrator of abuse that was not listed in the database, and this was brought to the attention of the principal social worker.

In addition, files did not have a unique identified number, so there were risks that there were duplicated files in the system.

Collection and analysis of information

The information system did not assist the management team to have access to quality information. Data was manually gathered on a monthly basis in relation to high, medium and low level prioritised cases allocated, awaiting allocation and the period of time that cases were awaiting allocation. This information was reported on a monthly basis to the regional and national office of the Child and Family Agency.

There were a range of inconsistencies in the service's data. Inspectors found that a database containing a list of closed cases had some open cases listed on it. Therefore the service could not be assured about the integrity of their information. In addition, there were variations in the figures of historical garda notifications. This meant that information stored on numerous databases was not validated and therefore any analysis may be inaccurate.

Record keeping

The quality of records was inconsistent. There was a national records management policy but it was not consistently implemented. For children who had an assigned social worker, their records were of a higher quality than children who were held for a long period of time on the duty system. However, the majority of children did not have an individual file.

The quality of records varied and not all records were held in line with the policy on record management and data protection legislation. Some files were in excellent condition, with clear recording and the necessary documentation on file. However, inspectors reviewed other files that were poorly maintained, with loose sheets of paper, yellow stickers with notes, records not dated or signed, and casenotes not up to date. Key information such as up to date child protection conference minutes were not present in three case files sampled by inspectors and in one of these cases, the minutes for the last two conferences were not on file. Therefore, there could be delays in staff implementing children's plans.

Chronologies were only present on a small number of files reviewed by inspectors. The inclusion of a case chronology may have assisted staff in tracking recurring trends of referrals, repeated initial assessments and re-referrals. The team leaders had begun to highlight the importance of chronologies with staff and inspectors found in a small number of cases, that chronologies were being completed.

The majority of case files reviewed by inspectors were family files. In some of these files, casenotes reflected information about all the family but there were separate sections for individual children with some specific information stored in these sections. However this was not consistently in place as inspectors reviewed files where information on all family members were recorded together. Therefore, it would be difficult for individual children to access their individual information.

In general, children's files were stored securely and a file tracking system was recently introduced. Inspectors observed that, in relation to open cases, children's files were stored in lockable, fire-resistant filing cabinets which were accessible to the case workers. Closed cases were in the process of being microfiched externally by a private company. Some staff told inspectors that there could be a delay in accessing these. However, inspectors requested a small sample of files, and were able to access them in a timely way.

There had been three data breaches in the 24 month period prior to the initial fieldwork. Reviews had been completed into two of these, and recommendations had been implemented, such as staff transporting files in locked briefcases when transporting files out of the office. Inspectors observed staff members adhering to this recommendation.

The majority of parents and children were not aware of how to access their own information. Inspectors observed parents being advised at child protection conferences that they could access professional reports through Freedom of Information requests. This practice was not optimal.

File audits occurred routinely. However, the findings of file audits were not collated for the overall area and therefore patterns or learnings were not identified for improvement throughout the service. While individual file audits did identify issues such as chronologies not being completed on specific files, they did not identify issues such as poorly maintained files and the absence of a unique identifier.

The majority of file audits that inspectors reviewed were held on case files in the child protection and welfare service and only a small number were on duty intake files. The file audits were of good quality and considered record keeping and the general maintenance of the file. They also focussed on specific issues such as whether children were seen, the extent to which children were engaged in the assessment processes and whether or not the children's voices were expressed in records and reports. Individual staff members received feedback from their team leaders on their specific file.