

## Statutory foster care service inspection report

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



<b>Name of service area:</b>	Dublin South West, Kildare, West Wicklow
<b>Dates of inspection:</b>	9-12 September 2019
<b>Number of fieldwork days:</b>	4
<b>Lead inspector:</b>	Tom Flanagan
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<b>Type of inspection:</b>	<input checked="" type="checkbox"/> <b>Announced</b> <input type="checkbox"/> <b>Unannounced</b> <input type="checkbox"/> <b>Full</b> <input checked="" type="checkbox"/> <b>Focused</b>
<b>Fieldwork ID:</b>	<b>MON 0027471</b>

## About the Health Information and Quality Authority (HIQA)

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

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

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

## About monitoring of statutory foster care services

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

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

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

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

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

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

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

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

## 1. Inspection methodology

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

During this inspection, the inspectors evaluated:

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

Inspectors also reviewed actions taken by the area in response to the Thematic Inspection that took place on 6 February 2018 in the following areas:

- assessment and approval of relative foster carers
- support and supervision of foster carers
- foster carer reviews
- the foster care committee.

The key activities of this inspection involved:

- the analysis of data submitted by the area and questionnaires completed by 72 children in care

- home visits to five foster care households
- meeting with or speaking to 10 children in care and with one young adult availing of the aftercare service
- interviews/meetings with the area manager, the service director, the principal social workers for fostering and children in care, the principal social worker for aftercare, the foster care committee chair and the child in care review team leader
- separate focus groups with children in care social workers, social care leaders and child protection social workers, fostering social workers, team leaders for the long-term children in care teams and aftercare workers
- two focus groups with foster carers
- review of the relevant sections of files of 50 children in care as they relate to the theme
- review of the relevant sections of six foster carer files
- review of foster care committee records and review of management meetings records
- phone calls or meetings with or questionnaires from two parents of children in care and two foster carers.

## **Acknowledgements**

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

## **2. Profile of the foster care service**

### **2.1 The Child and Family Agency**

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

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

- child welfare and protection services, including family support services
- existing Family Support Agency responsibilities
- existing National Educational Welfare Board responsibilities
- pre-school inspection services

- domestic, sexual and gender-based violence services.

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

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

## **2.2 Service Area**

According to data published by Tusla in 2018, the Dublin South West, Kildare, West Wicklow service area had a population of children from the ages of 0–17 years of 108,106.\*

The area is under the direction of the service director for the Tusla Dublin Mid-Leinster region and is managed by an area manager. There were two principal social workers in the area, who held responsibility for both the foster care service and the children in care service in two separate geographical locations. The aftercare service was managed by a principal social worker, who also had responsibility for child protection services.

There were seven children in care teams, of which four were based in Dublin and three in County Kildare. The aftercare team was based in Tallaght, Dublin. Child protection teams, who had responsibility for the care of children in care until they were transferred to the children in care teams, were also located throughout the service area.

At the time of the inspection there were 365 children in foster care in the area. Of these, 161 children were placed in relative foster care, one child was in supported lodgings, and 203 children were placed with general foster carers, 44 of whom were placed with private foster carers.

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

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

### 3. Summary of inspection findings

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

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

This is the third inspection of the foster care service in Dublin South West, Kildare, West Wicklow service area since February 2018. The foster care inspection in February 2018 identified major non-compliances and serious risks within the fostering service. The first inspection focused on the standards relating primarily to foster carers, such as assessments and reviews of foster carers, supervision and support, allegations and serious concerns made against foster carers and the foster carer committee.

The second inspection in November 2018 was a follow-up inspection that focused on the standards where the area was judged to be non-compliant moderate or major in the previous inspection. The findings of the November 2018 inspection found that significant risks remained in the area in relation to unallocated foster carers, assessments of relative carers and reviews of foster carers.

This area shares its foster carer committee with another service area. During an inspection in the other service area, the inspector identified risks regarding a Dublin South West, Kildare, West Wicklow case and, as a result, wrote to the area manager in March 2019. HIQA included a review of aspects of the foster care committee during this inspection in relation to approval of relative carers and tracking of the implementation foster care committee recommendations.

Due to the level of risks remaining in relation to the management of unallocated foster care cases, the delay in completing relative assessments, the backlog of foster carer reviews and the functioning of the foster care committee, HIQA decided to include these issues in this inspection. The findings in relation to the follow up on these issues are included in section 6 of this report.

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

- one standard was compliant
- one standard was substantially compliant
- four standards were non-compliant, all of which were moderate non-compliant.

Children who met or spoke with inspectors felt safe and were happy and well cared for in their placements. Of 70 children who answered the question of whether or not they see enough of their family and friends, 49 (70%) said they did, 13 (19%) said "sometimes", while 8 (11%) said that they did not. Children spoke warmly about their foster carers, and children who had an allocated social worker spoke positively about them. However, 12 children who responded to questionnaires said that they did not have a social worker.

The area had forums in place to identify children with disabilities and or complex needs and to ensure that long-term planning for these children began as early as possible. When there were delays in the provision of community services for these children, the area funded private assessments and therapeutic supports.

While over four out of five children in care had an allocated social worker, almost one in five children did not. This meant that these children did not have a consistent social worker with whom to develop a relationship of trust over time. The area had recruited a number of new social workers during 2019 and expected that more children would have an allocated social worker by the end of 2019. Statutory visits had not been carried out in line with regulations during the two years prior to this inspection. At the end of the inspection, there were a small number of children who had not been visited by a social worker within the previous six months. Inspectors wrote to the area manager and received an assurance that each of these children had been visited since the inspection. While there was evidence of case management on allocated cases, there was insufficient evidence of adequate oversight of unallocated cases by way of regular review of the cases.

Some children were living in other areas of the country for sufficiently long periods to have their care transferred there; however, this had not happened in a timely way. A large number of children stated that their social worker had not explained to them how to make a complaint, and children's verbal or informal complaints were not recorded on the area log and were not analysed for trends and for learning purposes. The quality of record-keeping in some children's files was either poor or in need of improvement.

Assessments of need were carried out on all children placed in foster care and were of good quality. There were systems in place to ensure that comprehensive assessments of need were undertaken and that children had medical examinations upon admission to care.

There was a system in place for ensuring that children whose child in care reviews were due were prioritised and that child in care reviews took place for children who did not have an allocated social worker. While managers told inspectors that considerable progress had been made to ensure that reviews took place in a timely manner, there were 34 children whose child in care reviews were overdue at the time of inspection. Inspectors observed one review meeting and examined the minutes of others. All aspects of the children's care were reviewed, there was input from all relevant parties and consultation with children prior to their child in care reviews was evident. While children did not routinely attend child in care reviews, their views were sought and represented. Children reported that they were encouraged to attend by their families and social workers.

There were also 34 care plans which were not up to date. While the quality of care plans varied, the majority (93%) of care plans reviewed by inspectors recorded consideration of all of the children's care needs. Placement plans had not been developed in the area prior to this inspection.

Inspectors found that the voluntary consent provided by parents regarding their children's admission to care were regularly reviewed and updated. However, in 15 cases reviewed, children were in their placements for more than two years but there was no evidence of plans to seek care orders for these children or discussion about whether the children's placements needed to be made more secure.

The area attempted to ensure that children were placed with foster carers who could meet their particular needs, but records of the matching process were not routinely maintained on the children's files. The area had not quantified the number of children awaiting approval of a long-term placement, and there was no plan in place to address the backlog that may have built up.

Social workers were committed to ensure that children were protected from all forms of abuse. There was good management and oversight of complaints, concerns and allegations against foster carers; however, the tracking of child protection and welfare concerns against people other than the children's foster carers required improvement. Social workers put safety plans in place to protect children, but there was no system of standardised safety plans to ensure that all elements of a good safety plan were in place and to assist with oversight of their implementation.

Inspectors found that not all foster carers were trained in their responsibilities as mandated persons under the legislation.

The aftercare service was not fully resourced to be able to provide a timely and comprehensive service. There were insufficient aftercare workers to enable the aftercare team to allocate an aftercare worker to all children and young people who were assessed as needing an aftercare worker. While children leaving care had their needs assessed and had aftercare plans in place, not all children had an aftercare plan by the age of 17 and a half years old. The aftercare manager's post was vacant, and an annual report on the adequacy of the service was not developed. There was no mechanism, such as exit interviews, for seeking regular feedback from children and young people about the quality of the service.

There were some improvements in the management of unallocated cases but inspectors found that management systems did not support good oversight by senior managers in relation to all unallocated foster carers. There were two different systems in place and, while cases that were audited received appropriate follow up, there was no overarching system to ensure oversight of the remaining unallocated cases. The number of unallocated and dual unallocated cases had reduced since the last inspection, and there was potential for this to reduce further once staff in the area gain more experience. The area had established a third fostering team and transferred unallocated cases to balance the risk across the service. A review of two unallocated carers' files showed that the audit undertaken was effective, as it had ensured they received visits from a duty social worker.

While assessments were increasingly outsourced to a private fostering service, there continued to be significant delays in the assessment of relative carers. This issue was escalated to the service director for assurance and the response provided was satisfactory.

Insufficient progress had been made in relation to foster carer reviews since the last inspection; however, there was a plan for a dedicated team leader and two social workers to work on foster carer reviews from October 2019. One social worker was in post and working on reviews at the time of inspection. One principal social worker estimated that, with these resources in place, the area would take a further 13 months to get all foster carer reviews up to date.

The foster care committee had introduced a system to track the implementation its recommendations and improved their filing system since the inspection in February 2018. However, issues remained in relation to the committee's ability to track the implementation of issues identified by the committee because issues were not consistently recorded as specific recommendations. A further issue identified by this

inspection was that the committee approved relative foster carers without undertaking basic training.

This area is now subject to a service improvement plan, which has been put in place by Tusla National Office. HIQA received a copy of the service improvement plan on 16 September 2019. While most of the actions relate specifically to the child protection service and focus on trying to reduce the numbers of unallocated cases, aspects of the plan such as workforce development and resourcing may also have an impact on the children in care and fostering services in the area.

Issues outlined above and other issues identified during the inspection are contained in the action plan, which can be found at the end of this report. These actions, along with the outstanding actions from the previous inspections and the actions outlined in the area service improvement plan will continue to be monitored as part of HIQA's regulatory activity.

## 4. Summary of judgments under each standard and or regulation

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

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

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

## What children told us and what inspectors observed

During the inspection, inspectors spoke with 10 children living in foster care in the area. Inspectors also met with one young adult availing of the aftercare service. Furthermore, inspectors received 72 completed questionnaires from children living in foster care.

Children told inspectors about the things they liked about living in foster care:

- "They are very nice and special."
- "They support and understand me. They supply me with my favourite chocolate biscuits. They're the best."
- "They're nice they look after us and we have our own rooms. We go on days out we have nice friends, we love the dogs, go on holidays. My foster family and my real family get on really well. I love everything."
- "They give me the love and things I need, they love me and are kind to me when I want to talk to them about stuff."
- "I like the way I am treated. I am loved for and cared for equally. I feel like a member of the family. I am supported to go and see my birth mam. I am encouraged to do things to the best of my ability."
- "Everything they are my parents."
- "I am really happy in my foster care and I feel safe."

Children told the inspectors that they liked living with their siblings, going to the playground, their dogs and "hanging out with friends".

Children said that they liked their house, garden, and bedroom; nice dinners; going on "days out"; their school; and contact with their birth families. Children also talked about some of the activities they loved doing, such as going on holidays, camping, singing, dancing, doing make-up, playing soccer on their local team, playing computer games and going to the cinema.

Children also told inspectors some hard things about living in foster care:

- "Mostly I am bored."
- "That the (social worker) should try more to prepare me for home and listen to me."
- "Going to school isn't easy and it's sad you only get like one and a half hours to see your mam."
- "My family don't keep in contact with me."

Of the children who had completed questionnaires, 50 indicated that they had an allocated social worker, 12 children said that they did not have a social worker and 10 children did not respond to this question. Thirty one children responded that their social worker visits them regularly in their foster home and outside the home, 15 children replied that they were not visited regularly, and 19 replied that their social worker visits them "sometimes".

The majority of children who had an allocated social worker were positive about their social workers. Children said:

- "She is nice."
- "My social worker is very good to me. She knows me very well."
- "She is a nice person."
- "My social worker is very nice. She's a nice talker I must say!"

Some children wrote or said things about their care that could be better:

- "I would like to have a full time social worker."
- "Don't see much of social worker, an odd phone call to facilitate supervised access..."
- "I haven't had a social worker for almost two years. I have just been allocated a new one this week..."
- "I wish the social worker could let us see our family more."
- "I don't have one [a social worker]."

Out of the 72 questionnaire respondents, 55 said they had a care plan and six children said they did not have a care plan. Nine children said that they did not know if they had a care plan. Out of the 72 children who completed the questionnaire, 50 said that they felt listened to by their social worker, while six children said they did not feel listened to. Six children replied that they sometimes felt listened to and four children were unsure.

Out of the 72 children who responded to the questionnaire, 39 children replied that they had attended or been invited to their child in care review. Some children who spoke to the inspector indicated that they had been asked to attend their child in care review meeting but had chosen not to attend.

Of the 72 children who completed the questionnaire, 42 said that someone does talk to them about the decisions made at the child in care review meeting, 10 children said they did not know and 12 children said no one talked to them about the decisions made in their child in care review.

Of the 72 children who answered the question on whether or not they see enough of their birth family and friends, 49 indicated they did, 13 said "sometimes", while eight said that they did not.

Ten young people over the age of 16 responded to the questionnaire. Six of these replied that they had an aftercare plan. One young person responded that they did not have an after care plan and three of the respondents said they did not know if they had an aftercare plan. It is possible that the young person who did not have an aftercare plan and the three who did not know if they had an aftercare plan may not have reached the age of 17 and a half, by which time aftercare plans should be in place.

The six young people who had an aftercare plan said that their aftercare worker listened to them, while one young person responded that they did not feel listened to. Of the 10 young people who completed the questionnaire, 7 said they knew what money they were entitled to. Two said they said they did not know what their financial entitlements were and one young person did not respond to this question.

## 5. Findings and judgments

### Theme 2: Safe and Effective Services

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

### Standard 5: The child and family social worker

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

### Summary of inspection findings under Standard 5

Data provided by the area prior to the inspection showed that, of 365 children in care in the foster care service, 294 (81%) had an allocated social worker while 71 (19%) did not have an allocated social worker. Seven (2%) of the children who did not have an allocated social worker were living in foster placements where the foster carers did not have an allocated link social worker (dual-unallocated).

Data provided to inspectors showed that there were three social work posts vacant and that one of the child in care teams did not have a team leader. The area manager told inspectors that the area had been allocated an extra 32 posts some years ago under the Tusla resource allocation model but that not all of these posts had been filled and the area had ongoing difficulties in recruiting staff. The area recruited seven social workers in 2019 for children in care and fostering teams. Eight agency staff were employed, some of whom had since been made permanent Tusla employees. The area manager told inspectors that, due to delays in registering newly-qualified social workers nationally, five newly-recruited social workers in the children in care teams were designated as "project workers" pending their registration as social workers. They functioned as allocated workers and were given protected caseloads, which meant that they worked with a smaller number of children for a period of time. The principal social workers told inspectors that, for the first time, the child in care teams in the Dublin part of the area were approaching full staffing levels and that they anticipated a drop in the number of unallocated cases by the end of 2019 as the newly-qualified social workers began to take on larger caseloads.

Seventy-one children did not have an allocated social worker and, in seven of these cases, the foster carers did not have link social workers, meaning that the cases were dual-unallocated. Inspectors found that cases where there was high risk or children had complex needs were prioritised for allocation of social workers. The area had oversight arrangements in place at the time of inspection to ensure that key up-to-date information was maintained in relation to all children in care. Social work team leaders maintained their own database of children allocated to their teams. The information included the dates of child in care reviews, care plans, and statutory visits. Social work team leaders told inspectors that they checked for updates in their supervision sessions with social workers. This information was transferred onto a database on a shared server and discussed at monthly child in care management meetings. The overall database was used at quarterly statistic meetings in order to identify children who required a statutory visit and to ensure that particular members of the team were delegated to undertake the visit to children who were unallocated. The principal social workers told inspectors that the teams had worked hard during the previous year to reduce the backlog of statutory visits and ensure that all children in care had an up-to-date statutory visit but that,

because of the shortage of staff, they had not been able to keep up to date with these visits. He stated that, with increased staffing in place, he was optimistic that statutory visits could now be maintained in line with regulations.

Inspectors reviewed the files of four children in dual-unallocated households. All were in stable long-term placements, their child in care reviews and care plans were up to date and each had had recent visits by a social worker. While there was no evidence of outstanding issues or risks that needed to be addressed in these cases, the practice of having both children and foster carers in the same household unallocated did not ensure that adequate safeguarding arrangements were in place, and it was not in line with the regulations.

There was evidence that, when children had an allocated social worker, the social workers were actively involved in implementing the children's care plans. For example, there was good coordination of services for children with diagnosed disabilities and or illnesses. Inspectors reviewed the files of seven children and found that all, except one, had an allocated social worker and, in that case, the social work team leader maintained oversight of the case. In both the Dublin South West and the Kildare, West Wicklow parts of the area, there were systems in place for social workers to identify children with disabilities at an early stage and for the cases of these children to be discussed at multidisciplinary forums. Social workers told inspectors that there were delays in children accessing specialist services; however, the area manager and principal social workers told inspectors that the area often funded private assessments or services for children who required them. Inspectors found that this was evident in the children's files. In two of the files reviewed by inspectors, there was evidence of very good practice in relation to children with disabilities. In a focus group, one foster carer told inspectors that they were caring for a child with disabilities and that the child had a consistent social worker for several years and child was provided with the multidisciplinary services they required.

In a focus group, five foster carers described mixed experience of social workers allocation and involvement. Three foster carers told inspectors that the children in their care had social workers and they visited regularly. One described social workers as "knowing their child very well" and being "on the ball". Two foster carers told inspectors that some children in their care had no social workers but one child had recently been allocated a social worker. One foster carer said that having an allocated social worker had made a big difference to the child and that children in care "need a sounding board" and that social workers provided this opportunity to a child.

The quality of statutory visits in the area was mixed. The majority, 50 (74%) of 68 children who completed questionnaires, said that their social worker visited them regularly or sometimes visited them regularly. Many of these children had very positive things to say about their social workers. In 9 of 23 files reviewed for this purpose, inspectors found that statutory visits were carried out regularly and there was good evidence of social workers visiting children in their foster homes and of seeing the children on their own. There was evidence that social workers followed up on actions arising from their visits and implemented the children's care plans. In 14 of these files, the statutory visits were judged to be poor, mainly due to the lack of frequency with which visits took place. Fifteen (22%) of children who completed questionnaires said that their social worker did not visit regularly, with 20 (30%) saying that their social worker did not meet them on their own.

Data provided to inspectors prior to the inspection showed that there were 45 children who had not been visited by a social worker in line with regulations. By the time of inspection, the area provided an update on this data and indicated that this number was down to five children who had not been visited in line with the regulations. After the inspection, inspectors sought and received assurances from the area manager that all of the five children had been visited by a social worker since the inspection. Inspectors reviewed 25 children's files to examine whether or not the statutory visits to the children during the two years prior to the inspection were in line with regulations, and they found that statutory visits were not in line with regulations in 19 of the 25 files reviewed. In four of the files reviewed, inspectors found that there were gaps between statutory visits of between 12 and 19 months during the previous two years.

The recording of statutory visits was of mixed quality. The records of some statutory visits viewed by inspectors were on standardised forms while others were in case notes. The area manager told inspectors that, as of mid-2018, all statutory visits were recorded on standardised forms. The records on these forms reflected good quality visits. The records were detailed and comprehensive. Use of the standardised form prompted a social worker to record whether or not they had seen the child in private and whether or not they had given the child information on complaints. In cases where few records of statutory visits were available on file or where records of visits were available on paper files but not on the electronic system, it was necessary for inspectors to seek assurances from team leaders and social workers that visits had been undertaken. These assurances were provided and paper records of visits were provided.

During the inspection, the principal social worker in the Kildare, West Wicklow area told inspectors of good practice in relation to an initiative for children in care in the

area. A group of children in care, facilitated by five members of one social work team, held regular meetings and took part in several social events, and some members of the group attended an international conference of children in care.

Social workers maintained links with the children's families. This was clear in 21 of 24 files reviewed for this purpose. Seventeen of these children had an allocated social worker while seven did not. Plans for contact between children and their families were outlined in the care plans and, in many cases, contact visits were facilitated by social workers or access workers, who met the families in this context. In their questionnaire responses, 43 (67%) of 64 children who answered the question said that their social worker kept in contact with their family and made sure that they got to see them regularly. Eight (13%) children said that this happened sometimes while 13 (20%) children said that they did not.

Social workers responded well to significant events involving children in care, such as when children went missing from care. Data provided by the area indicated that there had been 10 notifications of children missing from care in the 12 months prior to the inspection. Inspectors reviewed the files of two children, each of whom had been missing from care on a number of occasions. Social workers followed the missing from care policy and liaised appropriately with An Garda Síochána (police) and the foster carers. Parents were also notified, when appropriate. Social workers took appropriate measures to ensure the safety of the children, and absence management plans were put in place or updated. There was evidence that the needs of the children concerned were considered in how these events were managed.

An issue that had not been addressed in a satisfactory way by the area was, where children were living in other Tusla areas for several years, the responsibility for their care had not transferred to the areas in which they lived. Data provided by the area showed that there were four children awaiting transfer outside of the area and four children awaiting transfer into the area. However, the principal social worker for the Dublin part of the area had identified 25 children who lived outside the area and whose care should be transferred. The area manager told inspectors that these transfers should have happened but that the area's finite resources had been focussed on the priority of child in care reviews to date and that consideration was being given to re-allocating resources to enable these transfers to be completed in the short term. She also told inspectors that, while some children were placed outside the area, they lived in close proximity to their area of origin and that, in cases where a sibling group was in care but one of that family was placed outside the area, it was not always in the best interests of that child to transfer case management responsibility to another area. The service director was also aware that the issue of case transfers needed to be prioritised.

Inspectors reviewed the files of two of the four children awaiting transfer. Both children had allocated social workers, and there was evidence that the social workers followed up on issues arising for these children. However, while both children had recent statutory visits, there were long gaps between visits during the previous two years. In the case of one child, the issue of a long-term match had been discussed at a child in care review in March 2018 and again at the child's review in 2019 but the long-term match had still not been completed at the time of this inspection.

Data provided by the area showed that there were no complaints made by children during the previous 12 months. Social work team leaders told inspectors that on-line training was provided to members of all the social work teams on how to manage complaints and that complaints were dealt with at the lowest possible level. They said that verbal/informal complaints by children may be recorded in case notes but would not be recorded as complaints on the area complaints log. As inspectors did not find any complaints by children recorded in the files reviewed, it was not possible to tell if the complaints process was user-friendly for children. The recording template used by social workers to record statutory visits included a section on discussion of the complaints process by the social worker with the child. It was clear in two files reviewed that the children wrote in their child in care review forms that their social workers had spoken to them about complaints. In the questionnaires submitted by children, 40 of 66 children who answered the question said that their social worker explained how to make a complaint if they were not happy with something while 26 said that their social worker had not. Moreover, the area did not record verbal/informal complaints as complaints, which meant that they had no way of tracking and trending issues of dissatisfaction with the service that may be arising for children in care in the area.

Tusla's National Child Care Information system (NCCIS) for recording children's information was implemented in the area in July 2018. The area manager told inspectors that the NCCIS user liaison officer post was vacant for the first six months and not filled until January 2019. As a result, the NCCIS system was not as well embedded in the area as in other Tusla areas. The area used both paper files and the electronic system for recording children's information. The area manager told inspectors that NCCIS was discussed at the area management meetings and that issues on the agenda included the influx of new staff and their need for training in NCCIS, the need for refresher training for other staff, and the need for up-skilling of the principal social workers in relation to generating reports.

Inspectors found evidence of good record keeping in 20 (59%) of 34 files reviewed for this purpose. The records were comprehensive and easily accessible. However,

the quality was judged to be in need of improvement in 14 (41%) of the files reviewed. Inspectors found that there were long gaps in records, not all case notes had been uploaded in some cases and it was difficult to locate some records on the electronic system as there was no naming convention to ensure consistency throughout the files. There was no standardised case chronology template in use in the area. Information such as the number of social workers previously allocated to a child was not easily accessible. Significant events in the child's life were not recorded in a systematic way and, as a result, this information was not easily retrievable or accessible in a timely manner from the files.

While the area had recruited new social workers in the current year, almost one in five children in care did not have an allocated social worker. Oversight of unallocated cases required improvement. The quality of statutory visits was mixed, and statutory visits were not carried as frequently as required by the regulations. A large number of children were not receiving social work services from the areas in which they now lived. A large number of children stated that their social worker had not explained to them how to make a complaint. Verbal or informal complaints by children were not recorded on the area log and were not analysed for trends and for learning purposes. The quality of record-keeping in some children's files was either poor or in need of improvement. For these reasons, the area was judged to be in moderate non-compliance with the standard.

**Judgment: Non-compliant moderate**

**Standard 6: Assessment of children and young people**

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

**Summary of inspection findings under Standard 6**

Social workers carried out assessments of the needs of children placed in foster care. There was no stand-alone assessment of need document on which to clearly record the outcome of the assessment and to outline any unmet needs. Instead, children's needs were recorded on a variety of documents, including initial assessments, care plans and social work reports for court or child protection conferences. The way in which an assessment of need was recorded depended on

whether the admission of the child was a planned admission, an emergency admission or a change of placement.

According to data provided by the area, 121 children were admitted to foster care in the 24 months prior to this inspection, 37 of whom were placed following an emergency care order or under Section 12 of the legislation. Forty-two children had experienced a change of placement during that time.

Inspectors sampled the files of seven children for the purpose of examining the quality of needs assessments. All of these children had been received into care or moved placement within the 12 months of the inspection. The assessments of need were generally of good quality. They were comprehensive and included the input of other disciplines when this was required. Where appropriate, the children and their families participated in the assessments. There was also evidence that social workers ensured that children had medical examinations upon admission to care, although the medical examination was outstanding in the case of one child who had been admitted six weeks prior to the inspection. When the health needs of children required specialist assessment, social workers requested that the Health Service Executive carry out an assessment as soon as possible.

Inspectors reviewed the files of five children admitted to care in an emergency. Court reports contained good detail on the children's circumstances and the initial assessment of their needs. The comprehensive assessments of need to inform the children's care plans were begun immediately after the children were received into care. Furthermore, child in care reviews were held approximately eight weeks after admission; however, this was not as timely for two children, whose reviews did not take place until they were three months in care.

In the case of children whose admission to care or change of placement was planned, their assessments of need were completed prior to their placements and these assessments were comprehensive. In one case of a planned placement, there was evidence that the child and their parent were consulted about the proposed placement and the merits of the proposed placement were teased out with them. In another case, where the child had complex medical needs, the assessments that informed the decision on the most appropriate placement for the child were set out in a number of reports from specialists involved in the child's care.

Assessments of need were carried out on all children placed in foster care and were of good quality. There were systems in place to ensure that comprehensive assessments of need were undertaken and that children had medical examinations upon admission to care. For this reason, the area was judged to be compliant with this standard.

**Judgment: Compliant****Standard 7: Care planning and review**

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

**Summary of inspection findings under Standard 7**

Care planning and reviews for children in care required improvement within the area. Managers were aware of this, and interventions to address these deficits had begun to be implemented prior to this inspection. Inspectors found that, while the majority of children had an up-to-date care plan, care planning and reviews were not taking place within statutory timeframes for all children.

Data provided by the area prior to inspection indicated that 34 child in care reviews were overdue. The management team within the area had implemented a number of measures in an effort to improve compliance with statutory requirements in relation to reviews of children's care. The current independent chairperson for child in care reviews in the area took up her post in April 2018, and a priority objective of her role was to address the backlog of child in care reviews which existed. Quarterly management meetings were established to review progress in relation to statutory requirements such as child in care reviews and statutory visits to children. The independent chairperson took responsibility for chairing particular child in care reviews. Social workers and social work team leaders were responsible for scheduling the other child in care reviews which were not prioritised for completion by the independent chairperson and for completing the required preparation for child in care reviews.

The independent chairperson for child in care reviews told inspectors that individual children were prioritised by social work team leaders within their teams and their cases presented for discussion during quarterly management meetings. Prioritisation

of children for reviews was based on their individual circumstances and the length of time the review was overdue. Apart from attending quarterly management meetings, the independent chairperson also coordinated reviews, which included making contact with relevant people and scheduling the reviews prioritised at the quarterly meetings. She told inspectors that, while she took responsibility for ensuring all relevant people were invited to attend and contribute at reviews, social work team leaders along with principal social workers had responsibility, following reviews, to follow up on the agreed actions and ensure that they were implemented. She told inspectors that, when children were not allocated a social worker but identified as a priority for review, they were then allocated to a member of the team who completed the preparation for the review, attended the review and took responsibility, following the review, to share information with relevant people where necessary.

Social work team leaders told inspectors that they updated an electronic database which was in place for tracking all statutory requirements on a monthly basis. This database included information about care planning and child in care reviews. It was accessible to social work team leaders and overseen by principal social workers. Inspectors viewed printed extracts from this database, which the principal social workers told inspectors was monitored regularly and kept up to date as an additional safeguard to ensure that children, whose reviews, care plans or visits were out of date, were identified and prioritised for intervention to address these issues. They told inspectors that the scheduling of child in care reviews was discussed during supervision with allocated social workers and, in cases where children did not have an allocated social worker, they allocated responsibility to a team member to complete required work. Social work team leaders said that, often, this could be a social care leader or member of staff from the fostering team who were familiar with a child and their family. Social work team leaders spoke highly of the team work amongst various teams in the area and said that it was common practice in the area for members of the fostering or child protection teams who are familiar with a family, and or who have capacity to do so, to assist the children in care team to complete child in care reviews and update children's care plans, if required, where a child was awaiting allocation.

Child in care reviews were generally of good quality. In the majority of child in care review minutes examined, 24 of 27 (89%), it was evident that there was input from all relevant parties and good consideration of the children's needs. Children's health, education and placement needs were reviewed routinely as well as supports in place and arrangements for family contact. In all cases, inspectors found that children were consulted and involved in the review process, where appropriate. However,

inspectors reviewed 27 files for timeliness of child in care reviews and found that 17 (63%) had not been completed within timeframes required by regulations.

When significant events arose which threatened a child's placement or when a child's placement had ended unexpectedly, strategy meetings and or professionals meetings were routinely and promptly convened. Planning for and oversight of such cases were prioritised; however, child in care reviews were not always undertaken. Data provided by the service area indicated that in the 12 months prior to the inspection only five of the nine placements which ended in an unplanned way had been subject to a child in care review following the unplanned ending. In addition to these, six reviews were undertaken where there was a risk of placement breakdown in the 12 months prior to inspection.

As part of this inspection, children's experience of child in care reviews and care planning were sought through questionnaires, which were sent to all children in foster care in the service area. Of 64 children who completed the section of the questionnaire in relation to care planning and reviews, 39 (61%) said that they had either attended or been invited to attend their child in care review, while 25 (39%) said that they had not. Of 66 children who responded to the question of whether or not they felt listened to, 56 (85%) said 'yes' or 'sometimes', 4 (5%) children answered 'don't know' and 6 (10%) children said that they did not feel listened to.

Sixty-five children who completed questionnaires in relation to the outcomes of their child in care reviews answered the question of whether or not decisions from reviews were explained to them by their social worker. Forty-three (66%) said that decisions were explained, 12 (18%) said that they were not, and 10 (15%) answered 'don't know'. In a focus group, foster carers described mixed experiences regarding the outcomes of child in care reviews. One foster care said that they always received the care plan and two said they do not always receive the children's care plans. Two others said that they did not receive the most recent care plans, and one of these foster carers said that they had never received a copy of the child's care plan. Inspectors found that, in the files reviewed, there was a lack of evidence that decisions taken in reviews were communicated to children and that copies of the care plans were distributed to the relevant parties to the reviews.

Care plans were of good quality but not all were up to date. Inspectors reviewed 27 care plans and found that 24 of 27 (89%) were up to date. In two of these three cases, where care plans had not been updated as required, children's child in care reviews had taken place in the week prior to inspection and the process of updating care plans for these children was in progress. As care plans were updated as part of the child in care review process, the failure to carry out child in care reviews in line

with the timeframes set out in the regulations meant that not all care plans had been reviewed as required in the two years prior to inspection. Of 27 care plans examined, 10 (37%) had not been updated in line with statutory requirements. While these findings demonstrate non-compliance with statutory requirements in relation to the care planning and review for children in care, improvements were evident and interventions which were proving to be effective had been put in place prior to this inspection by senior management to address delays.

In 25 (93%) of 27 care plans reviewed, there was good consideration of children's care needs, including family contact, education, health, and other supports such as specific supports for children with additional needs or children with a disability. The suitability of foster care placements to meet the children's needs was also considered. In two (7%) care plans, arrangements for family contact, and decisions and the timeframes for actions were not set out clearly.

Inspectors observed one child in care review, which was attended by the child's parents, an allocated social care worker, a social work team leader, a fostering link worker and foster carers. The review covered the main aspects of the child's care, including long-term care needs. The views of the child's parents were sought and the social worker, who had recently been allocated, provided updated information from the child's school. Decisions were agreed and specific people were given responsibility for implementing actions according to clear timeframes. It was noted during the review that the child did not wish to attend and their views were represented by their parent and foster carer.

Children who had complex needs and or a disability received specialist supports as required. Inspectors reviewed files of 13 children with varying levels of disability for the purpose of examining the quality of care planning and review. Inspectors found that there was good quality care planning, co-ordination of services and review of children's needs in all cases. Specifically, in the cases of three children who were over the age of 16, inspectors found that the children were supported to develop their independent living skills and prepare for leaving care as required.

Twenty of 50 (40%) of files examined during the course of this inspection were related to children in care under the voluntary consent of their parents. Inspectors found that voluntary consents were regularly reviewed and updated. However, in 15 of 20 (75%) cases reviewed, children were in their placements for more than two years but there was no evidence of plans to seek care orders for these children or discussion about whether their care status should be made more secure.

Placement plans were not completed as required under the standards. The development of placement plans is a key feature of the standard on care planning and review and a key social work task following the admission of a child to care. A placement plan should outline the specific needs of a child in their current placement and set out the way in which a child's needs will be met day to day and the way in which the placement will contribute to meeting the child's needs as outlined in their care plan. Of 23 files reviewed for the purpose of examining placement plans, none had a placement plan on file. The area manager told inspectors that a memo had been issued to all social workers on 5<sup>th</sup> September 2019 regarding an implementation plan for placement plans. According to this plan, all children admitted to care from the 1<sup>st</sup> October 2019 would have a placement plan and all other children in care would have a placement plan developed at their next child in care review or when they moved placement.

Although the system to ensure that care planning and reviews were timely had been prioritised for improvement and progress was evident, data provided by the area showed that there were 34 child in care reviews overdue and 34 care plans that were not up to date. Placement plans had not been developed as required. The practice of communicating decisions taken in reviews to children and the distribution of updated care plans to foster carers required improvement. A significant number of children were in their placements for over two years with the voluntary consent of their parents, and there was no evidence of plans to seek care orders for these children. For these reasons, the area was judged to be in moderate non-compliance with this standard.

### **Judgment: Non-compliant Moderate**

#### **Standard 8: Matching carers with children and young people**

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

### **Summary of inspection findings under Standard 8**

The area tried to ensure that children were matched with foster carers who had the capacity to meet their needs and there was a matching process in place. Children who met inspectors either said that they were very happy in their foster home or they appeared to inspectors to be happy and relaxed there. Children who completed questionnaires made very positive comments about their foster carers, their placements and the way in which they were looked after. Given the large number of

children in care, there was also a low incidence of placement breakdowns reported in the 12 months prior to the inspection. There was a backlog of long-term matching and the number of children who required a long-term match had not been established.

Child in care social workers told inspectors that, when foster placements were required for children, they considered the children's extended family in the first place to see if a relative placement was possible. There was a process in place for child in care social workers and fostering social workers to carry out a joint assessment of the proposed relative placement in order to determine whether or not the placement was likely to meet the child's needs. In all, 161 (44%) of the 365 children were placed with relative carers who had familiarity with the children and their backgrounds.

If a relative placement was not possible, child in care social workers submitted a placement request form and a profile of the child to the fostering social work team. Fostering social workers told inspectors that they maintained a list of foster carers who had the capacity to provide a placement and that they considered these potential placements in the light of the child's needs and the experience and capacity of the foster carers. If no suitable match was identified in the area, the fostering social workers considered alternative Tusla placements outside the area before contacting private providers who may be in a position to offer a suitable placement.

Fostering link workers operated a duty system in each of the three offices in which they were based in order that placement requests could be followed up quickly. As there was no matching committee in the area, inspectors requested evidence of matching of children with foster carers. The principal social worker and fostering team leader told inspectors that no central record of matching was maintained and that much of the work done by fostering social workers to arrange suitable matches for children was not recorded. While, in general, evidence of matching was not recorded on children's files, they told inspectors that there was some evidence of matching on some children's files. Inspectors reviewed the files of six children where there was evidence of matching on file. In one case, where the child had complex medical needs, social workers visited the proposed placement and were guided by medical practitioners in relation to certain requirements of the placement. In another case, the suitability of the proposed foster placement was discussed at a multidisciplinary meeting prior to the placement being made. There was also evidence of discussions with foster carers regarding their ability to meet the child's needs.

The area did not have sufficient numbers of foster carers to place children within the area. Data provided to inspectors prior to this inspection showed that, of 365 children in foster care, 44 children were in private foster care, 33 of these outside the area. Sixty-seven other children were placed outside the area, and the area manager told inspectors that many of these children were placed with relative carers in other parts of Dublin city. There were 15 available foster care placements at the time of this inspection. Data provided to inspectors showed that there were seven foster care households where the number of children exceeded the standards. In these cases, the placements were notified to the Foster Care Committee for their consideration. Inspectors viewed one file in which there was reference to a concern expressed by the social worker for another child in placement. While there was no record of how this concern was addressed, the social work team leader explained that these concerns were discussed in the team and a pre-placement visit was arranged to enable the social worker to assess the suitability of the placement.

Social workers told inspectors that, when children were admitted to care in an emergency, social workers did their best to match them to available placements even though the children's needs may not be well known and a comprehensive assessment of their needs had not yet taken place. Inspectors reviewed the files of two children who had been admitted in an emergency and found that their needs were assessed when placements were found for them at short notice.

The area tried to ensure that children maintained their contacts with their local community when they were admitted to foster care. Seventy children answered the question of whether or not they see enough of their family and friends. Forty nine (70%) of these 70 children said they did, 13 (19%) said 'sometimes', while eight (11%) said that they did not. Of 68 who answered the question of whether or not they had to change school when they moved in to their new foster home, 33 (49%) said that they had to change school while 35 (51%) said that they remained in their school placements. When children were placed with relatives or in private placements at a distance from the area they used to live in, they were no longer in their own community or in close proximity to friends and they needed assistance to maintain the links they had created.

Social workers told inspectors that, when appropriate, children were given the opportunity to meet their prospective foster carers and their views were sought about the proposed placement. This was not always possible as some children were placed as very young children and others were placed in an emergency. Nevertheless, the responses received from children suggested that there was good practice in this regard. Of 63 children in care who answered the question of whether they got to meet or stay with their foster carers before they moved in, 41

(approximately 65%) children said that they had while 22 (35%) said that they had not. Thirty-eight (68%) of 56 children who answered the question said that they had been asked how they felt about moving to their new foster home while 18 (32%) children said that they had not.

Since the capacity of foster carers to meet the needs of children is not always apparent at the beginning of a placement, the suitability of long-term matches between children in care and foster carers is considered and approved by the Foster Care Committee. While the area followed this process, the number of such approvals was small. Data provided by the area during this inspection showed that 13 such approvals took place in the 12 months prior to this inspection and that there were four children awaiting approval of long-term placements. Since 121 children had been received into care in the 24 months prior to this inspection, the number of children reported as awaiting a long-term match seemed quite low. Inspectors discussed this issue with the principal social worker and the fostering team leader, who clarified that the numbers they had given of children awaiting a long-term match referred to children for whom the preparation of the long-term match had occurred and who were awaiting the approval of the foster care committee.

Managers could not provide an accurate figure for the number of children awaiting a long-term match, and the principal social worker told inspectors that, because the area had prioritised statutory visits and child in care reviews, the issue of the backlog in long-term matches had not yet been addressed and there was no plan in place to address this.

The number of children awaiting approval of a long-term match had not been established in the area and there was no plan in place to address the backlog that may have built up. For this reason, the area was judged to be in moderate non-compliance with the standard.

### **Judgment: Non-compliant Moderate**

#### **Standard 10: Safeguarding and child protection**

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

#### **Standard 10 Safeguarding and Child Protection**

Almost all allegations, concerns and complaints against foster carers were categorised correctly and they received an appropriate response. Child protection concerns were taken seriously and immediate actions were taken to protect children when required. There were seven foster care households which were dual unallocated, that is, where the foster carers did not have a link social worker and the children in care did not have an allocated social worker. There were a large number of foster carers who had not received training in relation to their responsibilities as mandated persons under the Children Act 2015. Social workers planned for the safety of children, but there was no formal system of safety planning in the area.

Data provided by the area indicated that there were four allegations and 10 serious concerns made against foster carers in the 12 months prior to this inspection and that three children had been removed from their placements due to child protection and or welfare concerns. Inspectors reviewed the files of the three children removed from their placements and found that appropriate action was taken and that the concerns were thoroughly investigated.

Inspectors reviewed three allegations against foster carers. The allegations were appropriately categorised and investigated in line with Children First (2017). Strategy meetings took place, initial assessments of the children concerned were carried out and An Garda Síochána were notified when appropriate. The outcomes were clearly recorded, and there was evidence that the foster care committee maintained oversight of allegations.

Inspectors also reviewed seven concerns against foster carers. In six of the seven concerns reviewed, the concerns were investigated according to the Interim Protocol for managing concerns and allegations of abuse or neglect against Foster Carers and Section 36 (relative) Foster Carers (Tusla, April 2017) and notified to the foster care committee. Supports were put in place to support the placements when that was required. However, in one case, while a strategy meeting was held and the concern was investigated, an outcome report was not completed and a social work team leader told inspectors that the concern had not been reported to the foster care committee. Inspectors also reviewed a case on the list of serious concerns which should have been initially categorised as an allegation against the foster carer as it concerned an allegation of physical abuse. It was categorised as a serious concern in the strategy meeting, and it was subsequently investigated and the outcome was reported to the foster care committee. Although an initial assessment was not carried out in line with the standard business processes, inspectors found that the child's needs were assessed and arrangements were put in place to support the placement.

Data provided by the area during the inspection indicated that there had been nine child protection concerns made against people other than the children's foster carers

in the 12 months prior to the inspection. Inspectors reviewed the files of three of these concerns. There were intake records on file and strategy meetings were held. The concerns were deemed to be welfare concerns which did not warrant initial assessments under the standard business processes. There was evidence the social workers followed up on these concerns and provided appropriate supports to the children and their foster carers when this was required.

Following the previous inspection of foster care services, the area committed to developing a tracker system to assist managers in their oversight of allegations and serious concerns against foster carers. Inspectors reviewed the tracker which contained details such as when the allegation or concern was reported, the nature of the allegation or concern, how it was responded to and the final outcome. It also contained the dates on which it was first reported to the foster care committee and when the outcome report was considered by the foster care committee. While the tracker assisted managers in maintaining good oversight of allegations and concerns against foster carers, it did not include a record of whether or not the categorisation of the allegation or concern was deemed to be correct and the response proportionate. These issues had also arisen on the previous inspection of the foster care service in 2018. The addition of such categories on the tracker would further strengthen managerial oversight. The tracker was completed by managers from two different parts of the area and this resulted in variations, such as the level of detail provided on the allegations and concerns.

In an update to inspectors in March 2019, the area indicated that quarterly oversight meetings had been scheduled for 2019 to review the tracker. Records provided to inspectors showed that a meeting of the oversight group took place in June 2019 and was attended by the two principal social workers for fostering and children in care and by the chair of the foster care committee. The minutes of the meeting showed that this process of oversight was in the early stages of development as terms of reference and aims for this group were discussed. A further meeting had been scheduled for September 2019.

There was no overall tracking system to ensure adequate management oversight of allegations made by children in care against other people, including family members and people in the community, or of the management of child protection and welfare concerns. The principal social workers told inspectors that the team leaders monitored the concerns relevant to their own teams and made the principal social workers aware of any such concerns. A principal social worker for child protection told inspectors that the progression of cases of children in relation to whom notifications had been made to An Garda Síochána was discussed at regular joint Garda/Tusla meetings. The area manager told inspectors that it was possible for managers to access the children's individual files on the electronic system and

monitor the progression of a case. However, there was no overall tracker to provide sufficient detail to the principal social workers for children in care to be assured that the correct process was being followed in each case.

In both individual meetings with inspectors and in a focus group, social workers and social care staff presented as having the appropriate knowledge and skills and demonstrated commitment to safeguarding and protecting the children for whose care they were responsible. They emphasised the importance of communicating with children about their rights, how to make a complaint if they needed to do so, and making sure that children knew who they could talk to if any issues of concern arose. They were able to clearly explain the process to be followed in the event of an allegation or serious concern against a foster carer or a child protection concern, and they outlined the policies that governed their practice.

In questionnaires returned by children, 64 (91%) of 70 children who answered the question said they knew how to keep safe and 56 (85%) of 66 children who answered the question said that their social worker had told them who to talk to if they felt unsafe. Many children commented on the support and advice that was given to them by their foster carers and social workers on how to protect themselves. There was evidence in some children's files of social workers meeting with children to advise them of the rights, including their right to complain and giving them information and leaflets regarding an independent advocacy service that they could access. An independent advocate told inspectors that the advocacy service received referrals regarding children in care in the area and that, with the permission of the children concerned, they were invited to meetings regarding the care provided to these children. A number of children in care, whose cases were before the courts, had court-appointed guardians ad litem.

Data provided by the area indicated that there were seven foster care households where the foster carers did not have a link social worker and the children placed in these households did not have an allocated social worker. Inspectors reviewed the files of five of these children and found that, while the children had child in care reviews and up-to-date care plans, statutory visits did not take place in line with regulations.

There was evidence that social workers put safeguarding measures in place for particular children in the form of safety plans. However, the area did not have a template for safety plans to ensure that each safety plan was formal and standardised to include essential elements such as a description of the risks involved, the measures in place to mitigate the risks, the arrangements for monitoring and review, and the agreement and signatures of the relevant parties to the safety plan.

Inspectors reviewed safety planning in relation to five children. In two cases, the safety plans were evident in the records of strategy meetings and involved measures such as increased visits to the child and the foster care household. In one case, the discussion of the safety plan was contained in the case management supervision record and, in another case, a social worker explained the work that he/she had done with a child and their foster carer in relation to safety planning but which was not formally recorded as a safety plan. In the case of one child, the safety plan was designed to empower a young person to manage their own safety in particular circumstances and the safety plan was signed by the young person.

The lack of standardised safety plans meant that managers did not easily know how many children had safety plans and they could not maintain adequate oversight of their implementation. In one case, following the receipt of a notification of an allegation against foster carers, the foster care committee recommended that a robust safety plan should be put in place and there was evidence that the foster care committee subsequently considered and approved the safety plan. However, in other cases, there was no evidence that all relevant parties were aware that safety plans were in place and it was not evident that the implementation of safety plans was monitored or reviewed in all cases.

There was a system in place to manage complaints in line with the Tusla complaints policy. Data provided by the area showed that there were five complaints made by foster carers, parents, or family members in the previous 12 months but that there were no complaints made by children in care. Inspectors reviewed the complaints log and found that one complaint was upheld and four were still in progress. There was evidence that complaints were taken seriously and responded to in a timely manner. The area manager told inspectors that the complaints officer was a principal social worker who did not have any operational responsibility for children in care. The policy of the area was to deal with complaints at the lowest possible level. If a complaint was complex, the area manager arranged for the complaint to be thoroughly investigated. Inspectors reviewed a child's file in relation to how a complaint was dealt with. The complaint was considered and investigated. Appropriate measures and supports were put in place and work was carried out with the parties involved to address the issues of concern.

Following the previous inspection of the foster care service in 2018, the area's action plan set out a number of actions to be taken in order to ensure that all foster carers were familiar with their legal responsibilities as 'Mandated Persons' in line with the Children First Act 2015. In an update on the action plan in March 2019, the area manager told inspectors that several actions had been completed in this regard.

Foster carers who attended focus groups told inspectors that there was a very good training programme available in the area for foster carers. In one group all foster carers said that they had received training in mandatory reporting and Children First (2017). In the other group, foster carers said that they received safe care training and guidance in how to manage children's behaviours. However, figures provided to inspectors showed that there remained 109, out of a total of 247 foster carers in the area, who had yet to complete training in relation to their legal responsibilities as 'Mandated Persons' in line with the Children First Act 2015.

Data provided by the area stated that there were no deaths or serious incidents involving children in care during the previous twenty-four months. Processes were in place to review all reported incidents should they occur.

Of the 10 allegations and serious concerns against foster carers reviewed by inspectors, nine were categorised correctly. Nine of the allegations and serious concerns against foster carers were notified to the foster care committee. The oversight of allegations and child protection and welfare concerns relating to children in care could be improved by having an overall tracking system in place to assist managers. While safety plans were developed in individual cases, there was no formal system of safety planning and there was no process in place in the area to ensure that the implementation of safety plans was monitored and reviewed. Although foster carers who met with inspectors said that there was a good training programme in place in the area, a large percentage of foster carers (44%) had not yet completed training regarding their legal responsibilities as 'Mandated Persons' in line with the Children First Act 2015. For these reasons, the area was judged to be substantially compliant with this standard.

### **Judgment: Substantially compliant**

#### **Standard 13: Preparation for leaving care and adult life**

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

### **Summary of inspection findings under Standard 13**

The aftercare service in the area was under-resourced and did not have the capacity to respond in a timely manner to referrals of children and young people to the aftercare service. Children who were referred to the aftercare team and allocated an aftercare worker had their needs assessed and had aftercare plans. However, the level of support available to them from the aftercare service was limited.

The aftercare service was provided by an aftercare team, whose work was informed by the Tusla national aftercare policy and associated guidance. However, the aftercare team was under-resourced at the time of inspection. The team was managed by a principal social worker for child protection as there was no aftercare manager in post. The principal social worker estimated that one third of her time was spent managing the aftercare service. There were 3.6 whole time equivalent aftercare worker posts allocated to the team but one aftercare worker was on long-term leave at the time of inspection. There were two fulltime aftercare workers and two part-time aftercare workers. There was a 0.4 administrative post supporting the team.

Inspectors met with the aftercare team who told inspectors that there were 313 children and young people eligible for aftercare services at the time of inspection. Data provided by the area prior to the inspection showed that there were 58 children and young people with an allocated aftercare worker. Figures published by Tusla for the period, Quarter 2, 2019, showed that, of 168 children and young people with an aftercare plan and assessed as needing an aftercare worker, only 88 (52%) had an aftercare worker. This percentage of allocation of aftercare workers was the lowest of all Tusla areas in the country. Aftercare workers told inspectors that they held caseloads of approximately 25 cases per worker and that they prioritised the completion of assessments of need and aftercare plans.

Managers at all levels acknowledged that the aftercare team was under-resourced. Social worker team leaders highlighted the limited resources available in aftercare. They told inspectors that most of the children who were referred to aftercare at 16 years were not allocated an aftercare worker until they were 17 and a half years old. They felt that there was very little learning regarding aftercare provision and that some issues, such as challenges for children with learning disabilities, and accommodation shortages, were recurring themes. They also expressed the view that young people who required additional supports can have very poor outcomes.

The shortage of staff in the aftercare service was an item on the areas risk register. The risk assessment described how there were over 200 young people between the ages of 16 to 22 years in the aftercare service unallocated and that current staffing levels resulted in high caseloads and workloads. The potential risks included the

possibility of children and young people not receiving a service in line with statutory requirements, young people falling through the net, which may result in homelessness, and young people with disabilities and or complex needs not receiving an adequate service to meet their needs. There was also a potential impact of increased workloads on staff. It also set out the need for a minimum of seven additional aftercare workers, a fulltime aftercare manager and a fulltime administrative staff member. The control measures included a service development plan and the commissioning of additional aftercare services from a voluntary organisation.

In order to supplement the work of the aftercare team, the area had a service level agreement with a voluntary organisation to provide aftercare support and settlement services to children and young people aged between 17.5 years and 21/23 years. This involved the provision of four whole time equivalent aftercare workers, who would have between 10 and 15 young people each on their caseloads, and specialised one-to-one work to help children who were leaving care and becoming independent. This work also involved the development of aftercare plans, assistance with finding appropriate accommodation and liaison with relevant agencies. The service level agreement specified the performance indicators according to which the voluntary organisation reported regularly, and the service level agreement was monitored by the area manager and principal social worker who held service reviews with the voluntary organisation twice a year.

As the 2019 service plan for aftercare did not specifically refer to any increase in resources for the team, inspectors raised the issue of the under-resourcing of the aftercare service with the area manager and also with the service director. The area manager acknowledged that the aftercare service needed to be developed and that the service was managing, in part, by having young people access the aftercare duty system. With regard to a plan for its development, she saw the post of aftercare manager as key to this. She told inspectors that delays in recruiting an aftercare manager had now been resolved and that, when the aftercare manager came into post, they would be tasked with developing a strategy and plan for the service. The service director told inspectors that the area had been under-resourced historically in relation to aftercare provision. She said that a gap analysis had been undertaken for aftercare provision and that a business case had been made for aftercare staff but that the area did not receive a full budget for staffing.

There was a system in place for ensuring that all eligible children were referred to the aftercare service and managers maintained oversight of this. The child in care register was checked monthly to identify all children who turned 16 years of age. This list of children was cross-checked against a list of those children who had

already been referred to the aftercare team. An administrative officer emailed the relevant social workers or team leaders to advise them of the need to refer children and, if this had not been completed by the next month, reminders were sent to the relevant social workers and team leaders. However, the system in place was not very effective. Data provided by the area prior to this inspection showed that, of 54 children aged 16 years and over in foster care, 20 had been referred to the aftercare service while 34 (over three of out every five children over the age of 16 years) had not yet been referred. Inspectors reviewed the files of eight children in care who were over the age of 16 years. Six of these children had been referred to the aftercare service between the ages of 16 and 17 years. Two were over the age of 17 years when referred, one being seventeen and a half years old.

The aftercare team told inspectors that they held a referrals meeting each month and that assessments usually commenced four to six months following receipt of the referral. However, cases reviewed by inspectors showed that a long period of time could elapse before the assessments were carried out. In five of the cases reviewed by inspectors, the assessments of need did not take place for at least six months following the referral of the children, and in three cases, the timeframe was between 12 and 14 months. The lack of capacity of the aftercare team to carry out assessments of need in a timely manner meant the opportunities for the aftercare workers to build relationships with the children and address their needs at an early stage were missed.

Aftercare workers told inspectors that they held induction meetings with the children and their foster carers and provided written information of the aftercare service and the children's entitlements. They also made the children aware that they could contact an independent advocate for support if they wished. Children were involved in planning for their future. Involvement in the aftercare service was voluntary for each child and children were asked to sign their consent to be involved in the aftercare process. Assessments of need and aftercare plans were drawn up in conjunction with the children and children usually co-signed these documents with the aftercare worker.

Inspectors reviewed the files of nine children between the ages of 17 and 18 years. Seven of these children had an assessment of their needs carried out by an aftercare worker, and an assessment appointment had been scheduled in another case. One child, who was over 17 years and had been in care for three years, had only recently been referred to the aftercare service and had not yet had their needs assessed. The assessments of need were adequate. They addressed all the issues outlined in the standards and regulations and were produced on standardised templates.

Inspectors reviewed the files of six children who had reached the age of 17 and a half years. Five of the six had a completed aftercare plan, while the plan for one child was still in draft. In four of the six cases, the aftercare plans had not been completed by the time the children reached 17 and a half years of age. The completed aftercare plans were of good quality. However, when aftercare plans are not completed in a timely manner, there is little time to address any significant issues that may arise as the young person is discharged from care at the age of 18 years. For example, one child was referred to the aftercare steering committee at the age of 17 years and eight months, which meant that the steering committee had very little time to address these child's needs before they left care.

The service had two aftercare steering committees, one for the Dublin South West part of the area and one for the Kildare, West Wicklow part of the area. They met approximately every six weeks, and were chaired by the principal social worker for aftercare. They comprised representatives from the Health Service Executive disability and mental health services, the local authorities and various voluntary agencies. The children's social workers and the aftercare team made referrals to the steering committee. Minutes of the steering group meetings showed that the committee considered the needs of children in care who had complex support needs or disabilities that required a multidisciplinary response.

The aftercare team told inspectors that they had good relationships with several housing agencies who provided assistance by identifying suitable accommodation for young people. Some young people in independent living arrangements also benefitted from the support of housing outreach workers.

Inspectors spoke to an independent advocate who confirmed that children and young people were aware of the advocacy service. Independent advocates sometimes supported children and young people and their foster carers in their meetings with members of the aftercare team. The area manager told inspectors that two members of the aftercare team met a small group of care leavers in November 2018 to seek their feedback, the aftercare team told inspectors that they did not have a formal mechanism such as exit interviews to elicit regular feedback from young people on the quality of the aftercare service.

Data provided by the aftercare team showed that an aftercare service was provided to 248 young people up to, but not including, the age of 23 years during the period of April to June, Quarter 2, 2019. A drop-in clinic was provided on one day per week for children and young adults with a care history, their family members and professionals involved in their care. The drop-in service was located in Tallaght, Dublin, where the aftercare team was based. This service included the provision of practical support, advice or signposting to other agencies. There were no drop-in

clinics provided in other locations throughout the area, which meant that many young people could not easily attend the drop-in service should they wish to. The aftercare team maintained records of all contacts from young people who were no longer in care. The aftercare team also operated a duty service which involved one worker per week providing a duty service to young people who did not have an allocated aftercare worker. Records provided to inspectors showed that, in Quarter 2, 2019, the aftercare duty service had 247 contacts from young people over 18. This figure did not include contacts with those children and young people who had an allocated aftercare worker.

While there was a 2019 service plan for aftercare, the principal social worker did not produce an annual report of the adequacy of the service in line with national policy. She did, however, maintain records and statistics on the activity of the aftercare team and on young people who had left care and were provided with an aftercare service. The principal social worker told inspectors that she reported monthly on this activity to the area manager. She also submitted quarterly returns to the Tusla national office on referrals, assessments undertaken, and aftercare plans completed and the timeframes involved. She provided inspectors with information on the outcomes for these young people under the headings of education and accommodation (figures for Quarter 2, April to June, 2019) as follows:

Of 204 young people between the ages of 18 and 22 years in receipt of an aftercare service, 111 (54%) were in educational or accredited training placements as follows:

- 17 (15%) were still in second level schools
- 43 (39%) were in post-leaving cert courses
- 7 (6%) was in vocational training
- 28 (25%) were in third level college or university and
- 11 (10%) were in accredited training
- 5 (5%) - Other (not specified).

The accommodation arrangements of the 204 young people in the 18–22 years age group were as follows:

- 81 (40%) remained with their former foster carers
- 35 (17%) were living independently
- 6 (3%) were in residential care
- 12 (6%) were at home
- 7 (3%) were in designated care leavers accommodation
- 4 (2%) were in supported lodgings and
- 59 (29%) were in some other type of accommodation (this number included young people who were living with previous foster carers, those in student

accommodation, those in outreach placements, those living with partners' families, and three who were accessing homeless services).

The aftercare service was not fully resourced to be able to provide a timely and comprehensive service to children and young people in the area and it did not have the capacity to allocate an aftercare worker to all children and young people who were assessed as needing an aftercare worker. Not all children had an aftercare plan by the age of 17 and a half years old. While the principal social worker maintained statistics and made quarterly reports to Tusla, an annual report on the adequacy of the service was not developed. There was no mechanism for seeking regular feedback from children and young people about the quality of the service. However, measures were being taken by the area to address the deficits in the aftercare service. The area was in the process of recruiting an aftercare manager and senior management believed this would assist in the development of the strategy for the service. Other control measures included a service development plan and the commissioning of additional aftercare services from a voluntary organisation. For these reasons, the area was judged to be in moderate non-compliance with the standard.

### **Judgment: Non-compliant Moderate**

## **6. Progress to address specific risks identified on previous inspections**

This is the third inspection of the foster care service in Dublin South West, Kildare, West Wicklow service area since February 2018. The foster care inspection in February 2018 identified major non-compliances and serious risks within the fostering service. The first inspection focused on the standards relating primarily to foster carers, such as assessments and reviews of foster carers, supervision and support, allegations and serious concerns made against foster carers and the foster carer committee.

The second inspection in November 2018 was a follow-up inspection that focused on the standards where the area was judged to be non-compliant moderate or major. The findings of the inspection in November 2018 identified that significant risks remained in the area in relation to unallocated foster carers, assessments of relative carers and reviews of foster carers.

The foster carer committee for this area shared their committee with another service area. During an inspection in the other service area, the inspector identified risks

regarding a Dublin South West, Kildare, West Wicklow case and as a result, wrote to the area manager in March 2019. Due to these additional findings, HIQA included a review of aspects of the foster care committee during this inspection in relation to approval of relative carers and tracking of the implementation foster care committee recommendations.

Due to the level of risks remaining in relation to the management of unallocated foster care cases, the delay in completing relative assessments, the backlog of foster carer reviews and the functioning of the foster care committee, HIQA included a follow-up inspection of these issues as part of this inspection.

### **Unallocated foster carers**

At the time of the first inspection in February 2018, there were 73 unallocated foster carers, 14 of which were dual unallocated. At that time, inspectors escalated the lack of a formal and planned system in place to respond to unallocated foster carers. Assurances were given that a system of oversight would be put in place to ensure all foster carers received a safeguarding visit at a minimum of every six months.

In November 2018, inspectors found there were 55 unallocated foster carers, 17 of whom were dual unallocated, three of whom were unassessed and unapproved relative foster carers. Of the 29 files reviewed by inspectors, three were individually escalated to the area manager for safeguarding visits to be completed. Despite the assurance received following the first inspection, systems had not been put in place to ensure that unallocated foster carers received visits every six months, at a minimum.

The action plan returned following the February 2018 inspection identified that the area would:

- establish a third fostering team
- generate an updated list of dual unallocated foster carers at the end of the month for review by relevant team leaders and PSWs
- audit dual unallocated foster carers every three months with a view to auditing all dual unallocated carers over a 12 month period
- review the list of outstanding visits each quarter and ensure plans are in place to conduct the necessary visits
- provide ongoing contact and support to unallocated foster carers, and strengthen the duty system in order to achieve this.

On this inspection, there were 19 unallocated carers who had children placed in their care. While there were 27 other foster carers open to the service who did not have an allocated link worker, no children were placed with these carers. In seven of these placements, there were children placed who also did not have an allocated social worker. These are referred to as dual unallocated foster carers.

In line with their action plan from February 2018, the area had developed a third fostering team since the last inspection which meant there were four additional link social workers in place. Due to the level of experience of these workers, they had protected caseloads at the time of inspection. However the principal social worker identified that they were optimistic that they would be in a position to increase the capacity of this team once it became more established. This should result in the area further reducing the number of unallocated foster carers.

There were two systems in place to manage unallocated cases at the time of inspection. In teams where there were a small number of unallocated cases, visits to carers were managed locally by the team leader. One team leader told the inspector they intended to use a caseload audit sheet to support their oversight of unallocated cases but this was not in place at the time of inspection. Up until recently, one team had held the majority of unallocated cases. In that office, a different system was in place. One social worker who worked two days per week was dedicated to visiting unallocated foster carers. This worker told the inspector that they had completed visits to approximately 24 foster carers since taking up the position in November 2018 and that the team leader prioritised which foster carers they would visit. Inspectors were informed following inspection that there were 19 foster carers overdue a visit from a fostering social worker.

Since the last inspection unallocated cases had been transferred between teams in an effort to balance risk across all fostering teams in the area. Inspectors were told that as a result of this they would be implementing a uniform system across the area to manage unallocated cases. In line with the area's action plan from February 2018, three-monthly audits were undertaken from the end of 2018 in relation to one quarter of dual-unallocated foster carers. In this way, the area intended to have audited all dual unallocated foster carers for statutory visits across a 12 month timeframe. One principal social worker told the inspector that they also audited 10 per cent of unallocated cases. According to the principal social worker, these audit findings were then used to identify which cases needed to be prioritised for allocation to the duty social worker for visits, which is consistent with the information given by the area in the update of their action plan in March 2019. The principal social worker told the inspector they prioritised cases on the basis of which foster carers were longest overdue for a visit and that they monitored visits through

monthly review of the lists of dual unallocated carers, which is in line with the February 2018 action plan. However, the inspector did not find evidence of this review on inspection. The area also held quarterly meetings to review data held in relation to unallocated cases but minutes of these meetings did not show what action was taken as a result of this information. One principal social worker told the inspector that this system would be implemented across the area due to the decision to divide the unallocated cases evenly across all teams.

The inspector reviewed the audit of dual unallocated cases for quarter two 2019 and saw that it recorded the date of the last statutory visits to the foster carers, if updated Garda vetting, health and safety check and foster carers reviews were overdue and the date of the last case note on file. One principal social worker told the inspector that due to the reduction in the number of dual unallocated cases, future quarterly audits would include unallocated and dual unallocated foster carers. The issue with relying on the quarterly audits to identify cases to be prioritised for visits was that this only identified those cases that were audited. Therefore, senior managers did not have access to information regarding the last statutory visits to unaudited unallocated foster carers. This meant that managers could only prioritise visits based on the files that had been audited rather than all unallocated foster carers. This will become less of an issue when the area has audited all unallocated cases, provided the facility to record dates of last visits to foster carers is recorded on the register. However, the inspector did not find evidence that the register was being regularly updated in relation to unallocated cases. One principal social worker told the inspector that they looked at data regarding unallocated foster carers along with the foster carer register in a quarterly fostering management meeting to prioritise visits to unallocated carers. Records of these meetings did not reflect this discussion.

The inspector reviewed two files of carers who were unallocated and caring for children who did not have an allocated social worker (dual unallocated). The inspector found that both of these files had been audited and received statutory visits by a duty fostering social worker. This showed that when cases were audited, the system was effective in ensuring that carers received a visit by a duty social worker. However, at the time of this inspection the area still had not implemented an effective system to be assured that all unallocated carers and dual unallocated carers received safeguarding visits.

While efforts were made to visit unallocated foster carers, there remained 19 carers who were overdue a visit at the time of this inspection. Despite escalating and receiving assurances at the time of the last inspection from senior management in relation to the oversight of unallocated cases, two different systems were in place,

and there was no system to track and report on this key area of risk to senior management.

### **Assessments of relative carers**

At the time first inspection in February 2018, the area had 33 unassessed and unapproved relative foster carers of whom four were unallocated. These foster carers were escalated to the area management at that time for immediate allocation and HIQA was provided with assurances that this was completed.

At the time of the November 2018 foster care inspection there were 23 unassessed and unapproved relative carers, of whom three were unallocated and this inspection found there was significant drift in completing assessments. There was no system to provide oversight of this, contrary to the action plan returned following the first inspection.

The action plan in February 2018 identified that:

- the area had put a tracking system in place for unallocated relative assessments that would be discussed in supervision between the area manager and principal social workers
- the principal social worker would advise the area manager of any non-compliance in relation to the completion of assessments and resource deficits in meeting this requirement
- a service agreement would be agreed for any future relative assessments commissioned by private fostering services.

Data provided by the area at the time of this inspection showed that there were 35 unassessed and unapproved foster carers. However, information provided by the area after the inspection reflected there were 31 unapproved carers. These records showed that 16 of these cases were progressing appropriately, in some cases with legitimate delays, and in two cases the assessment has since discontinued. However, there were undue delays in 15 of the 31 relative assessments.

Inspectors found evidence of improved communication with one private fostering assessor regarding the 10 assessments they have been commissioned to undertake. The area received updates on these assessments in the form of a report and optional meeting at a mid-way point in the assessment process. However, there were significant delays in seven of these cases prior to commissioning a private service to undertake these assessments. The period from the date of placement of the child to the time of this inspection ranged between nine months to two years

and five months, in six assessments being undertaken by the private fostering agency. In the seventh case, the child was placed with carers 6.5 years ago and the assessment was only commissioned for a private assessment in June 2019. One case was being assessed by a second private fostering assessor and was ongoing for three years at the time of inspection. It was not possible to access detailed information regarding the oversight of this case by the social work department.

There were considerable delays in seven assessments being undertaken by link social workers, with one case ongoing for four years and nine months at the time of inspection. In the remaining six cases allocated to link social workers for completion of the relative foster care assessments, children were placed ranging from 10 months to three years prior to this inspection.

As a result of the continued ongoing drift in the assessments of relative carers, and the lack of oversight of this found by the inspection, the inspector wrote to the service director to seek assurances on this issue. A response was received from the service director that outlined that a tracker had been put in place. In addition they advised that they received quarterly data in relation to the assessments of relative carers. However, this did not address the issues raised relating to the significant drift and lack of oversight. The service director subsequently advised inspectors that:

- one of the two principal social workers had been assigned responsibility for oversight and governance of the tracking system for relative/friend (S 36) assessments. This plan was on an interim basis, pending the appointment of one principal social worker specifically for the fostering service across the area
- additional information/data sections had been included to improve the tracking system
- unassessed relative assessments would be a fixed agenda item at the alternative care forum, chaired by the service director, to ensure continued focus and prioritisation of this area of work.

## **Reviews of foster carers**

At the time of the first inspection, there were 189 out of 298 or 63% foster carers who had not had a review for more than three years, in line with regulations. At the time of the last foster care inspection, there remained 135 out of 312 (43%) foster carers who had not had a review for more than three years. While the team in Athy were on target for clearing the backlog of reviews, a decision was taken in May

2018 not to undertake any further foster carer reviews in the Tallaght office because of deficits in staffing resources.

The action plan from the February 2018 inspection identified the follow actions:

- the backlog of foster carer reviews would be completed within 18 months
- principal social workers would have oversight of this issue through supervision and a quarterly meeting

On this inspection, data provided by the area showed that there were 115 of 247 (46%) foster carers overdue a review and that 34 reviews had been completed in the nine months since the last inspection. The number of foster carers fell by 65 since the last inspection, which the principal social worker said was mainly due to removing carers who no longer foster from the register. The area needed to complete seven foster carer reviews per month to clear the backlog of reviews but had only achieved a rate of less than four per month in the period between inspections. However, at the time of this inspection, one social worker had taken up a position to carry out all of the tasks required to prepare for a foster carer reviews. Another social worker and team leader were due to start by mid-October 2019 to establish a team focused on conducting foster carer reviews. Once in place, the principal social worker estimated that it would take a further 13 months to bring foster carer reviews up to date. This means that there would be a significant period of time before the area had managed to clear their backlog.

Progress was made in the area in setting out criteria for prioritising cases. For example, cases where there was an allegation, concern, complaint or disruption were to be prioritised for a foster carer review. principal social workers had drawn up a list of carers for review based on these prioritisation criteria and the staff member working on foster carer reviews had been allocated some cases from this list.

### **Foster Care Committee**

The foster care committee for this service area also operated as the committee for another service area. This meant that, unlike other Tulsa service areas, the workload of this foster care committee was determined by two service area, whereas other foster care committees operated solely for one service area. As part of an inspection for the other service area, the inspector identified issues with decisions made by the committee regarding Dublin South West, Kildare, West Wicklow cases. These issues were approving relative carers without ensuring appropriate safeguards were in

place and despite them not having completed basic training, as required by the policy. Inspectors wrote to the area manager in March 2019 seeking assurances in relation to the concerns raised. Based on the response of the area manager in April 2019, inspectors also followed these issues up during this inspection. The main focus was to review the committee's approvals of relative foster carers and the system in place to track the implementation of recommendations.

The chairperson of the committee established a system from January 2019 to enable them to track recommendations made by the committee. This meant that the chairperson maintained a log of cases heard by the committee that identified cases with recommendations for follow up. The chairperson had intended to review the recommendations in July 2019 and write to the relevant principal social worker regarding outstanding recommendations. This was rescheduled for September 2019, after this inspection; however, as an opportunity arose in July 2019 to implement a consistent filing system for the committee, this was prioritised.

The log of activity had improved the chairperson's ability to track the implementation of recommendations from January 2019. The chairperson of the committee told the inspector that they followed up more concerning issues by ensuring these cases were brought back to the committee on a regular basis until the risks reduced. This helped ensure that high priority issues presented to the committee since January 2019 were followed up by the committee. However, the chairperson told the inspector that there was no systematic process in place to ensure that recommendations made by the committee prior to January 2019 would be tracked for implementation.

According to data provided by the area, there were six relative foster carers approved since the inspection in November 2018. The inspector reviewed three files of foster carers that were approved by the committee. In two of these files the inspector identified issues that had not been adequately explored in the fostering assessment but this was not identified by the committee. In two cases, foster carers were approved without foundational fostering training or children first training. In one of these cases, the committee recommended the carers complete this training but did not make this recommendation in the second case. The chairperson of the committee acknowledged that there needed to be a greater onus on the social work team to ensure that training will be provided to foster carers. By not consistently recording training for completion by foster carers as a recommendation, it was not possible for the committee to be assured that foundational training was completed following approval. Routinely approving foster carers without basic training was a breach of the foster care standards and increased the risk that carers were fostering without the knowledge and skills to support them in their role.

The inspector identified similar issues in relation to foster carer reviews considered by the committee. Where the committee discussed issues for follow up but did not include these in recommendations, a case would appear on their log as approved by committee without being flagged as requiring follow up action. This meant that the system in place to track the implementation of recommendations made by the committee would not identify all cases where follow up action was needed. The inspector brought this issue to the attention of the chairperson of the committee who acknowledged this gap.

The March 2019 update provided to HIQA outlined that the area intended to establish a second foster carer committee so that this service area would have their own dedicated committee. Following inspection, the service director wrote to inspectors to advise that the position of chairperson for a second committee had been filled and they would commence in the post from November 2019.

## Appendix 1 — Standards and regulations for statutory foster care services

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

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

## ***National Standards for Foster Care (April 2003)***

### **Theme 2: Safe and Effective Services**

#### **Standard 5: The child and family social worker**

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

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

#### **Standard 6: Assessment of children and young people**

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

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

#### **Standard 7: Care planning and review**

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

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

#### **Standard 8: Matching carers with children and young people**

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

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

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

### ***National Standards for Foster Care (April 2003)***

#### **Standard 9: A safe and positive environment**

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

#### **Standard 10: Safeguarding and child protection**

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

#### **Standard 13: Preparation for leaving care and adult life**

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

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

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

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

*Part III, Article 5 Assessment of foster parents*

*Part III, Article 9 Contract*

#### **Standard 14b — Assessment and approval of relative foster carers**

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

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

*Part III, Article 5 Assessment of relatives*

*Part III, Article 6 Emergency Placements*

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

**National Standards for Foster Care (April 2003)***Part III, Article 9 Contract***Standard 15: Supervision and support**

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

**Standard 16: Training**

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

**Standard 17: Reviews of foster carers**

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

**Standard 22: Special Foster care**

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

**Standard 23: The Foster Care Committee**

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

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

*Part III, Article 5 (3) Assessment of foster carers*

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

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

***National Standards for Foster Care (April 2003)***

*Part III, Article 5 (2) Assessment of relatives*

### ***National Standard for Foster Care ( April 2003)***

#### **Theme 3: Health and Development**

##### **Standard 11: Health and development**

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

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

*Part III, Article 6 Assessment of circumstances of child*

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

##### **Standard 12: Education**

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

### ***National Standards for Foster Care ( April 2003)***

#### **Theme 4: Leadership, Governance and Management**

##### **Standard 18: Effective policies**

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

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

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

##### **Standard 19: Management and monitoring of foster care agency**

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

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

*Part IV, Article 12 Maintenance of register*

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

*Part IV, Article 17 Supervision and visiting of children*

**Standard 24: Placement of children through non-statutory agencies**

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

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

*Part VI, Article 24: Arrangements with voluntary bodies and other persons*

***National Standards for Foster Care ( April 2003)***

**Theme 5: Use of Resources**

**Standard 21: Recruitment and retention of an appropriate range of foster carers**

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

***National Standards for Foster Care ( April 2003)***

**Theme 6: Workforce**

**Standard 20: Training and Qualifications**

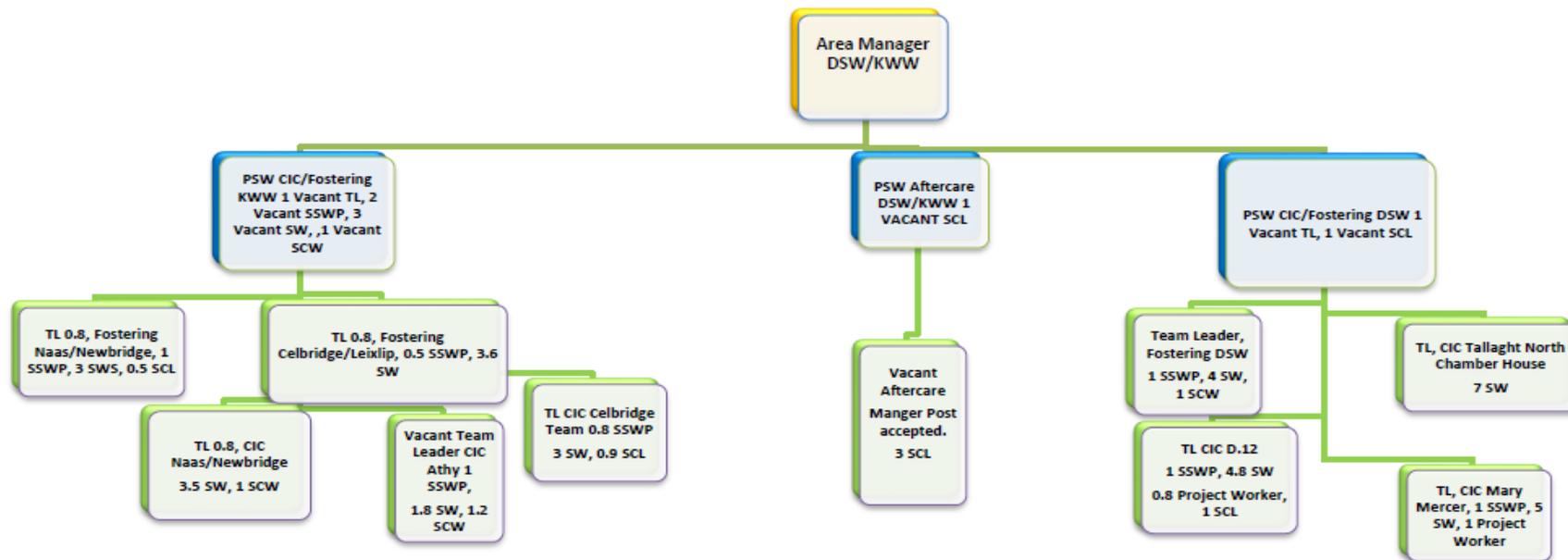
Health boards\* ensure that the staff employed to work with children and young people, their families and foster carers are professionally qualified and suitably trained.

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

**Appendix 2: Organisational structure of Statutory Alternative Care Services, in DSW/KWW Service Area\***



**Children in Care/Fostering – DSW/KWW**



\* Source: The Child and Family Agency



# Action Plan

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

<b>Provider's response to Report Fieldwork ID:</b>	MON 0027471
<b>Name of Service Area:</b>	Dublin South West Kildare West Wicklow
<b>Date of inspection:</b>	9 <sup>th</sup> September 2019
<b>Date of response:</b>	02/12/2019

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

## Theme 2: Safe and Effective Services

### Standard 5 – The child and family social worker

#### Non-compliant Moderate

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

1. Not all children in care had an allocated social worker.
2. There was insufficient evidence of adequate oversight of unallocated cases by way of regular review of the cases.
3. Statutory visits were not carried out in line with regulations.
4. A large number of children were not receiving social work services from the areas in which they now lived.
5. Verbal or informal complaints by children were not recorded on the area log and were not analysed for trends and for learning purposes. A large number of children stated that their social worker had not explained to them how to make a complaint.
6. The quality of record-keeping in some children's files was either poor or in need of improvement.

#### Action required:

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

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

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

##### **1. Not all children in care had an allocated social worker.**

- As graduates employed in the Area are building capacity we are able to increase their caseload. Each graduate in the ISA will be allocated 1 additional child from the unallocated list. This will reduce the number of unallocated children in the ISA to 36 given current numbers of children in care. This will also facilitate allocation of children in care transferring from Child Protection Teams.
- We have launched a rolling bespoke campaign specific to DSW/KWW for

PQSW posts. Should this be successful it will increase ability to allocate cases further. This bespoke campaign has been live since the end of November 2019.

- As part of the above campaign a comprehensive review of staff and staffing deficits is currently being undertaken in KWW/DSW by National Workforce Planning and a meeting with Senior Management was held with National Workforce Planning on 12<sup>th</sup> November 2019.
- Following this campaign, we will seek to fill any remaining vacant social work posts with Social Care Professionals who will be employed to ensure that the needs of unallocated children can be met.

**2. *There was insufficient evidence of adequate oversight of unallocated cases by way of regular review of the cases.***

- A tracker for Unallocated Cases will be developed by mid-December and this will include details of any child where there are outstanding Children in Care Reviews, Aftercare Plans, Statutory Visits or referrals to aftercare.
- This tracker will be reviewed on a monthly basis by the PSW to ensure that every child is visited in line with regulations and plans put in place and any resource issues will be escalated to the Area Manager.
- Each CIC will receive input from the team's duty social work service. Any identified needs will be monitored by the Duty Social Worker/Team Leader on an ongoing basis.
- The Team Leader for Child in Care Reviews will audit 25% of all unallocated CIC and Foster Carers on a quarterly basis and will generate a report each quarter for the Team Leader/PSW. A different 25% of all unallocated CIC will be audited each quarter ensuring that all unallocated cases are audited each year.
- The Team Leaders will review all unallocated cases on a monthly basis and complete a file audit sheet to identify any unmet needs and a plan will be placed on the file/NCCIS to ensure that these are met.

**3. *Statutory Visits are not carried out in line with regulations.***

- A tracker for out of date stat visits has been developed which will identify statutory visits due for the following 24 months for each child.
- The PSW and Team Leaders will vociferously manage and review all outstanding stat visits each month and a plan will be put in place to ensure these are completed.
- Senior Management Team will review current vacancies and a business case will be submitted for a new Social Care Professional post to be created and who will be assigned to complete out of date stat visits on an ongoing basis.

**4. *A large number of children were not receiving social work services from the areas in which they now lived.***

- The PSW's for CIC & Fostering will develop a tracker so Team Leaders can track the children who are placed outside the area and who require a transfer to other areas as per the National Transfer Policy. As part of this a plan of implementation for transfer of all cases within a 6 month period will

be put in place and targets set for individual case transfers.

**5. Verbal or informal complaints by children were not recorded on the area log and were not analysed for trends and for learning purposes. A large number of children stated that their Social Worker had not explained to them how to make a complaint.**

- Clarification from National Office has been received in relation to the recording of verbal and informal complaints and these will be recorded on the Complaints Log going forward.
- The Complaints Office will analyse the complaints on a quarterly basis to identify trends. This information will be fed back to teams for learning purposes during the ISA Pillar Meetings.
- A child friendly note to record how we explain the complaints process to children is being developed and will be placed on the file/NCCIS following the Child in Care review
- When files are audited this will be recorded as part of this process and recorded on the file.

**6. The quality of record keeping in some children's files was either poor or in need of improvement.**

- The Team Leaders will audit 1 CIC file (Paper and NCCIS) per month during supervision.
- The Quality & Risk Team Leader will randomly audit files (Paper and NCCIS) on a 3 monthly basis.

Proposed timescale:	Person responsible:
<b>1.</b> <ul style="list-style-type: none"> <li>• End of Quarter 1</li> <li>• 14<sup>th</sup> November 19 &amp; Ongoing.</li> <li>• 12<sup>th</sup> November 19 &amp; Ongoing.</li> <li>• Ongoing</li> </ul>	<ul style="list-style-type: none"> <li>• T/L &amp; PSW CIC</li> <li>• Regional HR</li> <li>• Workforce Planning &amp; Regional HR</li> <li>• Local HR</li> </ul>
<b>2.</b> <ul style="list-style-type: none"> <li>• 20<sup>th</sup> December 2019</li> <li>• Ongoing monthly from 20/12</li> <li>• Ongoing</li> <li>• Quarterly from Q1 2020</li> <li>• Monthly from January 2020</li> </ul>	<ul style="list-style-type: none"> <li>• PSW CIC</li> <li>• PSW CIC</li> <li>• Duty SW &amp; TL CIC</li> <li>• CICR TL</li> <li>• TL CIC</li> </ul>
<b>3.</b> <ul style="list-style-type: none"> <li>• Monthly from 01/12/2019</li> <li>• Monthly from 01/12/2019</li> <li>• 30<sup>th</sup> January 2020</li> </ul>	<ul style="list-style-type: none"> <li>• TL/PSW CIC</li> <li>• TL/PSW CIC</li> <li>• SMT &amp; Local HR</li> </ul>
<b>4.</b> <ul style="list-style-type: none"> <li>• 30<sup>th</sup> January 2020</li> </ul>	<ul style="list-style-type: none"> <li>• PSW CIC</li> </ul>
<b>5. Ongoing from 1<sup>st</sup> Jan 2020</b>	<ul style="list-style-type: none"> <li>• Team Leaders</li> </ul>

<b>6.</b> <ul style="list-style-type: none"> <li>• <b>From 1<sup>st</sup> January 2020</b></li> <li>• <b>End of Quarter one 2020</b></li> </ul>	<b>CIC team leaders</b> <b>Team Leader for Quality and Risk</b>
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## Standard 7 – Care planning and review

### Non-compliant Moderate

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

1. The completion of child in care reviews was not timely for some children in care.
2. Not all care plans were up to date.
3. The practice of communicating decisions taken in reviews to children and the distribution of updated care plans to foster carers required improvement.
4. A number of children were in their placements for over two years with the voluntary consent of their parents and there was no evidence of plans to seek care orders for these children.
5. Placement plans were not being developed in the area.

#### Action required:

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

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

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

**1. *The completion of child in care reviews was not timely for some children in care.***

- A bespoke recruitment campaign for the area and for PQSW's was launched on the 14<sup>th</sup> of November 2019 and it is anticipated that this will help to increase the number of Social Workers in post. It is envisaged that this will also provide further capacity within the Area to increase the caseload for newly qualified graduates and will ensure up to date CICR and Care Plans.
- 1 child in care will be allocated to each of the new graduates in the ISA to

ensure their capacity is increased by end Quarter 1 2020. This will decrease the number of children who have an out of date Child in Care Review.

- The Team Leader and PSW at quarterly management meeting will ensure rigorous management of outstanding CICR, care plans and out of date stat visits and build on progress made to date.

**2. *Not all care plans were up to date.***

- As per actions to 1 above PSW and Team Leaders will ensure that Care Plans will be completed following the Child in Care Review
- The Quality and Risk Team Leader will complete 3 monthly audits on NCCIS and this report will be provided to the PSW.

**3. *The practice of communicating decisions taken in reviews to children and the distribution of updated care plans to foster carers required improvement.***

- The Allocated Social Worker/Designated Worker who has completed the Child in Care Review will evidence on the child's file that feedback has been provided to the child where age appropriate and that feedback has been provided to the foster carer.
- The Team Leader for Quality and Risk will complete quarterly audits to ensure compliance with this.
- Training will be provided by SMT at ISA Pillar All Worker Meeting to staff to ensure that feedback is given to the child/foster carer.
- A copy of the Care Plan will be distributed to all carers, parents where appropriate and shared with children in an age appropriate manner. The Team Leader for Quality and Risk will conduct audits on a quarterly basis to ensure compliance.

**4. *A number of children were in their placements for over 2 years with the voluntary consent of their parents and there was no evidence of plans to seek care orders for these children.***

- The area completed an audit of voluntary care arrangements in September 2019 to ensure that all voluntary consents were in date and did not extend beyond a year. Quarterly audits on all voluntary agreements will now commence from the beginning of 2020 with the audit of quarter 1 to be completed by end of March 2020, to ensure that voluntary arrangements remain in date and are formalised as necessary.
- We will review all voluntary consents to clarify whether it is in the best interest of a child to secure a care order and if it is not in the best interests of the child to initiate court proceedings a note will be placed on the file/NCCIS to record this and voluntary consent will be tracked to ensure that they are in date.



**Action required:**

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

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

**Please state the actions you have taken or are planning to take:****1. Records of the matching process were not routinely maintained on the children's files.**

- The Principal Social Worker is devising a template that the Fostering placement teams will forward to the Child in Care Social Worker outlining the matching process and the carers identified. Once the match is secured a copy of the completed template will be uploaded onto the child's NCCIS record.

**2. The number of children awaiting approval of a long term match had not been quantified in the area and there was no plan in place to address the backlog that may have built up.**

- The number of children in the ISA awaiting long term matching has been quantified based on the foster care register. 58 children need long term matching. The PSW and TL's will devise a plan to respond to this need by the 19<sup>th</sup> December 2019.

**Proposed timescale:**

1.
  - Quarter 1 2020
2.
  - 19<sup>th</sup> December 2019

**Person responsible:**

- PSW Fostering
- PSW Fostering

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

1. There was no overall tracking system to ensure adequate management oversight of allegations made by children in care against other people, including family members and people in the community, or of the management of child protection and welfare concerns.
2. The processes in place for safety planning required improvement to ensure that:

- Formal written safety plans were put in place when required
  - Safety plans were reviewed and monitored as required
  - All relevant parties were aware of and in agreement with the safety plan.
3. A large number of foster carers had yet to complete training in relation to their legal responsibilities as 'Mandated Persons' in line with the Children First Act 2015.

### Action required:

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

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

- 1. *There was no overall tracking system to ensure adequate management oversight of allegations made by children in care against other people, including family members and people in the community, or of the management of CP&W concerns.***
  - A report will be generated each month from NCCIS regarding any allegation or welfare concern made by Children in Care against other people. It will be the responsibility of the Social Worker and Team Leader to ensure appropriate assessment of allegations and welfare concerns are conducted. This action will be monitored by the Principal Social Worker
- 2. *The processes in place for safety planning required improvement to ensure that formal written safety plans were put in place when required. Safety plans were reviewed and monitored as required. All relevant parties were aware of and in agreement with the safety plan.***
  - A practice guidance for safety planning will be devised to include all of the necessary components of a safety plan and to include signatories to the safety plan and an inbuilt review process for specific dates.
- 3. *A large number of foster carers had yet to complete training in relation to their legal responsibilities as "Mandated Persons" in line with the Children First Act 2015.***
  - Further training has been offered to carers in November 2019 and following this if there continues to be Foster Carers who have not completed the training, Fostering Link Workers will visit the carer in the home to complete this training.
  - The Area will develop a tracker to log and monitor this.
  - The Chair of the Foster Care Committee is developing a log which will track the mandatory Children First Training for Carers and training status will also be recorded on decision of the FCC.

### Proposed timescale:

1.

### Person responsible:

<ul style="list-style-type: none"><li>• <b>Monthly from January 2020</b></li></ul> <p>2.</p> <ul style="list-style-type: none"><li>• <b>January 2020</b></li></ul> <p>3.</p> <ul style="list-style-type: none"><li>• <b>November 2019 &amp; Ongoing</b></li><li>• <b>January 2020</b></li><li>• <b>January 2020</b></li></ul>	<ul style="list-style-type: none"><li>• <b>SW/TL Fostering</b></li><li>• <b>PSW CIC/Fostering</b></li><li>• <b>SW/TL Fostering</b></li><li>• <b>PSW Fostering</b></li><li>• <b>PSW FCC</b></li></ul>
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**Standard 13: Preparation for leaving care and adult life****Non-compliant Moderate**

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

1. The aftercare service was not fully resourced to be able to provide a timely and comprehensive service to children and young people in the area.
2. Not all children had an aftercare plan by the age of 17 and a half years old.
3. An annual report on the adequacy of the service was not developed.
4. There was no mechanism for seeking feedback from children and young people about the quality of the service.

**Action required:**

Under **Standard 13** you are required to ensure that: Children and young people in foster care are helped to develop the skills, knowledge and competence necessary for adult living. They are given support and guidance to help them attain independence on leaving care.

**Please state the actions you have taken or are planning to take*****1. The aftercare service was not fully resourced to be able to provide a timely and comprehensive service to children and young people in the area.***

- An Aftercare Manager post has been accepted and the post will be filled in April 2020 following the return of the post holder from Maternity Leave.
- Approval of a new PSW fostering post will create additional capacity within the CIC/Aftercare PSW post therefore creating capacity for the PSW to have added oversight until the Aftercare Manager post is in place.
- A workforce analysis study will be completed for the aftercare team and will inform the resources required to meet current needs.
- Following this a business case will be sent to the Regional Service Director based on the findings before end March 2020.
- On the 3rd 2019, a preparation meeting was held between Dublin South Central and DSW/KWW to review the allocation model to be used going forward for young people in Aftercare with both the commissioned Aftercare services and Tusla's own Aftercare service and to maximise the use of the aftercare commissioned services. A further workshop has been scheduled for the 11<sup>th</sup> December with both Tusla Aftercare Services and Commissioned Aftercare services where this allocation model will be agreed and signed off.

***2. Not all children had an aftercare plan by the age of 17 and a half years old.***

- The Team Leader and PSW will ensure that all aftercare referrals for CIC are

completed within a timely manner to ensure that adequate time is given to ensure that the Aftercare Plan is in place before the young person turns 17 and a half years of age.

- The Quality and Risk Team Leader will review all children in care referral to the aftercare team and complete an audit on all Aftercare Plans held. This will review on a quarterly basis.

**3. An annual report on the adequacy of the service was not developed.**

- An annual report will be completed for 2019 by the end of Quarter 1 2020.

**4. There was no mechanism for seeking feedback from children and young people about the quality of the service.**

- A mechanism for seeking feedback for aftercare service users will be developed by the PSW for Aftercare and the Alternative Care Manager.
- An Exit interview template is currently being drafted to elicit the views of children and young people leaving the service. This will be completed by end February 2020.

Proposed timescale:	Person responsible:
<p><b>1.</b></p> <ul style="list-style-type: none"> <li>• April 2020</li> <li>• Immediate</li> <li>• March 2020</li> <li>• January 2020</li> <li>• December 2019</li> </ul>	<ul style="list-style-type: none"> <li>• Aftercare Manager</li> <li>• PSW Aftercare</li> <li>• Senior Management Team</li> <li>• Local HR</li> <li>• PSW CIC and Aftercare</li> </ul>
<p><b>2.</b></p> <ul style="list-style-type: none"> <li>• Ongoing</li> <li>• Quarterly from Q1 2020</li> </ul>	<ul style="list-style-type: none"> <li>• TL/PSW CIC</li> <li>• TL Q&amp;A</li> </ul>
<p><b>3.</b></p> <ul style="list-style-type: none"> <li>• End Quarter 1 2020</li> </ul>	<ul style="list-style-type: none"> <li>• PSW Aftercare</li> </ul>
<p><b>4.</b></p> <ul style="list-style-type: none"> <li>• Quarter 1 2020</li> <li>• February 2020</li> </ul>	<ul style="list-style-type: none"> <li>• PSW Aftercare</li> <li>• PSW Aftercare</li> </ul>