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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Name of service area:	Cavan/Monaghan
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Number of fieldwork days:	4
Lead inspector:	Caroline Browne
Support inspector(s):	Niamh Greevy Sabine Buschmann Una Coloe
Type of inspection:	☒ **Announced** ☐ **Unannounced** ☐ **Full** ☐ **Focused**
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About the Health Information and Quality Authority (HIQA)

The Health Information and Quality Authority (HIQA) is an independent statutory authority established to promote safety and quality in the provision of health and social care services for the benefit of the health and welfare of the public.
HIQA's mandate to date extends across a wide range of public, private and voluntary sector services. Reporting to the Minister for Health and engaging with the Minister for Children and Youth Affairs, HIQA has responsibility for the following:

- **Setting standards for health and social care services** — Developing person-centred standards and guidance, based on evidence and international best practice, for health and social care services in Ireland.

- **Regulating social care services** — The Office of the Chief Inspector within HIQA is responsible for registering and inspecting residential services for older people and people with a disability, and children's special care units.

- **Regulating health services —** Regulating medical exposure to ionising radiation.

- **Monitoring services** — Monitoring the safety and quality of health services and children's social services, and investigating as necessary serious concerns about the health and welfare of people who use these services.

- **Health technology assessment** — Evaluating the clinical and cost-effectiveness of health programmes, policies, medicines, medical equipment, diagnostic and surgical techniques, health promotion and protection activities, and providing advice to enable the best use of resources and the best outcomes for people who use our health service.

- **Health information** — Advising on the efficient and secure collection and sharing of health information, setting standards, evaluating information resources and publishing information on the delivery and performance of Ireland's health and social care services.

- **National Care Experience Programme** — Carrying out national service-user experience surveys across a range of health services, in conjunction with the Department of Health and the HSE.

About monitoring of statutory foster care services

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

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

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

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

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

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

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

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

1. Inspection methodology

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

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

The key activities of this inspection involved:

- the analysis of data submitted by the area and questionnaires completed by 29 children in care and nine young people in aftercare
- meeting with or speaking to 11 children, and with six young adults availing of the aftercare service
- interviews/meetings with the interim area manager, the principal social worker for alternative care, the team leader for the long-term children in care team, the principal social worker for duty/intake and child protection teams, and the aftercare manager
- home visits to seven foster care households

- separate focus groups with children in care social workers and child protection social workers, fostering social workers, aftercare workers and with foster carers
- review of the relevant sections of 39 files of children in care as they relate to the theme
- observation of a child in care review meeting.

Acknowledgements

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

2. Profile of the foster care service

2.1 The Child and Family Agency

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

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

- child welfare and protection services, including family support services
- existing Family Support Agency responsibilities
- existing National Educational Welfare Board responsibilities
- pre-school inspection services
- domestic, sexual and gender-based violence services.

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

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

2.2 Service Area

According to data published by Tusla in 2018, the service area had a population of children from the ages of 0-17 years of 36,446.*

The area is under the direction of the service director for Tusla, Dublin North East region, and is managed by an interim area manager who started in this role in Janaury 2019. There were two principal social workers with responsibility for the alternative care services in the area, one principal social worker had responsibility for child in care, leaving care and aftercare services. Another principal social worker had responsibility for the foster care service.

The long-term children in care team were based in both Monaghan and Cavan Tusla offices, and the leaving care and aftercare team were based in Castleblaney. There was one child protection team, who held responsibility for children in care until they were transferred to the long-term children in care team, and this team was located in Cavan, Castleblayney and Monaghan.

At the time of the inspection there were 164 children in foster care in the area. Of these, 25 children were placed with relatives and 137 children were placed with general foster carers, four of which were placed in private placements. Two children were placed in supported lodging placements.

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

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

3. Summary of inspection findings

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

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

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

- One standard was compliant
- One standard was substantially compliant
- Four standards were non-compliant, of which three were moderate non-compliance and one was major non-compliance.

Children who met with or spoke to inspectors were happy and well cared for in their placements. The majority of children said that they had a good relationship with their social worker and they felt listened to. Social workers maintained good links with families and they encouraged and facilitated contact between the children and their families when appropriate. Twenty seven (71%) of the 38 children who answered questionnaires said that they see their family and friends regularly.

There was a well-established aftercare service in the area. Inspectors identified examples of good practice in the aftercare service. For example, there were two drop in centres in the area which facilitated young people to attend on an informal basis to access information and advice. The aftercare team had developed various resources for young people through this drop in centre such as yoga and a parent and toddler group. The aftercare service also offered a free phone service and the aftercare team were accessible to young people. The aftercare manager identified that housing for young people leaving care was an issue in the area; however no young people were reported as homeless. The aftercare team were proactive in working with local authorities and other organisations in order to increase accommodation options for young people leaving care. Five out of six (83%) of children's files sampled had an assessement of need completed. Four out of five (80%) of children's files sampled had an assessment of need and aftercare plan completed in a timely way.

All children in care were allocated a social worker at the time of the inspection. However, there were periods of time over the previous 12 months when children had been unallocated. There was a guidance document in the area which outlined the circumstances when children should not be unallocated. However, there was no robust mechanism in place to ensure children who had been unallocated had been visited in line with regulations.

Social workers maintained good links with children's families and encouraged this contact when appropriate. Social workers co-ordinated the care of children and the input of other professionals when required. There were ten placements to which the service had provided support packages in order to maintain the placements. The area had access to and had effectively sought a range of services to support placements and social workers identified this as a particular positive in this service area.

While comprehensive assessments were completed for children in care, these assessments were not always completed in a timely way. There was no effective oversight system in place to ensure that initial assessments were completed in line with timeframes prescribed by regulations.

There was a good system in place to manage child in care reviews when children were allocated. This system was not in place for children who did not have an allocated social worker. Children, their parents, foster carers and others involved in the child's care were invited to attend and the views of children were sought and listened to. However, the location where reviews were held was not child friendly or comfortable and the quality of records of child in care review required improvement. Voluntary consent given by parents at the time children were admitted to care was not subject to review at child in care reviews in regard to the continued appropriateness of the child's on-going placement in care.

The majority of care plans considered children's need, but not all care plans were completed in line with the timelines prescribed by regulations. The timeframes for actions and persons responsible for carrying out actions were not always clear which meant that these actions were difficult to monitor and review to ensure they were completed in a timely way for the child. Case management was generally of good quality with social workers receiving regular supervision, but some gaps in the quality of care plans and child in care reviews had not been identified through case management. Placement plans were not developed in respect of each child's placement in line with the child's care plan and the numbers of children with up-to-date placement plans was not recorded in the area.

The area sought to ensure that some level of matching was completed for children; however formal records of matching were not available on all children's files. The quality of matching was impacted by the limited number of foster carers in this service area. Due to the limited number of foster placements available, a small number of children were placed in placements which were not appropriate or suitable to meet their long term needs. The service area had started to complete long term matches for children who were longer than six months in their placements, however, there was a significant backlog of these matches to be completed.

Complaints, concerns and allegations against foster carers were categorised correctly. However, allegations made by children in care were not always assessed in a timely manner or in line with Children First: National Guidance on the Protection and Welfare of Children (Children First: 2017). As a result, formal protective measures were not implemented in a timely manner and the social work team could not be assured that timely actions were taken to protect these children from abuse. In addition, not all serious concerns reported by children in care were progressed in line with the interim protocol for managing concerns and allegations of abuse and neglect against foster carers of relative carers.

There was a system in place to manage complaints and inspectors found that complaints were managed in a timely way. However, informal complaints were not being recorded in the area and as a result it was difficult to identify trends or analyse complaints made by children in care.

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

4. Summary of judgments under each standard and or regulation

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

National Standards for Foster Care	Judgment

What children told us and what inspectors observed
During the inspection, inspectors met with 11 children in their foster care homes. Inspectors also received 38 completed questionnaires from children and young people living in foster care in the Cavan Monaghan area. Children told inspectors about the things they liked about living in foster care: "They buy stuff when we ask. That's called caring" "They look after us very well" "They listen to me and treat me like I'm their own" "Supportive, kind, very welcoming into their home" "I like being a part of the family" "I have more freedom and I am able to meet with my friends and be myself" "A place I can finally call home" "Everything. They bring me on holidays and they keep me safe." "I like the way they love me." "They are nice to me all the time. I love them all and they love me." "They are very kind and generous. They also involve me in family activities and outings and [*foster carer*] helps me with my homework and study for my Junior Cert which I greatly appreciate." "They make me happy when I'm feeling sad or upset or if something is wrong" Children also told inspectors about the difficult parts of living in foster care. "It was scary at first" "They [foster carers] seem to me unapproachable" "It's hard being away from your birth parents" "Tusla's complaints procedure needs to be clearer and quicker" "I am dissatisfied with the pace of an investigation into my previous foster placement". As a result, inspectors reviewed this case. 45 of 49 children who either met with inspectors or responded to the questionnaires indicated that they had an allocated social worker, the remaining four questionnaire respondents did not answer this question. 47 children were positive about their social workers. Children said:

"She sorts out access visits for us"
"My social worker is easily contactable at any time"
"She is nice", "She looks after us", "She visits us a lot"
"[*Social worker's name*] listens to us if we are in danger"
"My social worker is interested in my life in a real way"
"I should meet more frequently alone with my social worker"
"My social worker is a person of actions and not just words"
"She's a girl. She plays good football. She has a funny accent."
"helps me whenever I need her".

Two children expressed dissatisfaction with their social workers :
"Don't have a good relationship with her at all"
"She doesn't visit a lot. I have to ask her about my family, she doesn't tell me unless I ask."

The majority 29 (of 38) questionnaire respondents said they had a care plan, one child said they didn't have a care plan and eight said they didn't know. Similarly 28 children said they felt listened to, while three said they didn't feel listened to. When asked if they had been supported to attend their child in care review, 19 said yes while 12 said no. Twenty three children said their social worker had explained the decisions made in their child in care review, while eight said that they had not. All but one child said they felt their culture was understood and respected.

Twenty eight children said that their social worker explained how to make a complaint, while two children said that their social worker had not. Ten children reported they were happy with the outcome of their complaint while one child said they were unhappy with the outcome.

Nine young people over the age of 16 responded to our questionnaire. Three of these said that they had an aftercare plan and that their aftercare worker listened to them, one young person responded that they did not have a plan and feel listened to and another said they didn't know. Five respondents said they had a say in their plan while the remaining four did not answer this question. Seven (of nine) young people said they knew what money they were entitled to.

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 to inspectors prior to the inspection showed that all children in care had an allocated social worker. The principal social worker told inspectors that a social worker had recently returned from extended leave, therefore in the weeks prior to the inspection there had been 20 children in care unallocated. There was an additional vacant maternity leave post but this social workers caseload was re-allocated to other social workers.

There was a guidance document for managing unallocated children in care and unallocated foster carers. This guidance document outlined the criteria to be met for cases that could not be unallocated for any period of time. For example, this guidance outlined that there could be no dual unallocated children, cases where there were on-going allegations and serious concerns regarding a foster carer could not be unallocated and no child should be unallocated for more than one year. The team leader took responsibility for unallocated cases and they informed foster carers of their contact details should they need to be contacted. Inspectors reviewed children's files which had been unallocated throughout the year prior to inspection and found that this information had been communicated in writing to the foster carers. However, there was no system in place to ensure that statutory visits to these children were completed.

When children in care were allocated, a social worker visited the children in their foster care homes and met with them in private. Inspectors reviewed 24 children's files for the purpose of reviewing the timeframes of statutory visits over the two years prior to inspection and found that in 15 of the 24 children in care files reviewed the children were visited in line with regulations. Inspectors found that when there were difficulties in a placement, social workers visited more often to provide support to children. For example, one child in care where there was a safety plan in place was visited monthly. Another child who had been placed outside of the

area was visited by the allocated social worker and aftercare worker every three months to ensure they were provided with appropriate support.

On review of files, inspectors found that case management for allocated children in care was a good mechanism for monitoring home visits to children in care as case supervision was regular and recorded the social workers obligations with regard to statutory visits. The team leaders told inspectors that they monitored the visits to children in care through case management and that they were satisfied that all statutory obligations with respect to home visits were met. Social workers also told inspectors that case management records included the date of the last visit to the child. Inspectors found that there were records of case management on 23 files when these children were allocated a social worker. However, one file contained no records of case management. The principal social worker and the social workers told inspectors that the child in care register also recorded statutory visits to children in care which was an example of good practice in this area.

However, there was no robust system in place to ensure statutory visits were completed for children when they were unallocated. While, inspectors reviewed minutes of management meetings which discussed the number of unallocated cases in the area, there was no evidence of a formal review of these individual cases. As a result, social workers could not be assured that there were no new issues arising for the child which would require it to be allocated. Data provided by the area showed that 11 children had not been visited by a social worker in the past two years as they were unallocated.

Inspectors sampled seven of the 11 children in care files in which the child had not been visited in line with regulations and found that there were significant gaps in visits to these children. For example, in one case it was over a year since the child had been visited by a social work professional. Inspectors received assurances from the newly allocated social worker that this visit would be completed without delay.
While the other six children in care files sampled had recently been allocated due to the return of a social worker from leave, and had therefore been visited in the weeks just prior to the inspection, statutory visits to six of those children had not been completed within the timeframes prescribed by the regulations during the previous two years. For example, there had been no statutory visits for one year for three of those children, one child had not been visited for 14 months, one child had not been visited in 11 months and one child had not been visited in nine months.

The principal social worker told inspectors that children who had been unallocated would have had another Tusla professional seeing them, for example, through supervised access by an access worker, a social care leader completing direct work

with the child or a fostering link social worker visiting the foster care household. However, inspectors found that records of these visits or contact with the child were not always available and as a result, there was not always adequate oversight of these measures to ensure children were visited and that children were met with and spoken to. The principal social worker acknowledged that the records did not always reflect any additional direct work completed with children who were unallocated. There was a duty system in place on the children in care team, whereby all children in care social workers alternated on a weekly basis to cover calls relating to unallocated cases or when the allocated social worker was unavailable. This system meant that one social worker was on duty every week to respond to calls relating to children in care. However, this system did not include completing statutory visits for unallocated children.

The majority of records of visits to children were of good quality. In 15 of the 23 children's files where children had been visited in line with the regulations. Inspectors found that children were seen alone in the foster carer's home. Inspectors found that there were some examples of good recording such as some visits recorded on a template which was comprehensive. However, in three files reviewed, records of visits were not uploaded to the children's electronic files and in one of those the case notes were unfinished. In one file reviewed, inspectors found that the records did not include details of what was discussed during that visit.

Social workers maintained good links with families and they encouraged and facilitated contact between the children and their families when appropriate. Inspectors reviewed 23 files and found that in 18 files there was evidence that the social workers had maintained contact and links with children's families while children were in care. There was evidence of good practice in some cases. For example, there were 11 children who had family contact in the foster carers home, two of those contact visits in the foster carers home involved parents while nine related to siblings visiting each other in the foster carers home. In one case, inspectors found that the social work department also ensured that the child had maintained contact with the extended family members at the child's request. In their responses to questionnaires, of the 38 children who answered questionnaires, 27 (71%) children said that they see their family and friends regularly.

Social workers coordinated the care of children and the input of other professionals when this was required. Data submitted by the area identified that there were eight children with a diagnosed disability. The principal social worker identified that there were ten placements where additional supports were put in place in order to maintain the placement and support the foster carers to meet children's needs. Some of these supported placements related to children who had a diagnosed

disability or medical condition. Inspectors reviewed files of seven children with varying level of disability or medical conditions. All of these children had an allocated social worker and had been visited in line with regulations. Inspectors found that six children had access to specialist services and social workers provided good coordination of services for these children. Inspectors reviewed five of these files and found that social workers convened child in care reviews and updated care plans for all of these children, as required. Relevant professionals had been consulted for these reviews to ensure the children's therapeutic needs were met.

Social workers responded appropriately to significant events for children in care. Inspectors found that in ten files reviewed there was appropriate responses to significant events. For example, in five of the cases reviewed, support was put in place for children when a placement was at risk of breakdown. Child in care reviews were also held when four placements were at risk of breakdown. However, in one file reviewed where there was an allegation made against a foster carer, there was a significant time delay moving children to a new placement. Data submitted by the area indicated that there had been no notifications of children missing from care in the past 12 months. However, inspectors found that on review of one child's file that there was a notification made regarding one child missing from care. The social worker responded appropriately to this child.

Data provided by the area showed that there was one complaint made by a child in care in the last 12 months. Inspectors reviewed this complaint and found that it was well managed. The social worker reported the complaint to the relevant complaints officer. The social worker acknowledged the child's complaint, apologised for the error made and resolved the complaint in a timely manner. There were three complaints made by foster carers. Inspectors reviewed two of those complaints and found that they were appropriately responded to. Team leaders told inspectors that all children were provided with complaint information leaflets during visits by their allocated social worker. Social workers told inspectors that they gave children complaint information and discussed this with children on home visits. Inspectors found evidence in 16 out of 18 files reviewed for this purpose that the social worker explained the complaints process to the child or young person. Twenty eight of the thirty eight children who responded to questionnaires identified that their social worker had explained the complaints process to them. Thirteen children said they had made complaints and they felt listened to and that the complaint was taken seriously. Three children indicated that they were not happy with the outcome of the complaint. Complaints were resolved informally, therefore, there was no mechanism is place to monitor informal or verbal complaints and ensure they were appropriately responded to. Inspectors found that the absence of recording of informal complaints

meant that there was no way of reviewing or trending issues that were arising for children in care.

Records with respect to children in care were maintained on an electronic system but the management of records was poor. The principal social worker identified that not all records of work completed with children may be on the system, for example, the visits completed by the fostering team. Social workers told inspectors that there were some issues with the electronic system such as the speed of the connectivity which was slow and the electronic system did not always resemble the flow of a child in care paper file. In addition, social workers told inspectors that there were some issues with information which had been uploaded which had gone missing on the system. Inspectors found that there was no consistent way to log and store information and it was difficult to access information as each social worker uploaded documents in different folders and using different headings. There were no individual folders for home visits, statutory visits or allegations which made it difficult to monitor and oversee children's cases.

While all children in care had an allocated social worker at the time of this inspection there was a significant period of time in the last two years when children were unallocated. While there was a guidance document which set out the criteria for children whose level of needs meant that they could not be unallocated, there was no effective system in place to monitor and review children who had been unallocated for a period of time, as a result several children had not been visited, some for as long as a year. Complaints were resolved informally, therefore, there was no mechanism is place to monitor informal or verbal complaints and ensure they were appropriately responded to. The management of children's records was poor, the children's care files were not always up-to-date and their information was not always easily accessible.

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 an assessment of need of children when placed in foster care. There was no stand-alone document which was specifically used to outline children's needs when they were initially placed in care. The principal social worker told inspectors that children's needs were always assessed and these needs were usually outlined in the child's care plan or on an initial assessment in some circumstances. The standards require that an assessment of a child's needs is carried out prior to a child being placed in foster care. The standards also outline that in circumstances where a child is placed on an emergency basis, an initial assessment is to be completed within one week of the placement and a comprehensive assessment is completed within six weeks.

Data submitted by the area identified that in the 24 months prior to the inspection, there had been 59 new admissions to foster care. Data submitted also showed that there were 13 children in care that moved to alternative placements in the last 24 months and this figure had risen to 15 by the time of the inspection fieldwork. Eight children had been admitted to care on an emergency basis.

There was no effective oversight mechanism in place to ensure that the child's assessment of needs was carried out in line with the standards. The area were unable to identify how many assessments were carried out before a child was placed in foster care in the last 24 months, the number of assessments of needs on-going or the number of assessments completed within six weeks following an emergency placement. While the principal social worker told inspectors that these children's needs were assessed, there was no mechanisms in place to ensure that there was effective oversight of these assessments and that they were completed in line with the standard and regulations.

In the case of children admitted on an emergency basis, an initial assessment was the document referred to for the assessment of need. The child protection team completed these initial assessments when the child first came into care. Social workers told inspectors that the child protection team would notify the social worker who had responsibility for scheduling child in care reviews when a child was first admitted to care. The team leader with responsibility for oversight of reviews would then ensure that a child in care review was completed within eight weeks of the date of admission to care. The principal social worker told inspectors that ideally the initial assessment would be completed within the first few weeks, however it was an on-going process and would not be fully complete until the child in care review was held. In the case of a child who was already in care but required a new placement, the assessments of the child's needs were contained in the care plan.

Inspectors sampled seven files for the purpose of reviewing children's assessments of need. Seven of these files had an assessment of need on file, three of those were held in the form of an initial assessment and four were contained in a care plan.

Inspectors found that of the assessments reviewed, three assessments were completed in a timely way following an emergency admission of a child into care and these were comprehensive and included multidisciplinary professional consultation when required. However, four of these assessments of need were not completed in line with standards. For example, one of the assessments of need was completed three months following a child's placement move, and two were completed two months following a child's placement move. One was completed six weeks after the after the children moved placement.

Overall inspectors found that there were comprehensive assessments of need completed for children in care, which included multidisciplinary consultation; however, these assessments were not always completed in a timely way. In addition, there was no effective oversight system in place to ensure that these assessments were completed in a timely way, and in line with standards and regulations. For this reason the area was judged to be substantially compliant with this standard.

Judgment: Substantially compliant

Standard 7: Care planning and review

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

Summary of inspection findings under Standard 7

Care planning and child in care reviews were well managed when children were allocated a social worker. However the management of reviews for children who were unallocated was poor. The area had a nominated child in care team leader who had responsibility for scheduling and chairing child in care reviews. This team leader was an experienced social worker.

The team leader described to inspectors the process for organising reviews. When a child was newly admitted to care, the allocated social worker informed the team leader by email and requested that a child in care review was scheduled. The team leader would then schedule a child in care review for eight weeks following their admission to care. Once a child in care review was held, the team leader would then schedule a date for the next child in care review in line with the regulations, this may be in six months' time for a child who had recently been admitted to care or

one year if the child was in care for over two years. The next child in care review was scheduled one month earlier than it was due, in order to avoid the current care plan going out of date. The team leader maintained a database which identified the date of the current care plan and when the next child in care review was due to take place. The service area also submitted quarterly reports to Tusla National Office regarding the status of child in care reviews and updated care plans within the service area.

Once the team leader scheduled reviews invitations were sent out to key people involved with the child, such as parents, foster carers, social workers and other professional staff who were involved in the child's care.

Social workers met with children prior to reviews to help prepare them and to seek their views verbally or in writing using child friendly tools. Inspectors found that out of 23 children's files reviewed for this reason, this question was not applicable in five files reviewed, seven children attended their child in care review and 12 children were consulted by a social worker to seek their views with respect to the child in care review.

Social workers and other professionals working with the child, for example, a school principal were also requested to submit reports prior to the review in order to ensure all necessary information was considered. The team leader told inspectors that the social worker would usually meet with parents or request their verbal feedback with respect to the upcoming review. While the fostering link social workers would attend the review, recent practice was that the fostering link worker also submitted a report for the review. Reviews were mainly held in a pastoral centre which was located close to the Tusla offices.

Inspectors observed one child in care review, which was attended by the allocated social worker, the chairperson who was also the social workers team leader, two foster carers and a link social worker. However, the child did not attend this review. This review was held in the pastoral center during school hours. The allocated social worker came to the review with a draft care plan. Inspectors found that while the team leader was present at the child in care review as the chairperson, it was the social worker who reviewed the child's needs and invited comment from the attendees at the meeting. The social worker addressed the child's needs in areas such as health, education, social support, contact with parents, the foster placement and the child's views. Social workers were respectful of discussions about the child and the birth parents. Inspectors found that the location where the review was held was not child friendly and was not conducive to a comfortable meeting. Of the 38 children and young people who responded to questionnaires, 19 responded that they

had either attended or had been invited to attend their review, while 12 said that they had not, seven children did not respond to this question. Twenty eight children and young people said that they felt listened to with respect to their child in care review.

Data provided by the area indicated that 135 children in foster care had an up-to-date care plan and 29 children were without an updated care plan. Nineteen child in care reviews were overdue. Inspectors reviewed the files of 23 child in care reviews and care plans and found that seven care plans had not been updated and nine child in care reviews had not been carried out in line with the timelines prescribed by regulations. Of these files reviewed for both child in care reviews and care plans, inspectors found that they all related to children who had been unallocated for a period of time which was the reason for these delays. Team leaders told inspectors that these cases were usually those of children who were in long term placements and no issues were arising for the child in the placement and that the service did not have the capacity to complete these reviews in line with the timeframes prescribed by regulations. For example, two child in care reviews were overdue by three months and one child in care review was overdue by six months.

Inspectors found that the quality of records of child in care reviews was poor. Of the child in care reviews sampled for quality, inspectors found that 16 of the 22 child in care reviews did not contain full minutes of the meetings or a record of agreed actions. The minutes of the child in care reviews were used to record and reflect any changes, amendments or additional information discussed during the review. The children's social workers were responsible for drawing up the care plans and the practice in the area was that the social worker came to the review with a draft care plan, following their consideration of all reports and information received from professionals involved in the child's care. Social workers then made amendments to the care plan if any new information was discussed in the child in care review meeting.

There was no evidence that voluntary consent given by parents at the time of the child's admission to care was discussed at reviews. Minutes of the most recent team meetings showed that the issue of voluntary consent was discussed and direction was given by the principal social worker that verbal agreement could be sought from parents at child care reviews. Social workers told inspectors that this service area had not historically reviewed consent for children in voluntary care and they have only recently started to review this with parents. However, inspectors found that only three out of 11 children's files sampled for review of voluntary consent showed evidence that there was some discussion about voluntary consent. However, there

were no records of these discussions at child in care reviews and no documents signed with reviewed voluntary consent dates. For example, in two of those files the team leader during case management requested that voluntary consent was reviewed at the child in care reviews, however, there was no evidence of this review of voluntary consent occurring. One case note referred to a meeting with a parent to review voluntary consent, however there was no evidence of this review on file.

According to data provided by the area, there were five unplanned endings in the previous 12 months and child in care reviews were held following these unplanned endings. Data submitted also showed that there were an additional four placements identified as being at risk of ending and child in care reviews were held in these circumstances also. Inspectors reviewed the files of three children where placements had ended and one where the placement was at risk of ending and found that they were managed well. In particular, inspectors found that there was good communication between the allocated link social worker for the foster carer and the allocated social worker for the child, strategy meetings were held to discuss what was not working in their current placement and to consider alternative placements and the child was transitioned to their new placement in a planned way.

The outcomes of reviews were not always discussed with children following the review. There was no information sent out to children and social workers told inspectors that decisions made were explained to children during home visits.
Inspectors found that of the 22 child in care reviews sampled, this question was not applicable in three of those reviews, seven children had attended their reviews and therefore the outcomes of these reviews were known to these children. It was evident in five reviews where the child had not attended the review that the decisions were shared with children, but there was no evidence of this on the files of the remaining seven children. Of the 38 questionnaires returned 23 children and young people said the social worker had explained to them the decisions taken at their child in care reviews, eight said that the decisions were not explained to them and seven children replied that they did not know whether the decisions were explained to them.

Inspectors found that the quality of the care plans was mixed. Of the 22 care plans sampled for quality, inspectors found that the majority of care plans considered the child's needs, for example, they considered health, education and any complex needs that the child had. They also consulted with relevant professionals, considered if the placement was suitable and outlined the plan for family contact. While care plans considered children's needs and consulted with relevant professionals, inspectors identified that four care plans were of poor quality as they did not identify actions to meet the children's identified needs.

The timeframes for actions and persons responsible for carrying out actions were not clear in ten care plans which meant that these actions were difficult to monitor and review to ensure they were completed in a timely way for the child. Inspectors found that in many of these care plans, timeframes agreed were 'on-going' or 'as soon as possible'. In addition, there was no evidence that previous actions agreed were reviewed at current child in care reviews to ensure all actions had in fact been completed.

When children were allocated a social worker, care plans were completed in a timely manner and the majority had been signed off by a team leader. Inspectors found that child in care reviews and care plans were dated on the same day as the child in care review was held. Of the 22 care plans reviewed there were 16 care plans which had been signed off by a team leader, however three of those care plans had not been signed off in a timely manner and six care plans had not been signed off by a team leader. The principal social worker told inspectors that placement plans were developed when a child was admitted to care and if a child moved to a new placement, however inspectors found that placement plans were not used in the area in respect of each placement of a child which were consistent with the child's current care plan.

Children received specialist supports as agreed in their care plans. A review of seven files of children who had varying levels of disability showed evidence of a range of professionals consulted in relation to the child's care. The principal social worker told inspectors that the service area had a good number of services available to them which were used to support children and families and maintain placements. Inspectors found that there were extra supports provided to families where this was required.

The team leader who chaired reviews explained that the practice in the area was that care plans were not sent to foster carers and families however, the action plan was sent to foster carers. A letter was sent to both carers and parents to inform them that the full care plan was available in the social work office and it was open to them to visit the Tusla office if they wished to read through the care plan document. The team leader told inspectors that this was the practice in the area due to changes in data protection policies and the appropriateness of sending full care plans to personnel outside of Tusla.

Case management was generally of good quality with social workers receiving regular supervision. Case management monitored when the child was visited in line with regulations and when the child in care review was due. However, some deficits

in care plans and child in care reviews identified by inspectors had not been identified through the case management process.

The interim area manager told inspectors that the area has started reviewing individual cases at the complex case forum. The interim area manager identified that while complex case meetings acted as a good oversight mechanism this forum had not occurred this year to date. This forum was held four times in 2018 and was a means of reviewing cases which were not being progressed through normal case management procedures. The interim area manager identified that this forum will resume with a view to reviewing the most complex cases presenting to social work teams. While no audits have been completed to date, the interim area manager expects to have audits completed twice a year. In addition, Tusla national quality assurance and monitoring team had undertaken an audit in the area in February 2019, however, the findings of this audit were not finalised at the time of the inspection.

For children who were allocated a social worker, the child in care and care planning process was timely. The management of care plans and care plan reviews to ensure they were in line with statutory requirements for children who were unallocated required improvement. Twenty nine children did not have an up-to-date care plan and 19 child-in-care reviews were overdue. Placement plans were not used in the area in respect of each placement of a child which were consistent with the child's care plan. The requirement for placement plans as set out in foster care standards and Tusla's alternative care handbook outlines that the development of a placement plan as a key 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 how the child's needs will be met by foster carers on a day-to-day basis in line with the child's care plan. 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

There was a process in place for matching children with foster carers. The fostering team held bi-weekly placement planning meetings in which they discussed placement requests received and the children who were awaiting a placement. Link social workers attended this meeting and discussed the children's needs and whether possible foster carers were available. The aim of these meetings was to arrange the most suitable placements for children with foster carers who had capacity to offer placements.

Inspectors were provided with records of placement planning meetings, however these records did not contain full minutes of the meetings. Furthermore, it was not evident that a member of the child in care team attended these meetings. However, inspectors were provided with minutes of one placement planning which showed that the child in care team had attended. This placement planning meeting was held for six children who had been placed in short term foster care and who required long term placements, records showed that the principal social worker and child in care team leader also attended and the children's needs were discussed. However, there was no standardised matching tool used in the area. On review of these meeting minutes, while it was evident that there were some discussions about the children, their needs, and possible foster carers available, the records did not always provide sufficient evidence of the matching process. Foster carers also told inspectors that they had children placed with them without a matching process occurring or meeting the children prior to the placement.

Inspectors reviewed ten files for the purpose of matching and found that three files contained no evidence of matching and seven files contained some evidence of matching. There were various ways in which matching was evidenced in children's files and there was no consistent matching process. In three files reviewed where the placement moves were planned, there was evidence of good transitional planning, professional meetings were held and there was some level of matching of the placements considered. Some examples of good practice included children visiting the prospective foster carer's home before the placement was finalised and listening to children's views about the placement. Social workers also told inspectors of efforts which had been made to ensure there were good transitional plans when there was a planned placement move. However, formal records of comprehensive matching of children needs with the capacity of the foster carer to meet those needs were not available.

Data provided to inspectors indicated that there were eight children who were admitted to care on an emergency basis in the last 12 months. Five children were in short term placements and were awaiting long term placements. Inspectors reviewed three files of children admitted to care on an emergency basis and found

that while the children were in placements which they had not been matched, the social work team continued to make efforts to secure placements which were more suitable to their needs. Social workers told inspectors that there were not enough placements and that they had to place children where placements were available and in such circumstances matching was not always possible.

The area had limited foster carers, therefore this had an impact on the quality of matching undertaken for children and foster carers. Data provided to inspectors showed that of the 164 children placed in foster care, three children were placed outside the area. There were no available foster care placements at the time of the inspection and four respite placements were available. For the three children placed outside the area, there were clear rationales why these children were not placed in the area. Two children were awaiting a private foster care placement at the time of the inspection. Two of those children awaiting a private placement had complex needs and while significant efforts had been made by the service area to place the child, no suitable foster placements were available within the area. One of those children were also one of the three placed outside the area, however this was not an approved placement nor was it appropriate to meet that child's needs. HIQA requested and received satisfactory assurances that the area is making continued efforts to source an appropriate placement for these two children.

Two children under the age of 16 were placed in supported lodgings placements. Supported lodgings placements are intended for young people aged between 16 and 18 years, who cannot live at home but are not yet ready to live independently or who are in transition from care and in need of accommodation and support in a family setting. This type of arrangement is not suitable for children under the age of 16. While this was an emergency placement and was intended to be a short term arrangement, this placement had continued for two years and was not in line with foster care standards. While this departure from standards had been notified to the foster care committee, recommendations made by the foster care committee such as the requirement for the carer to be assessed as foster carers had not been implemented in a timely way.

Data submitted by the area showed that there were 12 foster carer households where the number of children placed exceeded the number recommended by the standards. Inspectors reviewed four files where the number of children placed exceeded the standards and found that all of these children had an allocated social worker at the time of the inspection who monitored the placement.

Practice in the area showed that social workers tried to ensure when possible that children maintained contact with their local community when they were placed in

foster care. Of the 38 children who answered questionnaires 27 (71%) children said that they see their family and friends regularly, 24 (63%) children remained in the same school when they moved to their placement while 10 (26%) children had to move school. 29 (75%) children identified that their culture and background was understood and promoted.

Questionnaires completed by children in care showed that there was mixed practice in the area when children first move in with foster carers and matching. The responses received from questionnaires identified 17 (44%) out of 38 children said that they got to meet with their foster carers before they moved in. However, 14 (36%) children said that they did not meet with the foster carer before they moved in and seven children did not answer this question. Thirteen (33%) children said that they were asked how they felt before the moved, while nine children said that they were not asked. Seven (18%) children did not answer this question.

In all, 25 of the 158 children placed in foster care were placed with relative carers, who had familiarity with their backgrounds. When a new relative placement was being considered there was a joint visit to the relative carer's home to complete an initial assessment of those carers for the proposed placement of that specific child.

While the capacity of foster carers to meet the needs of children is not always clear 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 in order to make timely decision for the child's future. This service areas policy in relation to long term matching sets out that the child's care plan will be formally reviewed when the child is six months in a placement and the review will consider whether the child is to remain in care and to determine the suitability and capacity of the carers to meet the child's needs.

However, this service area had only started completing long term matches in the last three years and as a result there was a significant backlog of these matches to be completed. Since 2016 the area has started to amalgamate long term matching with foster carer review reports for presentation to the foster care committee. When the link social worker was presenting a foster care review report to the foster care committee, the social worker also provided a report in order for the committee to consider the long term match of the child in that placement. It was the role of the committee to consider the foster carer's ability to meet the need of the child on a long term basis.

Data submitted by the area showed that there were 104 children awaiting approval of long term placements and 29 children had been approved for a long term match

with foster carers in the last three years. Inspectors reviewed five files where there had been an approval of a long term match. However, none of those long term matches had been completed following six months of the children being placed with foster carers. In the five files reviewed, the children were placed for a number of years prior to the long term match being completed.

While the area had completed some level of matching for children when the placements were planned, records of the formal of matching completed were not always available. The area had limited foster carers and therefore this had an impact on the quality of matching considered for children and foster carers. Four children were placed in placements which were not appropriate and were not suitable to meet children's needs on a long term basis. Three of these placements were not approved in line with standards. There was a large backlog of children awaiting a long term match and there was no plan in place to ensure these were completed in a timely way.

Judgment: Non-compliant moderate

Standard 10: Safeguarding and child protection

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

Summary of inspection findings under Standard 10

Complaints, concerns, and allegations against foster carers were categorised correctly. However, allegations made by children in care, that were not against current foster carers, were not always assessed in a timely manner or investigated in line with Children First (2017). Social workers required further clarity with regard to the implementation of both Children First (2017) and Tusla policy and procedures for responding to allegations of child abuse and neglect (2014). In addition, there were gaps in practice in the area such as delayed referrals to the duty/intake team, delays in scheduling strategy meetings and lack of appropriate safety planning for all children in care.

Data submitted by the area showed that there were six child protection and welfare concerns pertaining to children in foster care in the 12 months prior to the inspection and four of those remained open at the time of the inspection. There were two allegations made against foster carers in the past 12 months and these were closed at the time of the inspection. Data submitted by the area showed that no children

had been removed from foster care in the past 12 months due to child protection and welfare concerns.

Inspectors reviewed five child protection and welfare concerns reported by children in care. All of the allegations reviewed were correctly classified as allegations. However, these allegations were not processed and assessed in line with Children First (2017) and instead were managed according to Tusla policy and procedures for responding to allegations of child abuse and neglect (2014). Social workers told inspectors that because they were processed under this policy, no initial assessments had commenced on these allegations as required under Children First (2017). As a result, there was no timely determination as to whether the allegations were founded or not founded or whether formal protective measures were required for these children. Inspectors escalated this matter to the interim area manager and also requested assurances regarding the timely assessment of allegations made by children in care with regard to two specific cases. The response received did not provide adequate assurance and as a result this matter was escalated further to the regional service director. The regional service director provided satisfactory assurances and identified that additional governance measures had been put in place to oversee the management of these cases up to a final outcome.

Inspectors found that out of the above five allegations, strategy meetings were held for three. However, one of those strategy meetings was not held in a timely way. Inspectors found that there were long delays in the referral of these allegations to the duty/intake child protection team and in some cases it was difficult to see on the file whether the allegation was referred to the child protection team. For example, in one case an allegation was not reported to the duty/intake team for four months. As a result, the child in care social work team could not be assured that timely actions were taken to ensure children's safety and protect them from all forms of abuse.

Inspector's reviewed one allegation made by a child against a foster carer. Inspectors found that this allegation was appropriately managed in line with Children First (2017). There was a strategy meeting held in a timely manner and this allegation was referred to the duty/intake time in a timely way. An initial assessment was completed by the duty/intake team and the child was seen as part of the initial assessment. However, this allegation had not been notified to the foster care committee when first received, in line with the interim protocol for managing concerns and allegations of abuse or neglect against foster carers and section 36 (relative) foster carers policy.

There was insufficient governance and management of all child protection and welfare concerns made by children in care. All allegations made against foster carers were tracked by the area, which allowed the management team to assess how the allegation was being managed. However, when a child made an allegation against a

person who was not the child's current foster carer, the area did not have access to a tracker or mechanism to assess how the allegations were being managed by the social work department in order to avoid drift and delay.

Allegations and serious concerns were discussed at weekly leadership and governance meetings. While it was good practice that these allegations were discussed, this forum was not used to identify gaps in how allegations were being managed or to identify delays in the progress of the management of investigations.

There had been five serious concerns made against foster carers in the past 12 months and all of these serious concerns had been investigated and upheld. Inspectors reviewed three serious concerns made by children in care against foster carers. While these serious concerns were correctly classified, they were not managed in line with the interim protocol for managing concerns and allegations of abuse or neglect against foster carers and section 36 (relative) foster carers. In one case, the child had been met with and a safety plan had been developed and was implemented. However, inspectors found that there were no strategy meetings in relation to two of these serious concerns. In addition, in two serious concerns reviewed the child had not been met with by a social worker. In one case, some aspects of the serious concerns had not been identified as such and inspectors found that no immediate steps had been taken to ensure the child was safe. There were no records of strategy meetings held in order to review the concerns received. Inspectors escalated this matter to the interim area manager who identified that the social work team had considered this concern and were of the view that it did not constitute classification as a serious concern. However, records of these discussions and rationales for decisions made were not available at the time of the inspection.

Appropriate safeguarding measures, such as developing a safety plan, were not always implemented when required when a child in foster care made an allegation. Inspectors reviewed nine files for both allegations and serious concerns. Safety plans were not in place for children who had made allegations against persons in the community. In two allegations reviewed which had been made by children in care against people in the community, inspectors found that there was no safety planning discussed, risks explored or safety measures implemented with regard to these children and the possible risks posed to them while in the community. As a result, practices in the area did not ensure that children were protected from all forms of abuse.

Inspectors also reviewed a case where a care leaver was living in a foster home where a child was also placed who did not have the necessary An Garda Síochána

vetting. HIQA escalated this matter to the regional service director and received satisfactory assurances in relation to this matter.

The quality of safety planning was inconsistent. Inspectors reviewed seven files for safety planning and five of those files contained formal safety plans. In one file reviewed, while one child had moved foster placement, interim safety measures had not been put in place in order to assure the social work team of the child's safety while awaiting a new placement. Of the remaining six files reviewed for safety planning four of which contained a formal safety plan, three safety plans were of good quality, as they addressed all risks, appropriate supports had been put in place and safety plans had been monitored. However, in another case reviewed which required a safety plan, the social worker had verbally agreed aspects of a safety plan with the carers, however there was no formal written safety plan developed. Two further safety plans reviewed were of poor quality as they did not address all risks in the placement, there were delays in their implementation and one safety plan was not monitored regularly. Team leaders told inspectors that safety plans were monitored through supervision. Inspectors found that three out of the four safety plans were monitored for implementation. Two safety plans had been updated following a review. HIQA requested assurances following the inspection with regard to two particular cases, one of which had no safety plan in place and one due to the inadequacy of the safety plan in place. Satisfactory assurances were not provided by the area for one of those cases and upon request, HIQA received satisfactory assurances from the regional service director.

There were some good practices in place in the area to ensure that children were protected from abuse. Inspectors found that children had absence management plans which guided the foster carers on steps to take if the child was missing from care. In questionnaires received from 38 children and young people, 33 said that the social worker had told them who to talk to if they felt unsafe. 26 of the 29 children aged 6-15 years identified that they knew how to keep safe. There was also evidence that social workers had provided children with information about the complaints process.

In line with Children First (2017) foster carers are now considered mandated persons and are responsible for mandatory reporting of any concerns of a child protection and welfare nature to the duty social work team as appropriate. The interim area manager identified that the service area had written to all foster carers in relation to their responsibilities as mandated persons in 2017. While foster carers were reporting these concerns to the allocated social worker who in turn reported this to the relevant department, standard child protection report forms were not being submitted to the social work department by foster carers, as they were required to

do as mandated persons. The principal social worker acknowledged that foster carers were not submitting mandatory child protection forms when required. HIQA requested and received assurances from the regional service director following the inspection that children in care social workers and fostering link social workers will assist foster carers with making mandated reports and the targeted briefings in relation to mandatory reporting would also be provided for foster carers.

There was a system in place to manage complaints in line with Tusla complaints policy. Data provided by the area showed that there were three complaints made by foster carers in the past 12 months and there was one complaint made by a child in care. Inspectors reviewed the complaints log and reviewed three complaints in detail. Inspectors found that complaints were taken seriously and were responded to in a timely manner. The principal social worker was the complaints manager and complaints were also forwarded to the quality and risk manager who also tracked all complaints.

In one complaint reviewed, which was a complaint made by a child, inspectors found that it was dealt with by the allocated social worker and was responded to in a timely way. Two complaints made by foster carers were managed by the fostering principal social worker and were also responded to in a timely manner. However, informal complaints made by children were not being recorded by social workers and were being dealt with by social workers informally. Out of the 39 children and young people who responded to the questionnaires, thirteen said they had made complaints and they felt listened to and that the complaint was taken seriously. Three children indicated that they were not happy with the outcome of the complaint. As a result of the lack of recording of informal complaints, the management of complaints were not subject to review or analysed to identify trends in complaints made by children in care. The management of complaints was also a standing item on the agenda of management and leadership meetings. On review of the minutes of these meetings, it was identified that there may be under reporting of complaints and that further staff training may be required in this area.

Data submitted by the area identified that there was one serious concern regarding a child in aftercare in the last 24 months and a local summary report regarding this case had recently been completed. There was a process in place for serious and adverse incidents to be appropriately managed.

As all allegations made by children in care were not assessed and investigated in line with Children First (2017) which meant that the outcomes as to whether the allegations were founded or not and formal decisions as to whether robust safety measures were needed to ensure the child's safety were not occurring in a timely

way. While serious concerns were correctly classified, they were not managed in line with the interim protocol for managing concerns and allegations of abuse or neglect against foster carers and section 36 (relative) foster carers. Appropriate safeguarding measures had not been implemented for all children who had reported child protection allegations. The quality of safety planning in the area was inconsistent, therefore the area was judged to be in major non-compliance with this standard.

Judgment: Non-compliant Major

Standard 13: Preparation for leaving care and adult life

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

Summary of inspection findings under Standard 13

There was a well-established aftercare service in the area. The work completed by the aftercare team was guided by the Tusla National Aftercare policy and associated guidance. The aftercare service comprised of one manager and three aftercare workers. Due to an identified gap in staffing there was also one staff member who was contracted from a private provider to assist the aftercare team to provide an effective and timely service for care leavers. The service operated out of three offices across Cavan and Monaghan. The aftercare manager had previously reported directly to the area manager, however due to recent changes in the management structure the aftercare manager had begun reporting to the principal social worker for the children in care team. The aftercare manager also sits on the Dublin North East regional aftercare manager's forum.

Children, young people and foster carers were given adequate information about the aftercare services. On review of eight files of children who were aged over 16, inspectors found that adequate information was given to all of these young people and foster carers. There were two drop in centres in the service area and there was an information poster in relation to the drop in service available. At the time of the inspection, there were no information leaflets available to young people who were approaching care leaving age about the aftercare services. However, the aftercare

manager told inspectors that the aftercare team were currently drafting an information leaflet in consultation with a participation group about the service for young people and foster carers.

Once a young person has reached the age of 16, the allocated social worker was responsible for making a referral to the aftercare manager on a standardised Tusla referral form. This referral was sent with accompanying information, for example, a social history of the child and the most recent child-in-care review and care plan. Once this referral was received the aftercare manager reviewed the referral. The aftercare manager told inspectors that he would review cases and he would prioritise highly complex cases. The aftercare manager reported on a quarterly basis to Tusla in relation to how many referrals were received and how many were deemed eligible for the aftercare service. In quarter 1 of 2019, there were 11 aftercare referrals and all of these referrals were deemed eligible. Once the referral was deemed eligible and was prioritised, the referral would then be placed on a waiting list and was discussed at a monthly aftercare meeting. Following this, the young person was allocated an aftercare worker. Once cases were allocated, the aftercare team completed a file review, spoke to the social worker and attended a child in care review if there was one approaching.

There was a system in place for ensuring that all eligible children were referred to the aftercare service and the aftercare manager maintained good oversight of this. The principal social worker and aftercare manager told inspectors that when a child was approaching 16 this would also be discussed at their child in care review and it would be agreed that a referral should be sent for an aftercare service. The principal social worker and the aftercare manager also maintained oversight of a database which alerted the team when a child turned 16. The interim area manager told inspectors that the aftercare manager also had oversight of those who may have returned home to live with their families and who may also be eligible for an aftercare service.

Data submitted prior to inspection fieldwork showed that there were 25 children aged 16 and over that were in foster care in the area and all of these children were eligible for an aftercare service. Data showed that 20 of these children were referred to the aftercare service. By the time of the inspection, all 25 young people who were eligible for aftercare had been referred.

Formal lines of communication between the aftercare team and the child-in-care team required improvement. While the aftercare manager and the principal social worker communicated informally on a regular basis, there was limited formal communication between both the child in care team and the aftercare team. The

aftercare team met on monthly basis to enable a formal mechanism for a co-ordinated approach to the development, planning and management of services provided for care leavers in the area. The aftercare managers in the Dublin North East region also met regularly to discuss and make decisions on caseload management, communication, finance and operations. However, communication between the aftercare team and the child in care team was not consistent. Inspectors requested minutes of meetings which had occurred for the children in care and aftercare team in the two years prior to the inspection. A schedule of meetings for 2018 showed that three meetings were scheduled between the child in care team and the aftercare team. However, these records were not available for inspection. Of the records reviewed by inspectors, the aftercare manager attended one meeting with the child in care team and principal social worker in 2019.

Oversight mechanisms for the aftercare service required improvement. The interim area manager told inspectors that since starting in his position in January 2019 he was restructuring governance arrangements and that the formal communication meetings between the child in care team and the aftercare team was being reviewed at the time of the inspection. While the aftercare manager had met with the management team four times in 2018 at a complex case meeting forum, these meetings had not occurred in 2019 to date. The aftercare manager had met with the management team on an ad-hoc basis when requested. While there was a weekly management meeting held between the principal social workers and the area manager, there were no records of discussions regarding aftercare services at this meeting. The aftercare manager reported directly to the principal social worker for children in care, and one supervision meeting had occurred with the aftercare manager in 2019. The principal social worker told inspectors that she plans to attend aftercare meetings, but this had not occurred to date.

Comprehensive assessments of need were carried out on all but one child leaving care. Data provided during fieldwork identified that 13 children and young people had a completed aftercare needs assessment. Inspectors reviewed files of six young people between the ages of 16 and 18 years and five contained an assessment of need carried out by an aftercare worker. While one child did not have a completed aftercare needs assessment, this child did have a preparation for leaving care plan and an aftercare plan. On review of the remaining five files reviewed all but one of the five assessments of need were carried out in a timely way. One child's assessment of need was delayed until three weeks prior to their 18th birthday. The assessments were undertaken during one or more meetings between the aftercare worker, the young person and the foster carers and other relevant people. Inspectors found five assessments of need addressed all the issues outlined in the standards and regulations and were produced on national standardised templates.

Five assessments of needs were judged to be of good quality. However, one of those five assessments had not been completed with the timelines specified in the aftercare policy as it was delayed for over five months.

Children were actively involved in the aftercare process and in the planning for their futures. Involvement in the aftercare service was voluntary for each child and the aftercare team ensured that the young people led the process. Inspectors reviewed five assessments of needs and aftercare plans and found that they were drawn up with and co-signed by the young people.

All but one eligible children had a statutory aftercare plan six months prior to their 18th birthday. Data submitted by the area identified that there was seven children and young people who had an aftercare plan. Inspectors reviewed five files and found that four aftercare plans were completed in a timely way. Four aftercare plans were judged to be of good quality. However, one of those aftercare plans deemed to be of good quality had been delayed until three weeks before the child's 18th birthday. One of the five aftercare plans reviewed was deemed to be of poor quality because it was not sufficiently detailed to address the child's complex needs and how these needs will be addressed once the young person leaves care. All aftercare plans had been signed by the aftercare manager in a timely way. Data submitted by the area showed that eight children were allocated an aftercare worker. At the time of the inspection fieldwork, the aftercare manager told inspectors that there was no waiting list for allocation of an aftercare worker, all young people had an allocated aftercare worker, however some of these young people were waiting for an initial appointment with the aftercare worker.

Inspectors spoke with foster carers who were aware that they had a role to teach young people daily life skills and self-care skills in order to prepare them for leaving care. Foster carers also identified that they were involved in the assessment of need process with the young person and the aftercare worker. Inspectors reviewed nine files of children and young people aged 16 and over and found that six of those children were supported to develop independent living skills.

The service area involved children and young people in planning for the future. The aftercare service had developed a participation strategy and as a result a participation group of young people was established that met six times a year to provide a feedback mechanism for service provision. The aftercare team were in the process of developing an information leaflet with the participation group relating to what young people need to know about leaving care and aftercare. In 2018 as part of the participation strategy, the aftercare service developed an initiative whereby service users tell the aftercare team about their experiences in care. The service also

offered a drop-in service in communities across both counties which allowed young people to attend and seek advice on an informal basis. The aftercare team organised various classes for young people such as a parent and toddler group and yoga classes.

The service identified children in care aged 16-18 who had complex needs or disabilities who required a multidisciplinary response. An aftercare steering committee was established in 2016 which included representatives from both statutory and voluntary agencies who worked with children. This steering group met and reviewed the needs of children and young people presenting to the service who required a co-ordinated response. While this steering group had planned to meet four times yearly, quarterly meetings had not been occurring in this service area. Only one meeting of the steering group committee took place in 2018. Minutes of this meetings showed that there was a comprehensive overview of the young people discussed and their specific needs and extensive discussions in relation to planning for the young people's future. However, the interim area manager acknowledged that these meeting should occur on a quarterly basis in order to maintain good oversight of these complex cases.

Young people who left care continued to be provided with adequate support from the aftercare service. Of the 68 young people accessing the aftercare service 52 were over the age of 18. At the age of 18, the aftercare worker takes a lead on the provision of service to the young adult. The aftercare worker will support, guide and signpost the young adult in all aspects of their lives for the period up until their 21st birthday unless they remain in full time education, then this service is provided up to 23 years. The area developed a drop-in service for all young people and young adult's eligible for the services. This service was provided one afternoon a week in both Cavan and Monaghan. The drop in-service acted as a point of contact for young people and young adults who have been in care with Tusla. Inspectors spoke with six care leavers who were accessing the aftercare service and they were generally positive about the services offered by the aftercare team. One young person said that '*only for the aftercare service I am doing ok*'.

The aftercare team were proactive and worked with various agencies in order to access appropriate support for young people who left care. An aftercare adult accommodation project which was a pilot project had been developed to assess supported lodgings for young adults leaving care in order to enable them to start from a secure place. The service had also worked with relevant councils in order to have care leavers housing needs assessed in a timely way. The aftercare manager also identified that following consultation with various housing bodies one had recently committed to provide long term housing for care leavers.

The area had not previously measured outcomes for young people who had left care in the area. The aftercare manager told inspectors that a participation officer had recently joined the service and it would be their role to complete exit interviews. In 2018, as part of the participation strategy, the aftercare service developed an initiative to ascertain the views of care leavers. This study involved consultation with 26 care leavers in order to reflect their experiences of the aftercare service. This study explored with young people what was good about the service and what needed to improve. It is anticipated that this study will be used for service improvement across the service area. This report was in draft format at the time of the inspection fieldwork.

The aftercare manager maintained records and statistics on who had left care and remained in the aftercare service. No young people were reported as homeless. The aftercare manager reported the aftercare metrics to Tusla on a quarterly basis. These metrics included the number of referrals received, assessments undertaken, aftercare plans completed and the timeframes involved. At the end of quarter 1 2019, there were 68 young people and adults in receipt of aftercare services. Fifty two of these were young adults aged 18-22 in receipt of an aftercare service. The following data was also available.

The total number in receipt of an aftercare service aged 18-22 years and their accommodation arrangements:

- 0 (0%) were living in a residential placement
- 17 (32.7 %) remained with their carer
- 24 (46 %) independent living (including private sector, excluding those in designated care leaver accommodation)
- 0 (0%) designated care leavers accommodation
- 3 (5.8) were living at home
- 6 (11.5) were living in supported lodgings
- 2 (4%) in other accommodation,

The aftercare manager completed a 2018 annual overview report on the children in care and aftercare services in the area. Some of the findings of this report identified that:

- there was a good referral rate from the child in care team to the aftercare at the appropriate age,
- aftercare assessments were taking place in a timely fashion; however some gaps were due to staffing,
- complex cases had been referred to the steering committee appropriately,

- there was not a clear definition of a disability and children with some disabilities were not considered to meet the criteria for disability services
- social workers were not directly referring children to the steering committee.

There was also a review of the 2018 leaving and aftercare services operational plans and service development which reviewed four aims of the service for 2018. This review found that one of the four aims had been met and the further three aims have been progressed and will be prioritised in 2019.

The aftercare team provided a consistent service to care leavers and it was evident that the aftercare team made the services accessible to care leavers in the area. There were good initiatives in place such as the parent and toddler group and the drop in centre for care leavers. It was also evident that there was good interagency work particularly in the area of adult accommodation. For this reason, the area was judged to be compliant. All but one child did not have an assessment of need completed. In addition, one child did not have an assessment of need or an aftercare plan completed in a timely way. Lines of communication between the child in care team and the aftercare team and the management team required improvement. While the steering group received referrals for children with complex needs, the steering group did not meet on a sufficiently regular basis.

Judgment: Compliant

Appendix 1 — Standards and regulations for statutory foster care services

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

* 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*

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

***National Standards for Foster Care* (April 2003)**
Standard 14a — Assessment and approval of non-relative foster carers Foster care applicants participate in a comprehensive assessment of their ability to carry out the fostering task and are formally approved by the health board* prior to any child or young person being placed with them. ***Child Care (Placement of Children in Foster Care) Regulations, 1995*** *Part III, Article 5 Assessment of foster parents* *Part III, Article 9 Contract*
Standard 14b — Assessment and approval of relative foster carers Relatives who apply, or are requested to apply, to care for a child or young person under Section 36(1) (d) of the Child Care Act, 1991 participate in a comprehensive assessment of their ability to care for the child or young person and are formally approved by the health board. ***Child Care (Placement of Children with Relatives) Regulations, 1995*** *Part III, Article 5 Assessment of relatives* *Part III, Article 6 Emergency Placements* *Part III, Article 9 Contract*
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

* 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)**
skills and knowledge required to provide high-quality care.
Standard 17: Reviews of foster carers Foster carers participate in regular reviews of their continuing capacity to provide high-quality care and to assist with the identification of gaps in the fostering service.
Standard 22: Special Foster care Health boards provide for a special foster care service for children and young people with serious behavioural difficulties.
Standard 23: The Foster Care Committee Health boards* have foster care committees to make recommendations regarding foster care applications and to approve long-term placements. The committees contribute to the development of health boards' policies, procedures and practice. ***Child Care (Placement of Children in Foster Care) Regulations, 1995*** *Part III, Article 5 (3) Assessment of foster carers* ***Child Care (Placement of Children with Relatives) Regulations, 1995*** *Part III, Article 5 (2) Assessment of relatives*

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

National Standard for Foster Care (April 2003)
Theme 3: Health and Development
Standard 11: Health and development The health and developmental needs of children and young people in foster care are assessed and met. They are given information, guidance and support to make appropriate choices in relation to their health and development. ***Child Care (Placement of Children in Foster Care) Regulations, 1995*** *Part III, Article 6 Assessment of circumstances of child* *Part IV, Article 16 (2)(d) Duties of foster parents*
Standard 12: Education The educational needs of children and young people in foster care are given high priority and they are encouraged to attain their full potential. Education is understood to include the development of social and life skills.
National Standards for Foster Care (April 2003)
Theme 4: Leadership, Governance and Management
Standard 18: Effective policies Health boards have up-to-date effective policies and plans in place to promote the provision of high quality foster care for children and young people who require it. ***Child Care (Placement of Children in Foster Care) Regulations, 1995*** *Part III, Article 5 (1) Assessment of foster carers*

Standard 19: Management and monitoring of foster care agency

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

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

Part IV, Article 12 Maintenance of register

Part IV, Article 17 Supervision and visiting of children

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

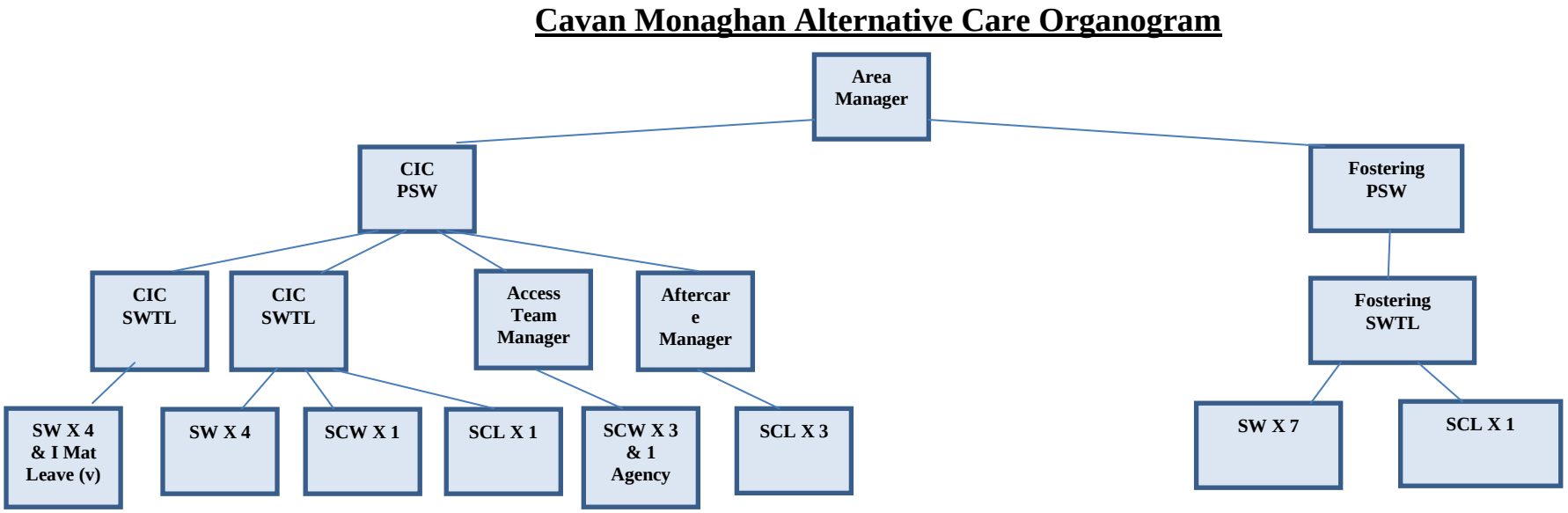
Health boards* ensure that the staff employed to work with children and

* 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).

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 xxxx Service Area*



* Source: The Child and Family Agency

Action Plan

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

Provider's response to Report Fieldwork ID:	MON 0026146
Name of Service Area:	Cavan/Monaghan
Date of inspection:	14-16 April 2019
Date of response:	28th June 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:

There was no robust system of oversight in place to ensure statutory visits were completed for children when they were unallocated.

The quality of some children's records were poor.

The management of records maintained on an electronic system required 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. There was no robust system of oversight in place to ensure statutory visits were completed for children when they were unallocated.

- The Cavan/Monaghan local protocol for managing unallocated children in care (2019) will be followed and unallocated children in care will be visited in line with the Fostering Standards
- Visits will be completed by either a social worker from the children in care duty rota or by the allocated fostering link worker
- These statutory visits will be written up on the standardized form and uploaded onto NCCIS
- The Principal Social Worker for children in care will have oversight of this and will discuss all unallocated children in care during supervision with Social Work Team Leaders
- The dates of home visits will be tracked on the children in care database

2. The quality of some children's records were poor

- All Statutory home visits will be written up on the standardized form for home visits
- A yearly calendar has been drawn up for audits of children in care records on NCCIS

These audits will be completed by Principal Social Worker, Social Work Team Leaders Senior Social Workers on a monthly basis and will review the quality of record keeping

3. The management of records maintained on an electronic system required improvement.

- A working group has been established to develop a system standardising how and where on the NCCIS system records for children in care will be stored
- All social workers on Children in Care and Child Protection Teams will be trained in this new system
- This system will be used until a national protocol is developed and implemented around the storage of data for children in care on NCCIS
- Any risks identified around the management of electronic records will be escalated to the Area Manager

Proposed timescale:	**Person responsible:**
Action 1: 30th May 2019 **Action 2: 30th September 2019** **Action 3: 31st October 2019**	**PSW Children in Care** **PSW Children in Care** **PSW Children in Care**

Standard 6 – Assessment of children and young people

Substantially compliant

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

Not all assessments of need were completed in line with the required timelines

There was no effective oversight mechanism in place to ensure that the child's assessment of needs was carried out in line with the standards

Action required:

Under **Standard 6** you are required to ensure that:

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.

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

1. **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.**

- The Screening, Assessment and Intervention Social Worker will complete an Initial Assessment on all children who don't already have one completed within one week of their Reception into Care
- Initial Assessment will be added to the children in care database which is monitored by the PSW for children in care
- Following the completion of the Initial Assessment, the Care Plan for the child will comprise their assessment of need

Proposed timescale:	**Person responsible:**
Action 1: 26th July 2019	**PSW Children in Care**

Standard 7 – Assessment of children and young people

Substantially compliant

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

The location where the child in care reviews were held was not child friendly and was not comfortable

Voluntary consent given by parents at the time of the child's admission to care was not subject to review at child in care reviews.

Not all children had an up-to-date care plan.

Not all child in care reviews were held in line with the requirements of the regulations.

The quality of some care plans and child in care reviews were poor, and not all care plans had been signed off by a team leader.

The outcomes of reviews were not always discussed with children following the review.

Case management did not always identify gaps in quality of care plans and child in care reviews.

Placement plans were not used in the area in respect of each placement of a child which were consistent with the child's care plan.

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 location where the child in care reviews were held was not child friendly and was not comfortable**

- By end Q4 2019 child friendly locations to convene Child in Care Review's will be available in the new social work offices in Cavan
- The rooms used in Monaghan for Child in Care reviews are child friendly and comfortable.

- The Area continues to have some child in care reviews occur in the foster carers home where it is appropriate

2. Voluntary consent given by parents at the time of the child's admission to care was not subject to review at child in care reviews

- The need for the child to remain in the care of Tusla will be reviewed at each child in care review and documented on the Care Plan
- A check that all forms for children in care by voluntary consent of parents is up to date will be part of the Care Plan
- An audit of children's files subject to Voluntary Care will be undertaken in the Area to ensure updated consent is recorded

3. Not all children had an up-to-date care plan

- By December 31st all Care Plans and Reviews will be completed in line with the Fostering Standards
- The care plans and reviews will continue to be tracked on the children in care register

4. Not all child in care reviews were held in line with the requirements of the regulations

- By 31st December 2019, all children in care will have an up to date care plan
- Care plan's record the next scheduled review date
- There is a schedule of reviews in the Area to address any outstanding reviews in line with the timelines set out in the Standards
- The care plans and reviews will continue to be tracked on the children in care register

5. The quality of some care plans and child in care reviews were poor, and not all care plans had been signed off by a team leader

- Social work Team leaders and Principal Social Worker will review each Care Plan before they are electronically signed off
- Audits will be completed by Social Work Team Leaders, Principal Social Workers, or Senior Social Workers every month to check on quality of Care Plans
- Social worker's will be provided with training on the preparation for Child in Care reviews and the quality of data required for care plans as per Regional Guidance

6. The outcomes of reviews were not always discussed with children following the review

- Care Plan actions will be discussed with all children in care in an age appropriate manner following child in care reviews (except in cases where children are too young to understand)
- These discussions will be documented in case notes titled "Discussion of

outcome of Child in Care Review with Child" on NCCIS

- A yearly calendar of audits of cases on NCCIS will be drawn up so that there are monthly audits conducted by Senior Social Workers, Social Work Team Leaders and PSW for children in care
- The named social worker and team leader will be given a copy of the audit and follow up audits will be done on some cases to see if the required actions have been completed
- Additional supports will be put in place to discuss outcomes with children where their ability to comprehend the discussion may be limited, aids such as the "Bubble toolkit" will be used
- Staff will receive briefings in the use of the "Bubble" toolkit to support implementation in the Area

7. Case management did not always identify gaps in quality of care plans and child in care reviews

- Social work Team Leaders and Principal Social Worker for children in care to review every Care Plan before electronically signing it off on the NCCIS
- Audits will be undertaken by Social Work Team Leader, Principal Social Worker or Senior Social Workers Monthly to review quality of Care Plans
- Case Management will be discussed in supervision, identified gaps in the quality of care plans and child in care reviews will be discussed in this forum
- Themes and trends will be discussed at team meetings in the Area and any identified risks escalated to the Area Manager
- Social worker's will be provided with training on the preparation for Child in Care reviews, the quality of data required for care plans as per Regional Guidance

8. Placement plans were not used in the area in respect of each placement of a child which were consistent with the child's care plan

- Placement plans are being utilised for each new placement as per the Fostering Standards

Proposed timescale:	**Person responsible:**
Action 1: 31st December 2019	**Area Manager**
Action 2: 30th July 2019	**PSW & SWTL's Children in Care**
Action 3: 31st December 2019	**PSW & SWTL's for children placed in care**
Action 4: 31st December 2019	**PSW & SWTL's Children in Care**
Action 5: 31st December 2019	**PSW & SWTL's & Senior Social Workers Children in Care**
Action 6: 31st December 2019	**PSW & SWTL's & Senior Social Workers Children in Care**
Action 7: 30th August 2019	**PSW & SWTL's & Senior Social Workers Children in Care**
Action 8: 27th June 2019	**PSW Screening, Assessment & Intervention Team**

Standard 8 – Matching carers with children and young people

Non-compliant Moderate

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

There were not enough foster placements available in the area on order to enable robust matching of children.

Records of comprehensive matching of children's needs with the capacity of the foster carer to meet those needs were not available.

There was a significant backlog of long term matches to be completed in the service area.

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. **There were not enough foster placements available in the area on order to enable robust matching of children**

- The Dublin North East Regional fostering team are responsible for the recruitment and assessment of foster carers in the area
- There are currently 10 applicants on the regional waiting list for Cavan Monaghan and 2 others who are resuming assessment following a pause. The Regional Team plans to assess these carers as soon as possible
- National Fostering Week is planned for the week beginning 14th of October 2019. The Area will support this plan to have both regional and local activities to coincide with that week to increase the pool of fostering applicants locally

2. **Records of comprehensive matching of children's needs with the capacity of the foster carer to meet those needs were not available**

- Weekly placement matching meetings are now occurring in the area. These meetings are chaired by the PSW or SWTL for fostering and representatives from Children in care and child protection teams attend also
  These meetings explore and record all matching considerations based on the identified needs of the child and the capacity of the foster carers to meet those needs
- A record of each placement request discussed, matching considerations and

decisions reached is placed on the child's file and on the foster carers file

3. There was a significant backlog of long term matches to be completed in the service area

- There is a schedule of reviews in the Area to complete all outstanding long term matches in conjunction with foster carer reviews
- Long term matches continue to be discussed at all Statutory Child in Care Reviews and the recommendation for long term matches recorded in the child's care plan where applicable

Proposed timescale:	**Person responsible:**
Action 1: 31st October 2019	**AM, PSW Fostering and Regional Fostering Team**
Action 2: 27th June 2019	**PSW Fostering**
Action 3: 25th June 2020	**PSW Fostering**

Standard 10 – Safeguarding and Child Protection

Non-Compliant Major

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

Not all allegations were processed and assessed in line with Children First (2017).

There was insufficient governance and management of all child protection and welfare concerns made by children in care.

Not all serious concerns were managed in line with the interim protocol for managing concerns and allegations of abuse or neglect against foster carers or relative (Sec 36) carers.

Appropriate safeguarding measures such as safety plans were not always implemented when a child in foster care made an allegation. The quality of safety planning was inconsistent.

Mandatory reports of child protection and welfare concerns were not being submitted to the social work department by foster carers as required.

The management of informal complaints were not subject to review or analysed to identify trends in complaints made by children in care.

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. **Not all allegations were processed and assessed in line with Children First (2017)**

- Allegations will be managed in line with Children First (2017) and the Interim Protocol – Managing Allegations of Child Abuse and Neglect or Serious Concerns in respect of a child or children in foster care
- An Initial Assessment will be carried out by the Screening, Assessment and Intervention team on each child making allegations
- Allegations made by children in care will be on the agenda for monthly supervision between the Principal Social Worker and Social Work Team Leaders in order to track such cases to ensure they are processed and assessed in line

with Children First
- All Allegations concerning children in care are updated on a tracker and discussed in the Fostering /Children in Care Governance meeting

2. There was insufficient governance and management of all child protection and welfare concerns made by children in care

- The PSW for Children in care maintains a tracker for all allegations (and serious concerns) made by children in care including those made against people in the community and retrospective reports of abuse
- The Principal Social Worker for Fostering maintains a tracker of all allegations (and serious concerns) made against foster carers
- The SWTL's will track progress with allocated social workers
- The SWTL's will provide the PSW's with updates on the progress and management of these and advise of any blocks/drift in cases in supervision
- An update in writing and verbally on the management of the allegations is provided at the Fostering/Children in Care Governance Meeting which is chaired by the Area Manager

3. Not all serious concerns were managed in line with the interim protocol for managing concerns and allegations of abuse or neglect against foster carers or relative (Sec 36) carers

- All reports deemed as serious concerns will be managed in line with the Interim Protocol for managing concerns and allegations of abuse or neglect against foster carers or relative (section 36) carers
- A clear rationale for categorisation and criteria for decision making processes will be documented

4. Appropriate safeguarding measures such as safety plans were not always implemented when a child in foster care made an allegation. The quality of safety planning was inconsistent

- Robust and Appropriate Safety Plans will be drawn up and implemented for all children who have made allegations of abuse by foster carers and/or people in the community
- These plans will be drawn up with the allocated social worker for the child (either children in care or child protection team) and fostering
- These plans and reviews of the plans will be agreed and signed off by all involved parties
- Safety Plans will be regularly reviewed in supervision with SWTL and as part of the Child in Care Review
- Safety Plans will be documented in the actions of the Care Plan

5. Mandatory reports of child protection and welfare concerns were not being submitted to the social work department by foster carers as required

- All foster carers were written to and informed of their obligation as mandatory reporters in 2017
- All foster carers have completed Children First online training
- The Area will re-issue the letter to all carers reminding them of their responsibilities, as per Children First
- The Area children in care and fostering link social workers will assist foster carers with making mandated reports as per Children First 2017, Chapter 3, Making a Mandated Report-Joint Reporting
- The Regional Children First Information Officers will be available to support the Area with targeted briefings for Foster Carers also, these briefings will be planned to commence in September 2019

6. The management of informal complaints were not subject to review or analysed to identify trends in complaints made by children in care

- Social workers will be asked as part of supervision to report any informal complaints by children in care and how they were managed to their SWTL
- These will then be sent on to the Quality and Risk Manager in the Area for record keeping and to complete a yearly analysis of the informal complaints
- Participation groups are being established with children in care, these groups will seek the views and gain feedback including complaints from children in care
- Statutory home visits forms will also be used to capture any complaints from young people in care in this Area
- The National Quality Assurance directorate have advised that the first phase of a new e-learning training on managing complaints should be ready for launch in July 2019, when this becomes available all staff will be mandated to completed this

Proposed timescale:	**Person responsible:**
Action 1: 27th June 2019	**PSW Children in care and PSW Screening, Assessment & Intervention**
Action 2: 27th June 2019	**PW & SWTL's Children in Care, PSW & SWTL Fostering and Area Manager**
Action 3: 27th June 2019	**PSW Fostering and PSW Children in Care**
Action 4: 27th June 2019	**PSW Fostering, PSW Children in Care and PSW Screening, Assessment & Intervention**
Action 5: 31st December 2019	

Action 6: 31st December 2019	**PSW Fostering and PSW Children in Care** **PSW & SWTL's for Children in care and PSW Screening, Assessment & Intervention and Quality and Risk Manager**