Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Child Protection and Welfare Service

Name of service area:	Mayo
Name of provider:	Child and Family Agency, Tusla
Type of inspection:	Focused CPNS
Date of inspection:	21 – 22 & 27 – 28 September 2021
Lead inspector:	Pauline Clarke Orohoe
Support inspector(s):	Sabine Buschmann Olivia O'Connell Leanne Crowe Jane O'Carroll Susan Talbot
Fieldwork ID	MON-0033788

About monitoring of child protection and welfare services

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

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

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

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

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

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

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

How we inspect

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

The key activities of this inspection involved:

- the analysis of data
- interview with the area manager
- interview with the chairperson of child protection case conferences
- interview with the national approach to practice network coordinator
- interview with the principal social worker
- focus group with social work team leaders
- focus group with social workers and social care leaders
- the review of local policies and procedures, minutes of various meetings, staff supervision files, audits and service plans
- observation of a review child protection conference
- the review of 10 children's case files
- phone conversations with five parents
- phone conversations with three children

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

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

Profile of the child protection and welfare service

The Child and Family Agency

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

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

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

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

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

Service area

Mayo is one of seventeen areas in the Child and Family Agency, forming part of the West Region and is the third largest geographical county in Ireland. Mayo is predominantly rural with larger urban populations based in Ballina, Castlebar and Westport. The population is reported at the 2016 census as 130,507 with 31,968 under the age of 18. Mayo has a deprivation score of -7.7 compared to the national average of -3.6.

The area was under the direction of the service director for Tusla West, and was managed by an area manager. The child protection and welfare social work team was managed by one principal social worker, who had line management responsibility for four team leaders. Children listed on the child protection notification system (CPNS) were case managed by three long term child protection teams based in Ballina, Castlebar and Swinford and a fourth intake duty team with workers based in each of the three offices. The area manager delegated child protection conferencing responsibilities to one principal social worker who was the CPC chairperson. The CPC chairperson also oversaw the work of the national approach to practice network coordinator. Administration staff were employed to assist in

the delivery of this service. Both of the principal social workers reported to the area manager.

At the time of the inspection there were 34 children listed as active on the CPNS. Nine children had been de-listed in the previous six months.

At the time of the inspection, there were seven whole time equivalent social work vacancies, and 1.8 key frontline social care and family support practitioner vacancies across the child protection and welfare service. One other social work post was being filled by agency staff.

Compliance classifications

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

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

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

1. Capacity and capability of the service:

This dimension describes standards related to the leadership and management of the service and how effective they are in ensuring that a good quality and safe service is being

provided to children and families. It considers how people who work in the service are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

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

This inspection was carried out during the following times:

Date	Times of inspection	Inspector	Role
21 September 2021	09.30 to 17:00 10.00 to 17.00	Pauline Clarke Orohoe Sabine Buschmann Olivia O'Connell Leanne Crowe Susan Talbot Jane McCarroll	Lead Inspector Support Inspector Remote Inspector Remote Inspector Remote Inspector Remote Inspector
22 September 2021	09.00 – 17.45	Pauline Clarke Orohoe Sabine Buschmann Olivia O'Connell Leanne Crowe	Lead Inspector Support Inspector Remote Inspector Remote Inspector
27 September 2021	10.00 – 11.30 (Interview with Area Manager)	Pauline Clarke Orohoe	Lead Inspector
28 September 2021	10.00 – 12.00 (Observation of a review child protection conference)	Pauline Clarke Orohoe	Lead Inspector

Views of people who use the service

HIQA inspectors spoke with three children individually over the phone. These children spoke positively about their experience of the child protection service. Two children stated that they did not like attending meetings but that their social workers represented their views and they were kept informed of any decisions or actions. They were satisfied with the level of contact they had with their social worker, and the support they received. Some of their comments about their social workers included:

"She is really nice and gave me her number in case I needed to talk to her."

"They told us afterwards about what happened at the meeting. They also talked to us before the meeting – they talked to us about our future and what we'd like to see change; if everything was ok."

"I got to talk to someone and now I feel safer."

"She always brings games to play. She's nice. She helps me."

Inspectors talked with five parents who had experienced the child protection conference (CPC) process and whose children were, or had been, listed on the CPNS. Parent's views of the service were mixed. The majority were satisfied with the service they received. The majority of parents described good communication between themselves, the social work department and the CPC department. Parents agreed that they were given information about the CPC service in advance. One of the parents explained that "I was informed about it and everything was always explained to me" while another parent said that the "written information provided is easy to understand". Most said that they were well prepared for the CPC and felt actively involved in the process.

Three parents described a quality service which had a positive impact on them and their children; as one family member told inspectors, "I did find it helpful in getting supports for my family. This has worked really well. It's a helpful meeting. People who run it are fine and fair". A second parent explained that "I was happy with the way it proceeded. I was able to share my views. I felt heard and respected". One parent described the CPC process as challenging, and explained that "there's no handbook to teach you how to go into these meetings and you're so defensive. But it's less adversarial now. Everybody gets a chance to speak now".

The majority of the parents spoken to felt that they were supported and encouraged to participate in the conference. They felt that their voice was hear. One parent told inspectors that "I was able to share my views, but I didn't have much to say", while a

second parent said that "if we had any issues, we'd bring them up. They would be discussed then". Most of the parents felt that the CPC was well managed to support their participation and they fully understood the outcomes and the child protection safety plan. The majority of the parents said that they were informed of the outcome of the CPC meeting, and two parents said that they were asked for feedback on the meeting process. One of the parents commented that "yes, the feedback can be given anonymously, however the feedback form already has identifying information on it".

Following the CPC, parents said that social workers and other people involved in their safety network supported them. One parent told inspectors that they "did find it helpful in supports for my family" and that "the social worker would always check if there was anything we needed. If we needed to talk about anything. Safety network worked really well. Supports we needed we got, always there to step in".

However two parents expressed dissatisfaction with aspects of the CPC process. One parent felt that "we don't really have supports in CPCs. It says you can bring someone with you but that person can't say anything or contribute to the meeting and it can be intimidating". This parent also felt that "sometimes we are still going over the same plan and actions, because of funding. So we are still waiting for things to happen. Everyone's workload and COVID can delay things". A second parent felt that the only support they were provided with was bus transport.

Capacity and capability

Overall, the service had effective leadership, governance and management arrangements which provided a consistent, well led service to children listed on the Child Protection Notification System (CPNS). The service performed its functions in accordance with relevant legislation, policies and standards, and by doing so it ensured that children were kept safe. There was a culture of openness and learning which focused on the needs of the children. Inspectors found that the service were striving for best practice and management followed through on recommended actions made following audits, inspections and quality assurance reports. This ensured the delivery of a good quality service that was well managed for children and their families.

This inspection occurred at a challenging time for both social work teams and children and families engaging in the services nationally due to the risks and public health restrictions associated with the COVID-19 pandemic. In addition, in May 2021 Tusla had been the target of a major cyber-attack which had compromised their national child care information system (NCCIS) for several weeks prior to the inspection. In this context, HIQA acknowledges that the service needed to adapt to how they worked with children and families to ensure they continued to receive essential support to ensure safety. These issues, and how they were managed, were reviewed within the overall assessment of local governance.

The focus of this inspection was on children placed on the CPNS register who were subject to a child protection safety plan and the aligned governance arrangements in place to ensure effective and timely service delivery to these children. As per Children First (2017), when concerns of ongoing risk of significant harm are identified during the assessment and intervention with children and families then Tusla is required to organise a Child Protection Conference (CPC). In circumstances where a child has been identified as being at ongoing risk of significant harm at a CPC, their name is placed on the CPNS register. This meant that children on the register were closely monitored by the social work department to ensure they were safe and interventions were provided to children and families to reduce risks to children. Children who have child protection plans continue to live at home, unless it emerges that a child is at ongoing risk, or if the child protection plan is deemed not to be working. These cases may result in a decision to remove the child from the home. This inspection also reviewed children whose names had recently been made inactive on the CPNS in the last six months. These children had been assessed as no longer being at risk of significant harm.

The Tusla interim national guidelines on CPC and the CPNS had not been subject to review at the time of the inspection and required updating by Tusla, as a means of assuring quality and consistent practice. Inspectors found that the area had developed a local process which provided clear guidance detailing the steps required to be taken when requesting a CPC. It outlined the timeframe for the invitations to the initial CPC and the safety network meetings. It provided clear instructions for the social worker on the need to complete the "Me and My Conference" booklet with children, and share their report with the family. Staff told inspectors that this document was helpful to them in their daily practice. The area had a standard practice of fortnightly visits to children listed on the CPNS. Social workers and management described clear procedures for the referral and organisation of a CPC, and demonstrated their knowledge of policies, legislation and standards in relation to the protection of children. Inspectors found that this was evident in the files that were reviewed, and that cases were appropriately referred for CPC.

The area held quarterly management meetings between the CPC chairperson and the child protection and welfare management service. The purpose of the meetings was to provide oversight of the CPC process in the area, and ensure that the service provided to children and families was in line with local and national policies and procedures. It also provided a forum to review the implementation of the national standardised templates, and local processes regarding fortnightly visits to children. Inspectors reviewed the minutes from these meetings and found that areas of good practice and service improvement were discussed, with clear actions recorded and followed through on from one meeting to the next. These local processes provided increased governance of the CPNS process, which in turn ensured consistent social work practice that kept children safe.

Inspectors found that when a child was placed on the CPNS register, the abuse category could not be changed nor could more than one category of abuse be recorded on the register. This meant when one type of abuse was no longer a concern for the child but another type of abuse had emerged, the register did not accurately reflect the concern for the child. Inspectors found that for one of the files reviewed, the category of abuse noted on the CPNS differed from the category of abuse recorded on the CPC record. The rationale for the difference in categorisation was not evident on the CPC record. The area manager reviewed their files, and found that this was the situation for four children listed on the CPNS. The area manager told inspectors that these cases were being reviewed to ensure that there was a clear rationale recorded on file for any changes made to the categories of abuse originally entered on the CPNS. However, as the category of abuse recorded on the national CPNS register could not be updated, there was potential for the area to be limited in their ability to ensure that professionals accessing the CPNS were receiving accurate

information in relation to the risks identified for the child. The area manager told inspectors that they were assured that professionals are getting accurate information in relation to the risk to a child listed on the CPNS as the out of hours social work service can access the child's record on NCCIS.

The service area had strong governance arrangements in place with clearly defined roles and responsibilities which provided assurance to senior management that children listed on the CPNS were receiving a good quality, safe service. The area manager delegated conferencing duties to a principal social worker who was the CPC chairperson. They were responsible for ensuring that requests for CPCs from social workers and determined if the referrals met the threshold for a CPC. The CPC chairperson was responsible for scheduling, organising and facilitating the CPC meetings. The CPC chairperson had responsibility for ensuring the CPNS register was updated and maintained. The social work teams were responsible for the implementation and monitoring of the child protection safety plans.

The area had developed specific service plans for the different aspects of the services provided across the area, including CPNS. This plan was aligned with Tusla's national corporate plan 2021-2023. This plan outlined the key goals for the CPNS service over a three year period, while also considering how the service worked in line with relevant policy and legislation. The service plan took account of the provision of a good quality CPNS service within the broader child protection and welfare service. Inspectors found that the service plan was due for review in the weeks following the inspection. The area had completed a review of the previous service plan and the required actions.

There was a culture of openness and transparency within the service. Inspectors found evidence of good communication systems and team working in the area. Senior managers valued the importance of open communication with staff teams. Inspectors found that team meetings across the area were informed by senior management and governance meeting forums indicating good communication within the service. Staff were well connected across the grades, and this was evident through discussions with staff throughout the inspection. Inspectors found that managers and social workers had a high level of knowledge of individual children listed on the CPNS. When clarifications or additional information was requested from the social work teams on actions or decisions made in relation to cases, the relevant information was provided to inspectors.

The senior management team were committed to continually improving the services they delivered to children and families. Learning and development was encouraged across the staff teams. The area had re-established a behaviour and values working group in the area to further explore these aspects service delivery. The area manager

told inspectors that the service was continually striving for best practice, and this message was evident in discussions with social work teams. Inspectors found evidence that feedback from families and professionals was regularly sought following CPCs. Staff members were encouraged to avail of learning and development opportunities, and this was evident throughout the discussions with social work teams during the inspection. The service had appropriate mechanisms for dealing with complaints and appeals made in relation to the CPNS service. There were some initial delays in dealing with one complaint, and this was acknowledged by the area in their final report. Inspectors found that families were given information on how to make a complaint where a CPNS appeal did not meet the appropriate threshold. Learnings from complaints, previous HIQA inspections and audits were discussed at meetings. Discussions regarding practice, research and the use of Tusla's learning and development resources were evident as standing agenda items.

The management team in the area were assured of the quality of the service provided to children through the CPC service through the governance meeting structures in place in the area. As noted earlier, quarterly meetings were held between the CPC chairperson and the child protection management team to maintain management oversight of the CPC service. There was a culture of openness across the service, where staff were supported to be involved in the development of the service and to challenge decisions that were made. This was evident throughout the minutes of team meetings at local and senior management level. The area also held regular standards meetings in order to ensure that practice in the area was in line with the national standards. Areas for service improvement were reviewed and discussed, with clear actions and next steps recorded. Inspectors found that standing agenda items included the strategy for service recovery following the recent cyber-attack, risk management, workforce and staffing, GDPR, management of complaints and learning from inspections and audits completed. Performance data and reports provided at the senior management team meetings provided assurance to the area manager in relation to quality and performance of services in the area as a whole. These reports informed further service development in the area. The CPC chairperson also provided updates and relevant data in relation to the CPC service. This information was used to develop appropriate actions to ensure the delivery of a good quality service to children. Furthermore, the area had held management meetings to support consistent implementation of the standardised letter templates for the child protection and welfare service. These meetings also reviewed the implementation process, and feedback was gathered and shared with Tusla's regional quality assurance officer.

The area operated a complex case forum to provide an objective, multi-disciplinary review of referred cases, and provided additional support and direction on challenging cases. Cases on the CPNS that were at their third review CPC were referred to the

Mayo Supporting Practice complex case forum for discussion and consideration. Cases were referred into the forum by Tusla social work staff. Inspectors reviewed some of the complex case forum minutes and found that they provided an objective review of the decision making for children listed as active on the CPNS. The minutes showed evidence of detailed discussion and consideration of the child's involvement with the social work department, and challenged the decision making in relation to the risks identified in the case, setting out next steps to be considered to address the child's needs. The complex case forum prevented drift in the case, and provided additional management oversight in relation to children listed as active on the CPNS. Social workers and managers told inspectors that the forum was a valued and effective process for supportive discussion on cases from a multi-disciplinary perspective.

Inspectors found the supervision provided to staff in the area was robust, and was seen as an assurance mechanism by management of the quality of service provided to children listed on the CPNS. Supervision was well embedded in practice across the service from frontline workers through to senior management levels, with detailed, written records available on children's files. Inspectors reviewed case supervision records and found that they were up-to-date and recorded on a standardised template. Challenges and risks within the case were identified and discussed. Detailed actions and next steps were agreed and recorded. Inspectors found that actions were appropriately followed up on in subsequent supervision sessions. Supervision records demonstrated that social work team leaders had appropriate oversight of the risks within each child's case, and ensured that timely actions were taken to keep children safe.

The principal social worker for the child protection and welfare service and the CPC chairperson received regular supervision from the area manager in line with Tusla policy. Managers told inspectors that the supervision process supported them in their practice. Inspectors reviewed a sample of the supervision records, and found that there were regular discussions in relation to the national approach to practice, the impact of staff vacancies on service provision and challenging cases that needed to be referred to the complex case forum. The independence of the CPC chairperson, and challenges presented during CPC meetings were also discussed during supervision. The area manager received regular supervision from the regional service director, where clear discussions were had in relation to service planning, staffing and standards.

The inspectors found that the area had robust monitoring and auditing systems in place. The area were monitored by Tusla's practice assurance and service monitoring (PASM) team. Areas for review in 2021 included the implementation of the national practice model and a six month follow up on the areas action plan following the PASM audit completed on the CPNS service in 2020. The area manager maintained a quality

assurance tracker which monitored the actions taken to address the findings in relation to the quality assurance audit process, local audits completed and HIQA inspections. The tracker provided updates to actions that were outstanding, and showed evidence of robust governance and service improvement in the area. The CPC chairperson maintained and updated a schedule of CPCs. This formed the basis of the quarterly audit of children on the CPNS. The area manager and CPC chairperson told inspectors that initial CPCs are scheduled when the required actions have been completed to ensure the process was meaningful for the child and their family. The area manager acknowledged that they are not routinely informed of cases where there may be delays in convening the initial CPC, and this is an area for development. The CPC chairperson provided quarterly audits to the area manager on the CPC service which included information on the involvement of parents and children in the conference process. The audit also reviewed the use of the "Me and My Conference" booklet in line with the service plan 2021-2023 for the CPC service in the area. The area manager told inspectors that a review of the findings from the quarterly audits and the feedback provided by children and parents was planned for the end of 2021. The plan in the area was that such a review would further inform service development. The area manager said that the audit processes within the area assured them of the quality of the service provided.

Social workers were also completing monthly self-audits on their cases, with priority being given to children listed on the CPNS. The principal social worker and social work team leaders maintained oversight of these audits on NCCIS. The principal social worker told inspectors that there were clear expectations regarding the completion of self and management case audits in order to share learning from good practice, and identify areas for continuous improvement. Inspectors found good evidence on case files of audits having been completed, with clear follow up actions identified. Areas for follow up included updating case notes, reviewing and updating of safety plans and updating family information. The area had a process in place whereby the allocated social worker informed the team leader in writing when the actions were completed. This provided a level of accountability and assurance to management that the required actions had taken place.

The area had appropriate systems which ensured that all risks in the service were reported on, managed and escalated when required. The risk register was reviewed regularly, and inspectors found that risks in relation to staff vacancies in the area had been escalated to the service director and an appropriate plan was put in place to address the risks identified. While the area had experienced significant staff changes in the 12 months prior to the inspection and had staff vacancies at the time of the inspection, the service delivered to children requiring a CPC was timely. Children listed on the CPNS had an allocated social worker, and regular case management and oversight was evident by the social work team leaders. Children on the CPNS were

referred to the required support services, and private funding was provided for the delivery of assessments when needed.

As stated, Tusla had recently been the target of a major cyber-attack which had compromised their national child information system (NCCIS) for several weeks prior to the inspection. Inspectors found that actions were taken to ensure the continued recording of CPC conferencing as well as other pertinent records in relation to the assessment of children's circumstances and safety. Inspectors found that the relevant children's records and conference documents had been uploaded, and were available on the child's file on NCCIS. This was in line with the service plan for the CPC service through increasing the use of NCCIS as the child's masterfile with the aim of becoming a paperless office.

The restrictions associated with COVID-19 had a significant impact on the delivery of services in the area, but these were well managed. Social workers had endeavoured to engage with children and families in alternative ways, and risk assessments had been carried in relation to home visits. Inspectors found that social workers had continued to visit and meet with children listed on the CPNS. There was an Interim Child Protection Conference Guidance which set out measures to mitigate against challenges in the facilitation of conferencing due to COVID-19. The area also had access to appropriate technology to facilitate teleconferencing where appropriate. At the time of the inspection the area were holding CPCs in a blended format, whereby the CPC chairperson, parents and social work staff met in the same room and other professionals joined the conference by phone.

Standard 3.1

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

The service had robust governance structures in place to support the delivery of a good service in the Mayo area. The area had developed a local process to support staff in relation to the CPC process. There were interim national guidelines on child protection case conferencing and the child protection notification system but these had not been subject to review and required updating by Tusla to ensure a consistent service was delivered nationally.

Judgment: Substantially compliant

Standard 3.2 Children receive a child protection and welfare service, which has effective leadership, governance, and management arrangements with clear lines of accountability.
The service had robust governance systems in place, with clearly defined lines of accountability. There was good service planning in the area, with strong leadership who promoted service improvement at all levels. There was an open culture within the service, and good management oversight was evident.
Judgment: Compliant
Standard 3.3 The service has a system to review and assess the effectiveness and safety of child protection and welfare service provision and delivery.
There were risk management systems in place to ensure that any risks identified within the scope of this inspection were reported on, managed and escalated when required. The area had robust monitoring and auditing systems in place. The service was committed to service improvement. Learning and development was encouraged across the staff teams.
Judgment: Compliant

Quality and safety

The service ensured that children who were assessed as being at ongoing risk of significant harm or neglect were referred to the CPC service in a timely manner. The area ensured that children, parents and the relevant professionals were involved throughout the CPC process in order to ensure that appropriate actions and decisions were made that kept children safe.

This inspection found that the convening of initial CPCs was timely and ensured that prompt action was taken to keep children safe. Six files were reviewed for the timeliness of initial CPCs. Inspectors found that all were convened within one to five weeks of the CPC request being made by the social worker. As noted earlier, inspectors found that the area had a local process in place whereby initial CPCs were to be convened, and invitations sent to participants three weeks following the request being made. While inspectors found that children were not placed at immediate risk while awaiting a CPC, the area had not adhered to their own timeline in two of the six cases reviewed. In these two cases, initial CPCs were convened between three and five weeks following the request being made by the social worker. In both of these cases, robust safety plans had been put in place while the initial CPC was being organised, and the children's safety had been maintained. The area manager and CPC chairperson explained to inspectors that while the area strives to convene the initial CPC within the local timeframe, delays had taken place in some cases where additional time was required to ensure that the initial CPC process was meaningful for the child and family. The area manager acknowledged that they are not regularly updated regarding any delays in the convening of initial CPCs, and this was an area of practice that they felt required further discussion. While the area had experienced significant changes to staffing within the previous year, staff told inspectors that initial CPCs were usually held within the three week timeframe and where there were delays robust safety plans were put in place.

CPCs were comprehensively facilitated by an appropriately trained, independent professional. As discussed earlier, while the CPC chairperson had management responsibility for the national approach to practice network coordinator, this role was specifically in relation to the scheduling and coordination of safety network meetings. The area manager was assured of the independence of the role of the CPC chairperson through regular supervision. CPC records clearly showed that the chairperson carefully facilitated conferences and ensured the involvement of parents, children, professionals and other family members. The CPC records clearly showed that the chairperson outlined the identified risks for the child and what needed to happen to keep the child safe with their family. The inspectors found that CPCs were well attended by professionals from external voluntary, statutory and community

services. Social workers told inspectors that external professionals were willing to attend CPCs in the area. The chairperson ensured that all participants at conferences participated in the conference, and identifying the actions needed to improve the child's safety.

At the time of inspection, the CPC chairperson was in post over two months and was very familiar with the service as they had held a senior management role in the area. The CPC chairperson told inspectors that they were reviewing the CPC process in the area. One of the areas that they wanted to develop was a process to share feedback with social workers and team leaders where a request for a CPC did not meet the threshold. The CPC chairperson also had oversight of the work of to the safety network coordinator. These supervision sessions focused on the frequency of safety network meetings, and continued professional development of the coordinator. While the CPC chairperson maintained this supervision role, the area manager was assured of the independence of the CPC chairperson through their regular supervision sessions, where the independence of the role was discussed.

Parents and children were encouraged to attend the CPC either in person, or remotely through teleconference. At the time of the inspection, the chairperson had introduced a blended approach whereby the parents and some of the professionals were in the room with the chairperson, and the remaining participants joined by teleconference. Inspectors were told that social workers work with the parents and children in advance of the CPC so that they were aware of Tusla's worries and bottom lines for the children. Social workers said that they talk through the CPC process with children, depending on their age, and parents are informed of the decision to request a CPC. Inspectors found that social workers and guardian ad litems advocated on behalf of younger children, and children who decided not to attend their conference. Inspectors found evidence of specific tools that had been used by social workers to gather information in a child friendly way. These included the use of "words and pictures" and also the "Me and My Conference" booklet. The views of children were clearly recorded in the CPC record and formed part of the decision-making in relation to child protection risks discussed at conferences. Inspectors found that the CPC records were appropriately shared with children and families, and that families and professionals received written copies of the CPC records. The service informed the family and the relevant services when a child was listed as active and inactive on the CPNS in writing in a timely manner.

The content of child protection safety plans developed during CPCs were of good quality. Inspectors reviewed seven files for the quality of child protection safety plans, and found that the individual plans were comprehensive and robust. The individual child protection safety plans set out the agreed actions to be completed by named members of the safety network based on the risks and bottom lines identified

during the CPC to keep the child safe. The standardised template was used to provide a comprehensive record of the key components of the safety plan, including the existing strengths and safety, identified risks and actions to be completed. The plans clearly recorded the identified the person responsible for completing each action.

Following the CPC, it was the responsibility of the allocated social worker to implement a child protection safety plan in partnership with the family, the identified safety network and relevant professionals involved with the child. According to the Tusla guidelines for CPCs and the CPNS, regular safety planning meetings were to be convened following the CPC to develop a more detailed child protection safety plan, review the safety of the child and also monitor the progress in relation to the case. The local process and practice in the area indicated that visits to children were to take place on a fortnightly basis, and safety network meeting were to take place every four to six weeks. Inspectors found that visits and network meetings took place consistently in line with locally agreed practice expectations. In addition, inspectors found that where required more frequent announced and unannounced visits to families took place and this was agreed in supervision and at the relevant meetings. Safety plans were well implemented and monitored to ensure that children were kept safe.

The area had developed a specific role of signs of safety network coordinator to support the development of safety networks. The network coordinator worked alongside the child's social worker to facilitate families to develop their safety network in preparation for the initial CPC and throughout the CPC process. Monthly safety network meetings with the family, the child's social worker and network members were scheduled and facilitated by the network coordinator so as to ensure the social work team monitored, reviewed and updated the safety plan in line with local policies and procedures. There was a clear expectation that the allocated social worker attended all network meetings in relation to their cases. Managers told inspectors that the safety network meeting process was being amended to ensure that social work team leaders attended the network meetings every three months. Inspectors reviewed seven files for the quality of safety planning implementation and found evidence of robust implementation and review of safety plans. Safety network meetings took place regularly in line with the local process and were clearly recorded on the standardised template. Emergency network meetings were held when needed, and additional steps including the decision to seek a supervision order were taken to ensure that children were kept safe. Networks were made up of professionals and people from within the families own network.

Inspectors reviewed seven files of children that were listed as active on the CPNS, and found evidence that safeguarding visits were consistently taking place to monitor the child protection safety plan. These visits included announced and unannounced visits to the family home. Children were seen alone and parents were met with in the home and during office visits. The case notes recorded comprehensive details of the discussion and interaction with the child. Social workers challenged parents when required in order to ensure that children were kept safe. Inspectors found that supervision orders were appropriately sought from the court in order to ensure that children were visited, and that their safety was maintained. Children and families were referred and encouraged to attend appropriate services within Tusla and in the wider community as a support. The service worked closely with extended family members also as a means of further developing safety for children. Inspectors found that when the allocated social worker was on leave, a member of the team completed the safeguarding visits to the family.

Inspectors found that there was good evidence of multi-disciplinary involvement and communication in relation to all files reviewed. Information was shared appropriately to support the assessment of the risk to the child, and planning in relation to the actions and supports required to keep the child safe. Strategy meetings were held when required, and interagency discussion was well facilitated.

Inspectors found that review CPCs were consistently held within six months of the previous CPC meeting. Review CPCs considered the length of the time the child had been active on the CPNS, and the progress made on reducing the risks to the child. Clear and detailed decisions were recorded on the standardised template in relation to the next steps to be taken.

Inspectors observed a review CPC by teleconference, and found the chairperson to be knowledgeable and appropriate in their role. The CPC chairperson ensured that the child protection risks were clearly outlined, and that the strengths demonstrated by the family and their safety network were discussed. The chairperson facilitated inclusive participation of all those in attendance, namely the parents of the child, Tusla staff and external services. While the child had decided not to attend the conference, they had completed the 'Me and My Conference' booklet used by social workers in the area. This booklet provided information on the child's views and wishes for their future, and ensured that their voice was included in the decision making process. Reports received were shared, and a clear decision was agreed as to why the child was to be listed as inactive on the CPNS register.

At the time of the inspection nine children had been listed as active on the CPNS for longer than 12 months. Inspectors reviewed three files focusing on the length of

time they had been active on the CPNS. Inspectors found that these children were receiving a good quality service and consideration was given to the length of time the child was active on the CPNS. The area had a process in place where cases that were not progressing as needed, or where there had been three review CPCs were referred to the Mayo Supporting Practice complex case forum for review and consultation. Inspectors found that this forum supported the decision-making in relation to challenging cases. It provided objective analysis, and prevented drift within the cases reviewed. One of the cases that had recently been made inactive on the CPNS had been referred to the complex case forum in advance of the third review CPC. Discussion at the forum focused on the need to consider balancing historical patterns of behaviour with current risk identified for the children. Clear actions were recorded for the social worker to complete following this review.

Inspectors reviewed three cases that had recently been listed as inactive on the CPNS. In two of these cases, the risks for the children had reduced and their safety was being maintained. In the third case, the child had been removed from the family and placed in care. Inspectors found that there were clear rationales recorded for the decision to de-list the child. The decision to remove the children from the CPNS had been discussed, and children did not remain listed on the CPNS longer than was required. Family members and relevant professionals were informed in writing of the decision in a timely manner. Inspectors also reviewed one case that had been de-listed in 2018, and due to increased risk a request for a CPC was made in 2020 where the decision was made to list the child as active on the CPNS again. Inspectors found that the decision to list the child as active on the CPNS for a second time was appropriate as the family situation had deteriorated and significant risks existed for the safety of the child.

There was evidence of good working relationships between the social work department and An Garda Síochána on the files that were reviewed. The area had quarterly senior management meetings with the Garda Síochána and had scheduled a joint Garda Tusla workshop for February 2022 to further develop relationships. Inspectors found that the area were also striving to develop their practice in relation to further developing their relationship with the local Traveller network, and also reviewing the support offered to children and parents who had experienced domestic violence. The service had planned to invite a member of the Traveller network to a management meeting to progress this area of practice. The principal social worker told inspectors that the service had also benefited from the involvement of a senior social worker in research which focused on the area of domestic violence.

The CPNS was held as a confidential register of children within the service area who had been identified as being at ongoing risk of significant harm during the CPC process. Inspectors found that the register of names of children was secure and well maintained. In line with policies and procedures, the entry of each child's name only occurred as a result of a decision made at a CPC that there was an ongoing risk of significant harm to the child, leading to the need for a child protection plan. Harm was defined as physical, emotional, sexual abuse and neglect. The chairperson's administration staff had responsibility for maintaining and updating the CPNS at child protection conferences. The CPC chairperson and area manager also had oversight of the CPNS register. Access to the CPNS register was strictly confined to Tulsa staff and members of n Garda Síochána. Should out-of-hours general practitioners and hospital medical, social work or nursing staff require information from the CPNS, they could access this through the Tusla out-of-hours social work service.

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

The convening of initial CPCs was timely and ensured that prompt action was taken to keep children safe. CPCs were comprehensively facilitated and ensured the involvement of parents, children, professionals and other family members. The identified risks and what needed to happen to keep the child safe were clearly identified with their family. Parents and children were encouraged to attend the CPC either in person, or remotely through teleconference.

Judgment: Compliant

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

The area reviewed CPCs and interventions in line with the requirements of Children First. There were no delays in convening the review CPCs. Children were appropriately de-listed on the CPNS, and there were clear rationales recorded for the decision to de-list the child.

Judgment: Compliant

Standard 2.9 Interagency and inter-professional cooperation supports and promotes the protection and welfare of children.
The service had strong working relationships with service providers in the area. Interagency working was embedded within practice, and was evident on all cases reviewed.
Judgment: Compliant

Compliance Plan for Mayo Child Protection and Welfare Service OSV – 0004377

Inspection ID: MON-0033788

Date of inspection: 21 September 2021

Introduction and instruction

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Standard Heading	Judgment
Standard 3.1	**Substantially compliant**
Outline how you are going to come into compliance with Standard 3.1: The service performs its functions in accordance with relevant legislation, regulations, national policies and standards to protect children and promote their welfare. Tusla Corporate Office have met with HIQA in relation to the requirement to review and update the interim national guidelines on child protection conferencing and the child protection notification system. It is agreed that a plan to ensure a consistent service is delivered nationally will be presented to HIQA by 08/11/21.	

Section 2:

Standards to be complied with

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

Standard	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Standard 3.1	The service performs its functions in accordance with relevant legislation, regulations, national policies and standards to protect children and promote their welfare.	Substantially Compliant	Yellow	08/11/21