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:	Carlow Kilkenny South Tipperary
Name of provider:	Tusla
Type of inspection:	Focused CPNS
Date of inspection:	8 - 11 March 2022
Lead inspector:	Pauline Clarke Orohoe
Support inspector(s):	Jane O'Carroll, Tom Flanagan, Grace Lynam
Fieldwork ID:	MON-0036047

About monitoring of child protection and welfare services

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

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, Equality, Disability, Integration and Youth 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.

HIQA 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 submitted by the area
- interviews with:
  - the area manager
  - the chairs of child protection case conferences
  - the principal social workers
- focus groups with:
  - social work team leaders
  - social workers
  - social care leaders
- the review of:
  - local policies and procedures, minutes of various meetings, staff supervision files, audits and service plans
  - 18 children's case files
- phone conversations with
  - eight children
  - 12 parents.

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
HIQA 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 six regions, each with a manager known as a regional chief officer. The regional chief officers report to the national director of services and integration, who is a member of the executive management team.

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

Service area

Carlow/Kilkenny/South Tipperary is one of the 17 areas within Tusla's Child and Family Agency. Situated in the South East of Ireland, Carlow/Kilkenny/South Tipperary is the 10th largest of the Tusla areas. The total population of the area based on the 2016 census is 244,435 and the area has a child population of 65,080. This represents 26.6% of the Area's total population and has the second highest percentage child population in the South Region.

The area was under the direction of the service director for the South region and managed by the area manager. There were two principal social workers responsible for child protection and welfare services and the adult retrospective team in the area. The area manager delegated child protection and welfare conferencing responsibilities to two principal social workers. Administration staff were employed to assist in the delivery of the service and both principal social workers reported directly to the area manager.

At the time of the inspection, there were 76 children listed as active on the CPNS and 51 children had been delisted in the previous six months. There was two whole time equivalent (WTE) social work vacancies, and one WTE senior social work vacancy on the child protection and welfare team.

There were three long-term child protection and welfare teams, one based in each county and each managed by a social work team leader reporting to the principal social worker. The teams

comprised of social workers, social care leaders and social care workers. There were senior social work practitioner posts on the teams in Kilkenny and south Tipperary only. The service also had access to a family support worker who worked across two teams in the area.

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
8 March 2022	09.30 to 17:00 10.00 to 17.00	Pauline Clarke Orohoe Jane McCarroll Tom Flanagan Grace Lynam	Lead Inspector Support Inspector Support Inspector Remote Inspector
9 March 2022	09.00 – 17.00	Pauline Clarke Orohoe Jane McCarroll Tom Flanagan Grace Lynam	Lead Inspector Support Inspector Support Inspector Remote Inspector
10 March 2022	09.00 – 16.00	Pauline Clarke Orohoe Jane McCarroll Tom Flanagan Grace Lynam	Lead Inspector Support Inspector Support Inspector Remote Inspector
11 March 2022	14.30 – 16.00 (Interview with CPC chairpersons)	Pauline Clarke Orohoe	Lead Inspector

Views of people who use the service

HIQA inspectors spoke with eight children individually over the phone. These children spoke positively about their experience of the child protection service, and the majority of children felt that their lives had improved because of the social workers involvement with their family.

Four of the children that spoke to inspectors had attended their child protection conference (CPC) for all or part of the meeting. One of these children said that they had attended the meeting "for a short while on the phone. I did get a chance to talk, I agreed with the worries". However, one child said that the meetings were "not fun……condescending, they spoke down to me". In preparation for the meeting, three children had completed booklets that the social worker read out at the meeting.

When asked if they had received a written copy of the child protection safety plan, five out of the eight children said that they had received a copy in writing, though one child was unsure but said they probably did receive it. While two children said they had not received the plan in writing, one of these children said the social worker had explained it to them.

Five of the children said that the social worker explained everything to them after the meeting. One of these five children told inspectors "I knew everything that was happening, the social worker wrote it all down". Seven of the children agreed that the social workers regularly visited and spoke with them. However one child said that they felt they were the "poster child for slipping through the system……put my life under the microscope". They felt that they were just passed on from one social worker to the next.

Seven of the children said that the process had helped and that the social workers "did an awful lot…we're back in school and back in activities". Another child felt that "they made me comfortable…made me feel at ease, helped a lot. I feel safe now". As one child explained "things were insanely better……if I didn't have my social worker I'd still be stuck".

Inspectors spoke with 12 parents who had experienced the (CPC) process, and whose children were, or had been listed as active on the CPNS. All of the parents agreed that their children's lives were improved as a result of being involved with the Tusla social work service. One of the parents said that "I've never seen them happier, wouldn't have happened without the social workers". Another parent commented that the social workers were "fantastic and their supervisors were fantastic". A third parent said that their family situation had improved in that "there was genuine problems that we needed to address and we addressed them…..it was beneficial for the kids".

The parents had mixed experiences of the CPC process. Nine of the parents felt listened to. One parent explained that "I spoke up the best way for my kids, they did listen". Another parent said that they were given the opportunity to speak up and ask questions at the meetings. A third parent told inspectors that they got the chance to state their views, and they felt that the people at the meeting "actually listened". However three parents were unhappy about the CPC process and did not believe it was beneficial. One parent said that while they were "allowed to say what I wanted, I felt intimidated by it all. ……nobody bothered with me for weeks while I was in the house with the kids on my own". They did not feel that the process was helpful to their family. Another parent told inspectors that they "felt I was being chastised" and that it was "not a nice experience" as they felt the process "can make you feel like you're not adequate". A third parent said that they felt intimidated by the process and that they did not get a chance to speak; they felt that they were "spoken down to".

Of the 12 parents who spoke to inspectors, 11 had received a written copy of the child protection safety plan. The remaining parent said they were aware that their children were remaining active on the CPNS, though they did not comment on whether they received the plan in writing. The majority of the parents said they were clear about the plan and the desired outcomes of the plan. While one parent said the plan wasn't clear, a second parent said that while the plan was not clear to them initially that it became clear as the process continued. Eleven of the parents said the social worker called to check that the child protection safety plan was working, and that everyone was doing what was agreed.

Overall, parents spoke positively about how the professionals involved worked together in the best interests of the child. Parents described how other professionals attended the meetings either in person or through phoning in. Parents spoke of having a variety of services calling to support them. All of the parents agreed that while the professionals had concerns for the children, they all worked together to improve the lives of their children. As one of the parents explained "everyone had the children in the centre, it was all based around the kids". A second parent said that "not once did I feel unsupported, didn't feel put down by them".

Capacity and capability

The service had effective leadership, governance and management arrangements in place which ensured that children listed on the Child Protection Notification System (CPNS) received a consistent, good quality service that was well led. The service performed its functions in line with the relevant legislation, policies and standards. There was an open, transparent culture within the service where learning was valued. Governance systems were well established within the area, and the recommendations from audits, incident reviews and inspections were implemented. The service had systems in place to review its performance and gather feedback in an effort to further improve the service provided to children and families. The area manager and her management team had identified a risk within the service relating to the absence of appropriate care placements for children who required them. In addition, the interim national guidelines on child protection case conferencing and the CPNS needed to be updated.

The focus of this inspection was on children placed on the CPNS and 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: National Guidance for the Protection and Welfare of Children* (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 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. This meant that children on the CPNS 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 unsafe despite a child protection plan being in place. This may result in a decision to remove the child from the home to the care of Tusla. This inspection also reviewed children whose names had 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 governance arrangements in the area were strong, with clearly defined roles and responsibilities identified across the team. The area manager told inspectors that these governance arrangements assured them that children listed on the CPNS service were in receipt of a good quality, safe service. Social workers and managers clearly outlined governance arrangements and structures in place within the CPC and CPNS. The newly appointed area manager had taken up their post one week prior to the inspection, and they were knowledgeable on the systems of oversight in relation to the CPC processes that were well embedded in the service area. The area manager delegated the conferencing duties to two principal social workers, who carried out the

role of CPC chairpersons. The chairpersons were responsible for ensuring that requests for CPC's met the required threshold for a CPC. The CPC chairpersons told inspectors that there was good communication with social work teams. This ensured that the required information was available within CPC referrals to inform their decisions about the appropriateness of a request for a CPC. In addition, good quality initial assessments supported the CPC chairpersons to determine the outcome of a request for a CPC. Social workers said that they had regular communication with the CPC chairpersons, and team leaders highlighted the good working relationships that exist across all of the social work teams in the area.

The chairpersons also held responsibility for scheduling, organising and facilitating the CPC. The administrative staff updated and maintained the CPNS with oversight from the CPC chairpersons. Inspectors were told that the CPC chairpersons used the CPNS to ensure that reviews were held in timely way. While some review CPC's were delayed, the CPC chairperson provided clear rationale for these delays. The area had also implemented special measures during COVID-19 which allowed the area to defer a CPC meeting where it was deemed safe to do so. The CPC chairperson said that this process was used in a small number of review CPC's where safety plans were deemed to be effective, with initial CPC's always prioritised for scheduling.

The Tusla interim national guidelines on CPC's and the CPNS were subject to review at the time of the inspection and required updating by the Child and Family Agency, as a means of assuring quality and consistent practice. Inspectors found that the area had developed a local guidance document which provided staff with clear direction on the actions required and associated timelines, from the point of requesting an initial CPC through to monitoring the child protection safety plan. Social workers and managers described clear processes and procedures from the point of request through to the completion of the CPC. They demonstrated a clear understanding of local and national policies, procedures and standards in relation to the CPC process.

The service had robust governance systems in place which ensured that service delivery was reviewed, progress on agreed actions was monitored and that there was a consistent flow of information across the service and the various teams. The service held monthly area management team meetings with senior managers in order to communicate and develop plans to manage issues arising for the teams across the service. These meetings had standing agenda items including staffing and recruitment, risk management and also included learnings and actions following audits and inspections. The area also held monthly CPNS meetings to provide additional oversight of the CPC process. Quarterly and annual reports were prepared and presented to the CPNS and area management team meetings on the work of the CPC service including information on the CPNS. Inspectors reviewed the minutes and found that presentations were made on the reports and the overall CPNS process.

Discussions were also had in relation to interagency working and how to further develop these relationships. The area had completed interagency training events with An Garda Síochána, local domestic violence and addiction services.

The service maintained oversight of the quality of the CPC service through monthly CPNS management meetings where the cases listed on the CPNS were reviewed. The focus of these meetings was on quality assurance of the CPC system. Updates were provided from each area in relation to the number of children on the CPNS across the service area, with specific discussions held in relation to children listed as active on the CPNS for extended periods of time. It also ensured that the CPC processes in the area were regularly reviewed, and appropriate actions were put in place when required. Areas for service improvement were identified and discussed, and were included in the service improvement plan if appropriate. The chairpersons provided feedback from the national meetings for CPC chairpersons, which ensured that local practice was in line with national policy.

The service had developed a specific service improvement plan for the CPC team in the area. The plan outlined key priorities for the service for the coming 12 months. Actions outlined in the plan included the continued participation of children and parents in the CPC process, and exploring further options for video and teleconference services in the area. The actions outlined in the service plan were informed by feedback from children, parents and staff, learnings from audits and the monthly managers meetings in conjunction with relevant legislation. Families and professionals were routinely asked for feedback in relation to their experience of the CPC process. Inspectors found that this feedback was appropriately compiled, and used to develop the actions within the service improvement plan. The CPC chairpersons told inspectors that seeking feedback from participants can present a challenge, and this is an area that the service will continue to focus on developing. Inspectors found that actions from the service improvement plan were being progressed within the area.

There were good communication systems within the service, and the senior management team were committed to maintaining a culture of openness, learning and service improvement. Monthly managers meetings and local team meetings were held across the service as a way to share learning, communicate relevant information and ensure that the service provided was in line with national policy, legislation and standards. These local processes ensured that a consistent approach to practice was maintained across the service area, and that actions agreed at meetings were followed up on. The service also held regular meetings with external agencies, such as public health nursing teams, which worked directly with children and families listed as active on the CPNS in order to review these cases. This ensured that the progress

being made in relation to these cases was monitored, and that children were kept safe.

Staff and managers demonstrated a knowledge of legislation, regulations, policies and standards for the protection and welfare of children appropriate to their role and responsibility. Learnings from HIQA inspections were shared nationally with the area, and this was discussed across the various staff meetings. Inspectors found that learnings from serious incidents, reports, audits and inspections were regularly shared at the various meetings held in the area. Social workers told inspectors that managers provided them with reports of investigations into child deaths and serious incidents. The area manager told inspectors that staff supervision is also used as an opportunity to discuss and share learnings with staff on an individual basis when required. In addition, a quality assurance service improvement post had recently been approved to support the area manager to drive service improvements across the area.

The service operated a monthly complex case forum which provided an objective review of cases. Cases were referred to the forum where complexities and challenges had emerged that required additional review and support. Inspectors found that detailed referral forms were completed in advance of the case being presented at the forum, and the complex case forum provided clear and concise feedback and recommended actions for consideration in relation to each case presented. Presentation of cases at this forum was used as a mechanism to provide oversight and prevent drift on these cases.

The provision of supervision to staff involved with the CPC process was robust, and provided assurance to senior management on the effectiveness and quality of the service provided to children and families. Inspectors found that case management records were available on children's files, and clearly detailed the actions that required follow up. Supervision records generally evidenced good analysis of the child's situation and the relevant risks that were present. Supervision was well embedded within local practice. This was evident across the staff teams from senior management through to social workers. Supervision was recorded on standardised templates, with a differentiation made on children's files between social workers supervision and that of social care leaders also working with a child. Regular audits of supervision took place across the service.

The service placed a strong emphasis on the monitoring and auditing of the service it provided to children and families. Audits were comprehensive and effective. They were conducted routinely on different areas of practice, including the completion of network meetings and file reviews of children listed as active on the CPNS, by managers with appropriate levels of experience and expertise. One of the principal social workers for the child protection and welfare service maintained oversight of the auditing and monitoring activity for the service. They held a detailed audit tracker and

developed action plans following the completion of each audit in the area. Actions arising from audits led to improvements in service provision, including the development of consistent naming conventions to be used when recording on children's files, and the provision of in-depth group supervision to further support staff in their work with children listed as active on the CPNS.

The area had appropriate systems in place to identify, report on, manage and escalate risks as required. There was a risk register which was up to date and reviewed regularly as required. Risks were appropriately escalated. Risks relating to the CPNS service included the lack of available residential placements for children, and the risk relating to the effectiveness of governance and oversight systems in terms of promoting continuous service improvement. While the service improvement post had been approved at the time of the inspection and would address the risk relating to oversight and service improvement, the lack of care placements remained an ongoing significant risk for the service since November 2021.

The service operated a "need to know" system whereby individual cases involving significant risk were escalated to senior management. Inspectors found that the lack of appropriate children's residential placements was a significant risk at the time of inspection. While the service had escalated this risk to the national office, suitable residential placements could not be sourced for children who required them, and at the time of inspection some children remained at home in unsafe situations because no suitable placements could be identified. Despite supports being provided to these children keeping them safe at the time of inspection, there remained a long-term risk to their development and safety. The shortage of suitable residential placements for teenagers involved in risk-taking behaviours, was reflective of a lack of such services throughout the country and presented significant risks for the service.

There were staff vacancies in the area, however, the area mitigated against this risk for children on the CPNS by ensuring that all children listed on the CPNS had an allocated social worker. This ensured that children assessed as being at ongoing risk of significant harm received an appropriate level of social work support to promote children's safety through adequate service provision. The area manager told inspectors that a number of additional posts had been approved for the service including two additional social care worker posts, a quality assurance post, a commissioning post and a clinical psychology post. These roles would further support the work of the existing staff teams.

At the time of the inspection, the service was continuing with a blended approach to CPC's as this allowed the family to be in the room with the chairperson, and it also allowed professionals to join remotely. The service facilitated CPC meetings through video and teleconference. The CPC chairpersons said that this approach allowed a greater number of network members to attend the meeting. However, the facilities

within the area were described as unreliable, which made participation difficult at times. Improvements in relation to the teleconference and video calling facilities had been included in the service improvement plan for the CPC service. While this remained an issue at the time of the inspection, each CPC chairperson was utilising the most reliable form of conference facility for their area. The restrictions associated with COVID-19 had a significant impact on the delivery of the service in the area but these were managed well. Social workers engaged with children and families in alternative ways and 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.

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.

Staff and managers demonstrated a knowledge of legislation, regulations, policies and standards for the protection and welfare of children appropriate to their role and responsibility. Inspectors found that learnings from such incidents, reports, audits and inspections were frequently shared across the various meetings held in the area. The area had developed a local guidance document for staff in relation to the CPC process. However, while the interim national guidelines on child protection case conferencing and the CPNS were under review at the time of the inspection, they required updating by Tusla to ensure a consistent service delivery 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 which ensured that service delivery was reviewed, progress on agreed actions was monitored and there was a consistent flow of information across the service and the various teams. There were clearly defined roles and responsibilities identified across the team. The service placed a strong emphasis on the monitoring and auditing of the service it provided to children and families.

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.

The area had appropriate systems in place to identify, report on, manage and escalate risks as required. However, the escalation of risk did not result in the provision of the necessary alternative care services to children listed as active on the CPNS. The absence of suitable placements for children who required them posed a significant risk within the service area.

The service placed a strong emphasis on the monitoring and auditing of the service it provided to children and families. The service had developed a specific service improvement plan for the CPC team in the area. The actions outlined on the service plan were informed by feedback from children, parents and staff, learnings from audits and the monthly managers meetings in conjunction with relevant legislation.

Judgment: Not 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 and effective manner. Initial CPC's were scheduled without delay, and robust child protection safety plans were put in place to keep children safe. Children, parents, family members and support services were involved throughout the CPC process to form safety networks for children, and ensure that appropriate decisions were made. Some delays existed in the scheduling and convening of review CPC's and records of reasons for these delays required improvement.

The service held timely initial CPC's for children who had been assessed by social workers as being at ongoing risk of significant harm or neglect. Local practice in the area was that initial CPC's were convened three weeks from approval of the CPC request. Inspectors reviewed eight children's files for the timeliness of initial CPC's, and found that seven children had their initial CPC held within the three week timeline. While the initial CPC for one of the files reviewed took place six weeks after the request was made, this was appropriate. Inspectors found that this was a considered and planned delay at the request of the team leader to support the specific needs of the family concerned. A robust safety plan had been put in place, with significant evidence of interagency working and cooperation in relation to the case. Social workers told inspectors that they have good working relationships with

the CPC chairpersons, and have not experienced delays in relation to the scheduling of initial CPC's.

The CPC's held in the area were comprehensively facilitated by appropriately trained, independent professionals who were not directly involved in the assessment and management of child protection cases. Though both of the CPC chairpersons had responsibility for additional tasks across the service area, the area manager was assured of the independence of their roles through regular communication with both of the chairpersons. The area manager explained that should the potential for a conflict of interest be identified, the alternate chairperson in the service area would step in to chair the CPC. The CPC records reviewed clearly showed that the chairperson of the conference ensured the involvement of children, parents, network members and professionals. The CPC chairperson offered to meet with parents in advance of the conference. They outlined the risks for children during the conference, and what needed to happen to keep children safe with their family. Inspectors found that CPC's were well attended by professionals from external services.

Parents and children were encouraged to attend and participate in their CPC meeting. Social workers told inspectors that they met with parents to explain the reasons for requesting a CPC. They also met with parents in advance of the CPC to discuss their report for the meeting. These practices were in line with local policy and guidance. There was evidence that parents were facilitated to attend the CPC. CPC records reflected detailed discussions of the risks and allowed opportunities for parents to have their say and to raise questions. Where appropriate, children were given the opportunity to attend these meetings also. Inspectors found that social workers used creative practice to gather children's views in advance of the CPC. This included the use of child-friendly tools such as "My Three Houses" and "words and pictures" in line with Tusla's national approach to practice. The area had also adapted a "Me and My Meeting" booklet as a tool to support social workers to gather the views of children to inform decisions made at the CPC.

At the time of the inspection, the chairpersons were continuing to use a blended approach to holding CPC's, whereby the parents and network members were in the room with the chairperson, and the remaining participants joined the meeting through teleconference or video conference. The chairpersons told inspectors that this approach has allowed more network members to attend the meeting, and has supported good attendance by external professionals. Social workers told inspectors that they meet with children following CPC meetings to share the safety plan with them in an age-appropriate manner, this was confirmed by children who spoke with inspectors. Inspectors found that CPC records and decisions were appropriately shared with parents and children. Inspectors found that parents received a written

copy of the CPC records. Inspectors were told that these reports were sent by registered post.

Tusla guidelines for CPCs direct that regular safety planning meetings are convened following the CPC to develop a more detailed child protection safety plan, to review the safety of the child and also monitor the progress made in relation to the case. The local guidance document in the area indicated that children who were active on the CPNS should be visited weekly by one of the services involved in the safety network, and on average be visited fortnightly by their social worker dependent on the age of the child and the level of risk at any given time. In addition, safety network meetings were to take place at least twice over the course of the six-month period between CPC's, with regular contact being maintained between the safety network group.

Child protection safety plans were developed based on the social work assessment of what children needed to keep them safe with their family, and these plans also involved the family and professionals. Overall, the child protection safety plans developed during CPCs were of good quality. Inspectors found that child protection safety plans were recorded on a standardised template which provided a comprehensive record of each plan. Child protection safety plans were further developed at network meetings or professionals meetings if required. Of the 12 files reviewed by inspectors for the quality of child protection safety plans, 10 were found to be of good quality with clear actions agreed based on the risk and bottom lines identified during the CPC. In one of the files reviewed, inspectors found that while there was good analysis of the risks posed to the child, improvements were required in evidencing discussions with children on their understanding of risks and safety plans. On another file, inspectors found that the quality of the child protection safety plan was poor. There was no up-to-date analysis of the impact of harm on the child's safety, welfare and development. The document contained some of the same information from the previous plan as sections of the form were automatically pre-populated through the electronic recording system. This was brought to the attention of the social worker, who explained that this was an error. The social worker explained that the reports presented at the review CPC contained new and additional information and this was confirmed by inspectors.

Inspectors found that child protection safety plans were less effective for some children who themselves were engaged in risk-taking behaviours in the community. Inspectors reviewed two children's files where the decisions were made at the CPC eight and six months prior to the inspection that they were no longer safe at home and that each child required an alternative care placement. However, the service was unable to identify a suitable placement for these children, and they remained at home at the time of inspection. Both of these cases had been risk escalated through the need to know system, with one of the children presented to Tusla's national

placement team seeking a private residential placement for the two weeks prior to the inspection. The area manager provided assurance to inspectors that additional extensive supports had been put in place to ensure the immediate safety of these children. The social workers were continuing to monitor these cases, and making representation at the weekly meetings of the placement team seeking alternative care placements. The area manager also provided assurances that both of these cases were being closely monitored by the social work team, and that extensive professional support would remain in place. The CPC chairpersons and area manager told inspectors that the availability of placements did not impact the ability of the CPC process to make a decision that a child needs an alternative care placement, despite their inability to provide this placement when required.

Social workers completed announced and unannounced home visits which generally took place on a fortnightly basis in line with local policy. Social workers had regular contact with safety network members through meetings and phone calls. The scheduling of home visits was carefully considered, and there was evidence of good interagency involvement with families. In two of the 12 files reviewed, inspectors found that, in the 12 months prior to the inspection, network meetings had not been held in line with local policy. However, this did not pose significant risks for the children. At the time of inspection, there were improvements evident in relation to network meetings which ensured they were held at regular intervals to monitor the progress made on child protection safety plans and to ensure practices were in line with local policy.

Inspectors found that safety plans were reviewed at network meetings, as well as by the social worker with their team leader in case supervision which generally took place monthly. Network meetings and also professionals meetings were held to monitor the progress of the child protection safety plan. Social workers told inspectors that practice in the area was for between two and three network meetings to be held between CPCs. In addition, inspectors found that where it was not possible to identify a safety network of family members, social workers will develop a safety network of professionals to support the family and monitor the child protection safety plan.

Where required, additional actions were taken by the area to keep children safe, including the decision to apply to court for a supervision order. The service had also developed a process whereby a voluntary service in the area could at times be tasked with coordinating and chairing network meetings. This was a recent development in the Carlow Kilkenny area, and the CPC chairpersons told inspectors that it has been beneficial to children and families in the area. Where this arrangement is in place, the social worker maintains responsibility for the implementation and monitoring of the child protection safety plan and they attend the network meetings. The service has

provided training to the voluntary organisation on Tulsa's national approach to practice as part of this process.

There was good evidence that the service supported and promoted multidisciplinary involvement and cooperation to ensure that the needs of children were met in a timely way. Inspectors found that the implementation of child protection safety plans improved children's access to services and ensured that their safety was monitored. There were effective communication systems in place to ensure that information was appropriately shared with the relevant professionals, and the progress of interventions by other services was monitored and reviewed. Strategy meetings were held when required, and multidisciplinary discussion and involvement was evident on children's files. There was good attendance by other professionals at CPCs. There was also evidence of social workers checking with individuals from other agencies that actions agreed in the child protection safety plans had been progressed. Social workers conducted joint visits with other professionals where appropriate. Inspectors found evidence of training and briefing sessions held across the area with social work teams and other professionals across the statutory, community and voluntary sector. Training sessions had taken place between the social work department and An Garda Síochána in relation to the relevant processes and legislation. Principal social workers told inspectors that the social work teams have regular meetings with key services in the areas, and they were represented on steering committees for relevant services. This ensured that good working relationships were developed with services in the community with a focus on keeping children safe.

Review CPC's were timely in the vast majority of cases reviewed. The reviews were scheduled at the initial CPC which supported the service to ensure that the reviews occurred within six months of the previous CPC. Of the eight files reviewed, inspectors found that there were delays in the review CPC's in five of these files. The reasons for these delays were not consistently recorded on the child's file. Inspectors sought assurances with respect to reasons for delays in three cases and the CPC chairperson provided clear rationales for these delays which included, social workers not being able to access children's files due to the cyber-attack and the impact of COVID-19 on family member's availability. However, these rationales were not recorded on children's files. Improvements were required to ensure that the reasons for these delays were clearly recorded on each child's file in order to evidence the decision making on the case. The CPC chairpersons told inspectors that the priority was to have the right people attend the conference to ensure that good decisions were made in order to keep children safe. For example, one review CPC was due to take place in May 2021, and due to the cyber-attack the decision was made to re-schedule the review for September 2021 to ensure that the school were in attendance. Inspectors also found evidence that, where appropriate, due to an

increased risk to a child, review CPC's were held earlier than the six month timeline. This ensured that appropriate actions were taken to keep children safe.

At the time of the inspection, 10 children had been listed as active on the CPNS for longer than 12 months. Inspectors reviewed five of these files focusing on the length of time they had been active on the CPNS. Inspectors found that in four of the five files reviewed, consideration had been given to the length of time that the children had been listed as active on the CPNS. There was detailed discussion and analysis in relation to the progress that had been made, and the risks that remained. Inspectors found that where there was a delay in progressing the actions of a child protection plan, social workers took steps to protect a child by seeking a supervision order so as to progress the actions required to keep the child safe. In the remaining file, while the child was receiving extensive professional support to address their complex needs, the length of time that the child was listed on the CPNS had not been discussed. The area manager told inspectors that all cases listed as active on the CPNS for an extended period of time are discussed at the CPNS monthly meetings to ensure appropriate oversight and monitor the quality of the child protection safety plans.

Inspectors found that clear rationales were given where children had remained active on the CPNS for an extended period of time. The area held monthly quality assurance meetings in relation to the CPNS process. These meetings were chaired by the area manager, and discussion took place in relation to children listed on the CPNS, and in particular those children that were listed for longer than 12 months. In addition, the area had a complex case forum whereby cases that were not progressing as expected could be presented for review and consultation. Inspectors found that the complex case forum provided objective analysis of cases, and supported decision-making in relation to these cases. One of the cases that had recently been made inactive had been referred to the complex case forum in advance of their second review CPC. Clear actions were recorded following this meeting for the social worker to follow up on, and this guided their practice in relation to this case. Staff and management in the area acknowledged that changes to allocated social workers can have an impact on the progress made in relation to actions from a child protection safety plan. The service had appropriate systems in place to manage appeals and complaints made in relation to the CPNS service. At the time of the inspection, the area had received three appeals, and two complaints in relation to cases listed on the CPNS. Inspectors reviewed two of the appeals and one of the complaints that were received, and found that all were managed in an appropriate manner. Delays in receiving one of the appeals was outside of the social work department's control, and once received the service addressed it in a timely manner.

Inspectors reviewed five cases that had recently been made inactive on the CPNS. There were clear rationales and decision-making recorded for the decision to delist each child which were appropriate. Inspectors found that there were good quality closure summaries and safety planning close out forms completed. CPC chairpersons told inspectors that the administrative process for delisting children on the CPNS had been reviewed and updated in January 2022 to ensure that practice was consistent across the service area, ensuring children were delisted in a timely manner. In one of the files reviewed, the child and their family had been transferred out of the area. Inspectors found that the service had ensured that the formal transfer of the case had taken place prior to making the child inactive on the CPNS. All relevant professionals were informed that the family had transferred out of the area. Families were appropriately informed when children were no longer active on the CPNS. Of these five cases, one case had been reactivated in November 2021 having been made inactive nine months earlier. Inspectors found that appropriate steps had been taken to bring the case back to the CPC process when the existing safety plan was no longer keeping the children safe. Inspectors also reviewed two additional cases that had been reactivated on the CPNS. One case had been inactive over 12 months and the second case had been inactive for six months. Inspectors found that the decisions which led to the children becoming active on the CPNS again were appropriate as the risks for the children had significantly increased.

Inspectors found that when a child was placed on the CPNS, the abuse category could not be changed nor could more than one category of abuse be recorded on the CPNS. This meant that 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. The CPC chairpersons told inspectors that, in an effort to ensure that the information recorded on the CPNS accurately reflected the concerns and risks for a child, additional information was recorded in the commentary box on the child's record on the CPNS. This allowed the service to record information in relation to additional forms of abuse that were a concern for the child.

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 children's names 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 and this was overseen by the chairperson. The CPNS was updated immediately following each CPC. The CPC chairpersons and the area manager also had oversight of the CPNS. Access to the CPNS was strictly confined to

Tulsa staff and members of An Garda Síochána. Should out-of-hours general practitioners (GPs) 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. The service received notifications from the national CPNS support lead in relation to when a CPNS search was requested on a child in the service area and this was monitored and overseen by the area manager and the local CPNS team.

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

Initial CPC's were scheduled without delay, and robust child protection safety plans were put in place to keep children safe. The CPC's held in the area were comprehensively facilitated by appropriately trained, independent professionals who were not directly involved in the assessment and management of child protection cases. Parents and children were encouraged to attend and participate in their CPC meeting. Child protection safety plans were generally of good quality with clear actions agreed based on the risk and bottom lines identified during the CPC.

Judgment: Compliant

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

Review CPC's were timely in the vast majority of cases reviewed. However, where delays occurred, the reasons for these delays were not consistently recorded on the child's file on NCCIS. Clear rationale was given where children had remained active on the CPNS for an extended period of time. Children were appropriately delisted with clear rationales provided for the decision to delist the child.

Judgment: Substantially compliant

Standard 2.9
Interagency and inter professional cooperation supports and promotes the protection and welfare of children.

The service supported and promoted multidisciplinary involvement and cooperation to ensure that the needs of children were met in a timely way. The service worked creatively with other professionals in an effort to support children who were not actively working with services. There were effective communication systems in place to ensure that information was appropriately shared with the relevant professionals. The service ensured that there was a regular and timely review of the progress of interventions and information from professionals involved with families.

Judgment: Compliant

Compliance Plan for Child Protection and Welfare Service OSV – 0004389

Inspection ID: MON-0036047

Date of inspection: 08 March – 10 March 2022

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. ➢ National guidance is under revision by TUSLA National, and the area is informed that this in the final stages. A date for implementation is awaited.	

Standard Heading	Judgment
Standard 3.3	**Not compliant**
Outline how you are going to come into compliance with 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. ➢ Clearly record on child's file in the supervision record the alternative arrangement in place to keep the child safe in the instance of lacking of residential placement. ➢ Hold a network meeting to outline and record arrangements in place to keep child safe. ➢ Such cases to be discussed at monthly CPNS meetings attended by area manager, chairs of CPC"s, PSW, SWTL's and SW representative of the Duty and Assessment team and child Protection and Welfare teams. ➢ Risk is added to the National Tracker. ➢ Referrals for residential placements are reviewed nationally on a weekly basis by the NPT ➢ Hold a network meeting if a decision is reached not to continue to pursue a residential placement, based on an up to date assessment, which includes that the alternative support and safety arrangements in place are keeping the child safe, meeting his/her needs and is in the child's best interests. ➢ The child's name will be removed from the national residential placement team and this decision reflected on the file.	

Standard Heading	Judgment
Standard 2.7	**Substantially compliant**
Outline how you are going to come into compliance with Standard 2.7: Children's protection plans and interventions are reviewed in line with requirements in Children First. ➢ The current practice of maintaining a spreadsheet of delayed reviews and reasoning will continue. ➢ In addition all CPC records will state in the reason for delay to the CPC (as this is highlighted at the start of all CPC's where appropriate) ➢ Where discussions take place between the SW team and the CPC Chair regarding the reasons for a delay to CPC, this will be recorded by the SW/SWTL on NCCIS case file in case notes.	

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	Timeline is awaited from National Office regarding implementation of the revised guidelines

Standard	Regulatory requirement	Judgment	Risk rating	Date to be complied with
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.	Not compliant	Orange	Immediate and ongoing

Standard	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Standard 2.7	Children's protection plans and interventions are reviewed in line with requirements in Children First.	Substantially Compliant	Yellow	Immediate and ongoing