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:	Cavan Monaghan
Name of provider:	Tusla
Type of inspection:	Focused CPNS
Date of inspection:	30 May 2022 – 1st June 2022
Lead inspector:	Niamh Greevy
Support inspector(s):	Sabine Buschmann Hazel Hanrahan Susan Geary
Fieldwork ID	MON-0036818

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
- interviews with the area manager, principal social worker (PSW) for assessment and intervention, PSW for service improvement and chair for child protection conferences (CPCs)
- focus groups with social work team leaders
- focus group with social workers
- the review of local policies and procedures, minutes of various meetings, staff supervision files, audits and service plans
- the review of 16 children's case files
- phone conversations with four parents
- phone conversations with one child

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 Chile Protection Notification System.

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

Cavan/Monaghan is one of the 17 service areas in the Child and Family Agency (Tusla). The area is comprised of a large rural configuration of Cavan and Monaghan bounded by the border with Northern Ireland. The geographic area covers 1245 square miles. The total population of the area based on the 2016 Census was 137,562. There were 37,587 children (27.3%) of the total population which was slightly above the national average of 26%. The population of Cavan Monaghan was 137,562 (2016 census) and represents an increase of 2.9% from 2011 census. The number of children (0-17yrs) had increased by 2%. The child population of area as a percentage of total population was 28%. (2016)

Cavan/Monaghan is ranked as a deprived area relative to the national average (Pobal H.P deprivation index) with an unemployment rate of 12.4% in Monaghan and 15% in Cavan compared to the national average of 12.2%. 13.2% of the population in the area classify themselves as non- Irish nationals, while 0.54% of the population classify themselves as Irish Travellers. The area is characterised by a large rural spread with Tusla offices based in the in the towns of Cavan and Monaghan and Castleblayney.

The Census had highlighted that less than one third of the Area's population lived in towns with a population of more than 1,500 people. This had resulted in a very high rural dispersion of the remaining two thirds of the population. This had significant implications for the delivery of all types of services across the area.

As of the 1st May 2022, Cavan Monaghan area had 41 children on the CPNS and all of these children had an allocated worker. The area had one Child Protection Conference

Chair who was delegated this duty by the Area Manager. The CPC Chair was fully independent and was supported by dedicated administration staff.

There was one PSW for assessment and intervention who oversaw two assessment and intervention teams, one in Cavan and one in Monaghan. All children on the CPNS were allocated to these two teams.

The area had two social work team leaders, two senior social work practitioners, six social workers, one social care worker and one social care leader across the whole assessment and intervention service. There were three vacant social work posts.

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
30/05/2022	14:30 – 16:00	Susan Geary	Regional Manager
31/05/2022	09:30 – 17:00	Niamh Greevy	Acting Regional Manager
	10:30 – 17:00	Sabine Buschmann	Inspector
	09:30 – 17:00	Hazel Hanrahan	Inspector
	14:30 – 16:00	Susan Geary	Regional Manager
01/06/2022	09:00 – 17:00	Niamh Greevy	Acting Regional Manager
	09:00 – 17:00	Sabine Buschmann	Inspector
	09:00 – 17:00	Hazel Hanrahan	Inspector
02/06/2022	09:30 – 13:30	Niamh Greevy	Acting Regional Manager
07/06/2022	12:00 – 13:30	Niamh Greevy	Acting Regional Manager

Views of people who use the service

Hearing the voices of children and families was very important in understanding how the service worked to meet their needs and improve outcomes in their lives. Children who were consulted with were provided with the freedom to choose to participate or not in speaking with the inspectors.

The inspectors spoke with one child and four parents and listened to their experiences of the service. These parents had experienced going through the child protection conference (CPC) process and whose children were, or had been, listed on the Child Protection Notification System (CPNS).

A child spoke positively to inspectors about their experience of the service. The child voiced that the social worker had been *'doing a good job helping the family'* and that she was *'deadly'*. The child said that the social worker had *'got me support'* and they had regular contact with the social worker through home visits and phone calls. They told inspectors that her social worker had provided information that explained what a Child Protection Plan was and Child Protection Conference meetings. They had attended their conference. However, the child said that their experience of these meetings was that the adults *'a lot of times they don't listen to me'*. The child reported their experience to their social worker and said:

- *[social work] 'helped change things'*
- *'they started listening to me'*
- *'Got a choice to speak more'*

The parents spoke positively about the service they had received and voiced that they were supported throughout. All parents spoken to had developed a good rapport with their social worker and were informed of the reason for the service involvement. This was done through home visits and phone calls by the social worker. The service was depicted by parents as having a culture of being proactive in the sharing of information with parents in order to support understanding. This was done through home visits and the use of leaflets. Parents told inspectors that social workers were:

- *'Very good at breaking it down and going through the process'.*
- *'takes her time [with parents] and 'asks do you understand it'*
- *'don't have to press her for information'*
- *'came to the house and explained what is happening'*
- *'gave help to understand information and asks me questions'*

- *'Very good in explaining …. And help me understand'*
- *'there throughout it all'*
- *Made a big difference'*
- *'very supportive to me'*
- *'very understanding and on the ball'*

The majority of parents who spoke with inspectors said that their children were kept safe by the service. A parent told inspectors that their children were *'kept safe'* by the service and that it was *'done nicely and privately'*. Another parent said that the social worker gave 'lots of support' and that *'before didn't know what to do'*. The parent continued and stated that the children were more open to the social worker and that they *'didn't know about everything'* that the children had experienced. However, one parent voiced that they *'didn't get where [the service] were coming from'*.

Parents spoke of their experience of the Case Conference meetings in a positive light. Two parents said that they had been contacted by the Chair and their social worker prior to the meetings to explain the process. All parents were provided with an opportunity to have their say at the meetings but their experiences varied. Parents said that at the meetings they were:

- *'very relaxed'*
- *'Felt calmness'*.
- *'listened'* to
- 'asked to talk and give update'
- 'very good' meetings

However, one parent told inspectors that at their first meeting they were *'not supported through it'* and would had *'liked to have my say more'*.

All parents spoken to were provided with a copy of the Care Plan. Reports were also available and provided to parents in different languages to meet their needs. All parents had regular contact with their social worker which promoted positive communication and relationship building. A parent told the inspectors that they *'would love'* for the social worker to stay with the family and that they were *'happy'* that the social worker was around and *'helping us'*.

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 focus of this inspection was on children placed on the CPNS, 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, 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. There was an experienced area manager in position at the time of inspection, who oversaw the work of the CPC chairperson, the PSW for quality improvement and a recently appointed PSW for assessment and intervention. Two team leaders reported to the PSW responsible for the child protection service.

The chairperson was responsible for managing CPCs, overseeing the CPNS and ensuring that requests for CPCs met the required threshold. The CPC chairperson told inspectors that there was good communication with social work teams and except for one case, sufficient information was available on requests to inform their decisions about the appropriateness of a request for a CPC. Administrative staff updated and maintained the CPNS with oversight from the CPC chairperson. The CPC chair told inspectors they used the CPNS to ensure that reviews were held in timely way and no

reviews were overdue at the time of inspection. Social workers said that they had good communication with the CPC chairperson.

The Tusla interim national guidelines on CPCs 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, 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. Management team meetings were held regularly to deal with issues affecting the whole service area. Nine management team meetings took place in the year prior to this inspection, but from January 2021 the CPC was no longer a standing agenda item, as governance meetings with greater focus on the CPNS were scheduled separately on a quarterly basis. General management meetings dealt with issues such as COVID-19, finances, health and safety, staff training, interpreters and cultural champions and data protection. With the exception of one action regarding recording of CPC reports, actions relevant to this inspection were consistently followed up at subsequent meetings.

CPNS governance meetings were held to review all cases on the CPNS. CPNS cases were audited and discussed in a CPNS governance meeting twice in 2021 but this had commenced on a quarterly basis in 2022. At the time of inspection, the system set up involved social workers auditing their own cases on the CPNS, which was then given to team leaders to present at the quarterly governance meeting. These audits were discussed in the meeting, additional information or actions added where necessary and signed off by the Area Manager. The audit was then uploaded to NCCIS with social workers and team leaders responsible for implementing any recommendations. Files reviewed to track the implementation of audit actions found the actions were implemented with the exception of one case where the audit had just been complete.

Monthly governance meetings were held to oversee the child protection service. High level information regarding CPNS cases and the status of audits linked to CPNS were reported at this meeting twice in 2021 and at three meetings up to this inspection in 2022. Actions were recorded such as the need for a review to be completed and

inspectors found this had been acted on. These meetings also dealt with broader issues including staffing and recruitment and risk management.

The service had developed a specific service improvement plan for the CPNS in February 2022 for completion throughout 2022. The plan reflected the learning and themes arising from reviews undertaken by the service. This plan included 33 actions, two of which were completed and the remainder were not due for completion but progress against these actions was recorded on the plan. These actions included the identification and assessment of risk, participation of children during CPCs, oversight of the CPNS by management meetings, audits, Children First training and learning from feedback. Inspectors found evidence of measures in place to progress actions such as a schedule in place for meetings and evidence on files reviewed that practice was consistent with the service improvement plan. The aim to share child protection safety plans with families within two weeks of the CPC had not been achieved at the time of inspection. This will be detailed further under the *Quality and Safety* section.

The review of evaluation forms for the previous 12 months by the CPC chairperson summarised the feedback provided to the service and made appropriate recommendations based on this. Aspects of this feedback were evident in the service improvement plan, for example, efforts to improve the quality of participation from children and their families.

Quality, risk and service improvement (QRSI) meetings were effectively used to bring together learning from a range of sources. Minutes were provided to inspectors for October 2021 and monthly between December 2021 and March 2022. These meetings included learning from audits, reviews, HIQA reports and feedback. They also tracked the development and implementation of the service improvement plan for CPNS which was reviewed at this meeting in March 2022. The risk register was discussed in this meeting and it was evident from records that the service were working to embed good risk management practices throughout the service from frontline workers to senior managers.

The PSW for assessment and intervention and chairperson for CPCs intended to meet quarterly to ensure good communication and governance of CPNS cases. The first of these meetings took place in March 2022 and working to improve participation of children, parents and professionals was a central part of the discussion recorded. Other agenda items included a review of the service improvement plan for CPNS and learning from HIQA reports.

Records of two group supervision records dating from 2021 showed how the service had used this forum to look at the role of the social worker under the CPC policy and the use of the safety planning form.

There was evidence of good communication throughout the service. Management meetings took place regularly between PSWs and team leaders to communicate up and down through the service. These meetings were used to communicate information and decisions from senior management meetings and to provide data regarding the stages of CPNS cases within teams. In the year prior to inspection, there were eight of these meetings. The PSW for assessment and intervention also told inspectors that team meetings were held monthly prior to the Area Assessment & Intervention Governance meeting so that information could be fed upwards to this meeting and to share accountability throughout the service.

The service had conducted good quality reviews that identified areas for further development of the service. Managers conducted a number of reports and reviews of the CPC service including a 2021 end of year report, review of cases closed to the CPNS in the previous 12 months, review of evaluation forms and a review of a case re-referred to the CPNS. The annual report outlined the activity of CPC cases for the year and summarised the key strengths and challenges for the service. Strengths included the quality of social work assessments presented at conferences, the return to face-to-face meetings, implementation of Tusla's practice model and improved recording. Challenges included the impact of COVID-19 on running the service, the prevalence of domestic violence and related complexities, and issues regarding data management. Though the report referenced the number of conferences held, it did not analyse the number of children these conferences related to. The service had managed conferences that related to multiple children. There are many good reasons for doing so, such as consideration for the demands placed on families in participating in a conference. However, conferences related to multiple children also bring challenges, such as ensuring the individual needs of children are fully considered. Further consideration of data and practice in this regard could help the service to continue to improve practice in such circumstances.

Audits were effectively used to monitor cases open to the CPNS. Inspectors reviewed audits of individual cases as well as an audit of the CPNS. The audit of the system identified that it had been accessed by authorised personnel only and rectified data errors identified in the course of the audit. An audit of timeliness of review CPCs found that the rationale for delays were not consistently evidence on files and so the area had introduced a decision sheet to capture this information which was evident on some files reviewed by inspectors. Audits were also undertaken quarterly on each casefile and reviewed at quarterly governance meetings. Audits were evident on files

reviewed by inspectors and showed good oversight through the chain of management up to the Area Manager. While the area had not formally collated and analysed these audits, trends had been identified and actioned by the service. For example, managers told inspectors that the prevalence of domestic violence cases became apparent as a result of audits of the service and as a result specialist training was made available to staff.

Staff and managers demonstrated knowledge of legislation, regulations, policies and standards for the protection and welfare of children appropriate to their role and responsibility. As noted above, learning was identified from a range of sources and used to inform practice.

Regular supervision by the Area Manager of the three senior managers involved in the CPNS was evident in records. Minutes of supervision provided clear information regarding the status of work ongoing within the service. Actions were identified and there was evidence of gradual progress against these. Work to improve participation of children, families and professionals was evident in supervision records. The chairperson for CPCs reported the CPNS statistics in supervision, including any cases overdue for review.

Supervision was used effectively to manage cases but improvements were required to ensure frequent supervision took place on all cases. Inspectors reviewed seven cases for the frequency of supervision and found that it took place consistently on four cases. In the fifth case, there was a three month gap in supervision records but subsequent supervision occurred regularly. The two remaining cases showed supervision had taken place infrequently. Files reviewed for quality of supervision showed that actions from supervision had been implemented to effectively manage cases.

Appropriate risk management systems were in place at the time of inspection. The risk regarding staff was created in February 2022 and reviewed in April 2022. While there were staff vacancies in the area, managers had 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 CPNS cases were unaffected by staffing issues, except for the capacity of staff to complete trajectories.

Measures in place to ensure accurate data was held on the CPNS had been effective. There had been two meetings held on a quarterly basis in 2022 to oversee and

manage the data held on the CPNS. These meetings had identified and rectified errors on CPNS. Monthly data integrity governance meetings had also been held between January and April 2022 regarding the wider child protection service.

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 the service had good systems in place to identify and implement learning from a range of sources. 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.
Appropriate strategic and operational plans were in place in respect of the CPNS. Managers articulated a clear vision for the service. The service had a risk management framework in place which was used to identify and manage key risks. The service had audited and reviewed the CPNS. While audits of cases had not been collated, managers had identified trends in cases and used this information to improve the service. Findings of reviews and audits led to clear recommendations and actions to address issues identified. Inspectors found evidence of actions being followed up. There were clear lines of accountability and systems in place to monitor practice. This had resulted in improvements to practice. Management and governance meetings were effectively used to monitor and oversee the CPNS.
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 service monitored, audited and reviewed practice to identify and mitigate risk.
Judgment Compliant

Quality and safety

Referrals for initial CPCs were made in a timely way but there were delays in convening conferences. Inspectors found that referrals for CPCs were made in a timely way in five of six files reviewed for this. In the nine cases reviewed for timeliness of scheduling, one was scheduled in a timely way and took place within three weeks of the referral being made. Delays were evident in the remaining cases with three initial CPCs scheduled within five weeks of referral, two within six weeks, two within eight weeks and one took ten weeks to schedule. Reasons for delays related to COVID-19, however, on one case the reasons were not recorded. An independent and suitably qualified staff member undertook the role of chairing CPCs. The chair for CPCs told inspectors that capacity to hold conferences was not an issue for the service and decisions to delay reviews were usually made to make sure that relevant professionals, especially schools, were able to attend. An audit by the service identified that reasons for delays in holding CPCs were not consistently recorded on files. As a result, the service had introduced a form to record reasons for delays and measures in place to make sure children were safeguarded in the interim. These forms were evident on some files relating to delays in holding review CPCs. This will be detailed further below. Inspectors reviewed how the safety of children was addressed while cases were waiting for initial CPC on three cases and found that appropriate steps were taken to manage risk while waiting for a conference to be convened.

Inspectors found that children's views were represented well in most of the CPC minutes reviewed for this purpose. Of the files reviewed, inspectors found children were invited to attend reviews where this was appropriate but children had chosen not to attend. Further work to improve the participation of children was in the planning stages at the time of inspection. This may support the service to identify how they can better support children to participate in the CPC process. Of ten files reviewed, children's views were reflected in the minutes of the review in eight cases, while this required improvement in two cases. In one of these cases, the case records showed good involvement of children but the child's views were not reflected on the CPC record. In the month before inspection, the service had introduced a '*me and my conference'* booklet to support social workers to represent the views of children in the CPC process. Given the recent roll-out of this tool, it was not evident on files reviewed as part of this inspection.

The timeliness of meeting children after CPC required improvement on some cases. For example, in some cases it was one, three or five months after the conference that inspectors found evidence of discussions taking place with children regarding the CPC and safety planning. Inspectors found that following CPC, social workers had met

with children and two files showed that 'words and pictures' had been used to help children understand their situation. In one case, where there was a difficulty with meeting with a child, the service had obtained a supervision order from the courts to allow this to happen. Inspectors reviewed files for visits to children while they were subject to a child protection safety plan and found that in eight cases social workers visited monthly but in three of these cases there had been between one and three months where visits were not evident. In a further case, a child had only had two visits from a social worker in a period of eight months. Announced and unannounced visits were evident on files reviewed. Direct contact with social workers is an important safeguarding measure in place for children subject to safety plans. Safety planning will be dealt with in further detail below.

Inspectors found that parents were consistently invited to CPCs and supported to participate and share their views. Parents spoke with the chair before the CPC in all but one case reviewed, where the chair had made efforts to make contact. Parents' views were reflected in all initial CPC records reviewed for this purpose. Records showed that risks and strengths were discussed with parents in reviews.

Inspectors found that in all nine cases reviewed, relevant professionals were invited to reviews, and where available people from the family's network. Professionals invited included general practitioners (GPs), An Garda Síochána, youth services, mental health professionals, teachers, childcare staff, addiction counsellors, psychologists and CAMHS professionals. Records of these meetings showed evidence of these staff contributing to CPCs, sharing information and contributing to safety planning. There were significant challenges for chairing reviews evident in some cases reviewed by inspectors, for example, reviews that related to multiple children, reviews that included a large number of participant and reviews relying on tele- and videoconferencing technology. The challenges of participating in reviews that took place through conferencing technology was reflected in feedback given to the service by participants. However, minutes reviewed by inspectors showed adequate participation by families and professionals.

At the time of the inspection, the service was continuing with a blended approach to CPCs as this allowed the family to be in the room with the chairperson, and it also allowed professionals to join remotely. The CPC chair told inspectors that CPCs continued throughout COVID-19 with the help of video and teleconference. The CPC chairperson said that remote access had its benefits and drawbacks. The chair was hoping to return to more in-person conferences to support better communication and engagement from all participants.

Records of CPCs were issued to parents and professionals from three to seven weeks after the conference. It was not consistently evident on files when records of CPCs were shared with families but the service maintained a tracker of the status of records for 2022 to support good oversight. This tracker showed that two reports had been issued within three weeks, two within four weeks, three took five weeks to issue including one that required translation, one was issued six weeks after the conference and three took almost seven weeks to be sent.

The quality of safety planning was good in the majority of cases reviewed. Inspectors reviewed 14 child protection safety plans related to 11 cases. The main aspects of the safety plan were agreed at CPCs, with further, more in-depth safety planning taking place after the conference. Ten of these child protection safety plans were found to be good quality. They addressed the safeguarding concerns appropriately and identified suitable supports for families. Inspectors found network meetings took place as required on seven of these 10. In two the remaining three, regular network meetings had taken place but outside the timeframes agreed on the safety plan. In the last case, no network meetings had taken place. One network meeting was postponed due to illness but there were four months before this without a network meeting.

Four child protection safety plans, related to three cases, required improvement. Two of these safety plans were on one case. On this case, while the safety plans dealt with the main safeguarding concerns, it has not responded to a complicating factor. Inspectors discussed this with the social worker who provided assurances that this would be addressed. One safety plan lacked detail and social workers struggled to identify a network to support the family. Despite this social workers told inspectors they regularly visited the family to monitor any concerns. In the last case, significant efforts to work with the family to address concerns and identify a network were evident on file but a safety plan was not developed after the CPC in September 2020. This case had been subject to review CPCs and subsequent good quality safety plans were developed and are included in the paragraph above.

Inspectors found that children were admitted to care as needed. In three files reviewed, children were admitted to care in a timely way. In a further case reviewed, legal advice was being sought due to a lack of progress in relation to concerns. The Area Manager and PSW for assessment and intervention told inspectors that placements were identified for children as needed.

CPCs were attended by a range of professionals and there was evidence of good interagency work to safeguard children on files. Files showed that children were supported by a range of professionals and services, including schools, family support

services, GPs, CAMHS, disability services, domestic violence services including refuges and the local county council. Files also showed good communication with An Garda Síochána. Inspectors found examples of good advocacy by social workers on behalf of families, for example, to ensure that calls regarding domestic violence would be prioritised by Gardaí for a response, or with the council to support families to access suitable housing. There was evidence on files of social workers following up with services to monitor progress on actions agreed at CPCs.

Formal briefing sessions with other services operating in the service area were planned for the end of 2022. Briefing sessions had not taken place in recent years and the chair for CPCs told inspectors this was due to COVID-19. At the time of inspection the chair for CPCs and the PSW for assessment and intervention were in the early stages of developing presentations and making a plan to meet with other services in the area such as An Garda Síochána, public health nurses and hospital staff. The chair for CPCs told inspectors that the aim of this included providing information to relevant professionals regarding the CPC process and how they can best support and contribute in the interest of children.

Case transfers were managed in line with policy. One family had transferred into the area shortly before inspection but no cases had transferred out in the period reviewed as part of this inspection. Inspectors reviewed the file of one child who had transferred in and found that the service area had supported the prompt transfer of the case to best support the children. Both the team leader previously responsible and the newly allocated team leader were present for the handover meeting. The social worker promptly met the family and began to work on the case. The review CPC was scheduled within three months of the transfer, in line with policy. Upon transfer, this service identified issues with information missing from the file. This was escalated to the Area Manager who wrote to the other service area and a plan was agreed to resolve these issues.

Review CPCs were held in a timely way and where they were not, the reason for this was recorded on files. Review CPCs should be held within six months of the previous conference. The purpose of the review is to consider the progress since the last conference and ensure timely decisions are made in the best interest of children. The review considers if children can be delisted, or if continued listing is required, in which case a further safety plan is needed. In two cases, the delays related to the social worker's circumstances and a third case was delayed to afford more time to put supports in place for the family. Inspectors found social workers had begun to use the form introduced for this purpose which recorded the reason for delay and the measure in place to safeguard children while waiting for the review.

Inspectors found that cases listed for over 12 months were appropriately managed. Inspectors reviewed one case listed for 20 months and found that significant supports were put in place for the family. The first review on this case had not taken place in a timely way and reasons for provided for this. The subsequent review had been timely and there was evidence of significant advocacy with network services to provide the family with the supports needed.

The service operated a complex case forum which provided an objective review of cases. Staff told inspectors that cases listed for over 12 months were referred to the complex case forum. Cases were referred to the forum where complexities and challenges had emerged that required additional review and support. Three cases related to this inspection were discussed at this forum and minutes were provided to inspectors. These minutes showed clear and appropriate recommendations for action. On the file reviewed by inspectors the recommendations from the complex case forum were acted on promptly.

There had been no complaints, or appeals that met the threshold within the scope of this inspection. The service provided inspectors with positive feedback received in relation to the service. This included three compliments within the scope of this inspection that related to the support provided to children and families by Tusla.

Cases closed to the CPNS were closed appropriately and clear rationales for closure were evident on files. Two of six cases reviewed for appropriate closure were closed because the child was admitted to care. In the remaining four, appropriate supports were in place and parents were informed of closure.

Inspectors reviewed one case that had been reactivated. The service had completed a review of this case and identified that the concerns had not been adequately addressed when the case was initially placed on the CPNS. Inspectors found that the case had received appropriate supports and management by the social work department since it was re-listed on the CPNS.

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. The chair for the CPC acknowledged that this meant that where more than one category posed a concern, this could not be fully reflected in the categorisation information.

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 and the chair had conducted an audit of access to ensure that only authorised persons had accessed the register. 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.

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 timeliness of scheduling initial CPCs required improvement. Inspectors found that referrals for CPCs were made in a timely way in five of six files reviewed for this. In the nine cases reviewed for timeliness of scheduling, one was scheduled in a timely way and took place within three weeks of the referral being made. Delays were evident in the remaining cases which had their initial CPC between five and ten weeks after referral.

The quality of safety planning was good in the majority of cases reviewed. Plans generally addressed the identified concerns and appropriate supports were identified for families. Where issues were identified with the quality of safety planning, the social worker provided assurances that they would follow up on an issue on one case and on a second case, the issue had already been addressed by the service.

CPCs were facilitated by an appropriately trained and independent professional who had no role in the day-to-day management of cases.

Parents and children were encouraged to attend and participate in their CPC meetings and the service were working to improve their practice in this regard.

In eight of ten cases, the views of children were well-represented in the CPC record. While children were met with following the CPC, this did not always occur in a timely way.

CPC records were not always shared with families in a timely way and no records in 2022 had been shared in line with the timeframes set out in policy.

This inspection found that the CPNS was updated and managed in line with Children First (2017) and that children's names were placed on the CPNS where there child protection concerns related to abuse or neglect.

Judgment
Substantially compliant

Standard 2.7 Children's protection plans and interventions are reviewed in line with requirements in Children First.
Review CPCs were held in a timely way on two cases reviewed and appropriate reasons for delays were evident on files of the remaining cases reviewed. Clear rationales were evident on the few files where children remained active on the CPNS for extended periods. Children were delisted from the CPNS appropriately.
Judgment Compliant
Standard 2.9 Interagency and inter-professional cooperation supports and promotes the protection and welfare of children.
The service supported multidisciplinary involvement and cooperation to ensure that the needs of children were met in a timely way. 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 – 0004404

Inspection ID: MON-0036818

Date of inspection: 30 May – 02 June 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. The updated Child Protection Conference guidance and the accompanying standard operating procedures for the administration of the CPC has been finalized and an implementation date has been set for 30th September 2022. In the interim, Cavan Monaghan will continue to implement the revised local practice matter and guidance which ensures that the gaps in the National Interim policy are bridged and the protection of children enhanced.	

Standard Heading	Judgment
Standard 2.6	**Substantially compliant**

Outline how you are going to come into compliance with Standard 2.6: Children who are at risk of harm or neglect have child protection plans in place to protect and promote their welfare.

Action:

- Implementation of the updated Child Protection Conference guidance and the accompanying standard operating procedures for the administration of the CPC will be completed by 30th September 2022.
- In the interim, the local practice matter and guidance will be amended to include an emphasis on adherence to timeframes for convening CPCs. A clear rationale shall be documented on NCCIS where this is not possible.
- The tracker for monitoring scheduling of CPC's will be reviewed at governance meetings.
- My Conference and Me book to be completed in advance of CPC for children under 12 and/or those who choose not to attend.
- Children will be met within two weeks of the CPC to discuss safety plan and outcome of CPC meeting.
- Children on CPNS will be met with every four weeks.

All above additional actions to be included on Area CPNS Quality Improvement Plan for tracking.

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	30th September 2022

Standard	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Standard 2.6	Children who are at risk of harm or neglect have child protection plans in place to protect and promote their welfare.	Substantially compliant	Yellow	30th September 2022