Child protection and welfare inspection report

Health Information and Quality Authority
Regulation Directorate monitoring inspection report on child protection and welfare services under the *National Standards for the Protection and Welfare of Children*, and Section 8(1) (c) of the Health Act 2007

Name of Service Area:	Dublin South Central
Dates of inspection:	17, 18, 19, and 20 September 2018
Number of fieldwork days:	4
Lead inspector:	Erin Byrne
Support inspector(s):	Grace Lynam Ruadhan Hogan Caroline Browne Eva Boyle
Type of inspection:	☒ Announced ☐ Unannounced ☐ Full ☒ Themed
Monitoring Event No::	MON-0024676

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 and Youth Affairs 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-centered Services	☐
Theme 2: Safe and Effective Services	☒
Theme 3: Leadership, Governance and Management	☐
Theme 4: Use of Resources	☐
Theme 5: Workforce	☐
Theme 6: Use of Information	☐

1. Inspection methodology

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

The key activities of this inspection involved:

- the analysis of data
- interview with the area manager and one principal social worker
- interview with three social work team leaders
- meetings with social workers and social care workers
- the review of local policies and procedures, minutes of various meetings, staff supervision files, audits and service plans
- reviewing 128 children's case files
- Observing duty staff in their day-to-day work.

The aim of the inspection was to assess compliance with national standards related to managing referrals to the point of completing a further assessment, excluding children on the child protection notification system (CPNS). During this inspection inspectors identified if Tusla child protection and welfare services took timely, proportionate and effective actions when responding to referrals about children in need and at risk by evaluating the following:

- timeliness and management of referrals
- effectiveness of assessment and risk management processes
- provision of safety planning where required
- effectiveness of inter-agency and multidisciplinary work
- the managing and monitoring of child protection cases in order to improve outcomes for children

Acknowledgements

The Authority wishes to thank the staff and managers of the service for their cooperation with this inspection.

2. Profile of the child protection and welfare service

2.1 The Child and Family Agency

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

The Child and Family Agency 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 areas.

2.2 Service Area

Dublin South Central is one of 17 service areas in the Child and Family Agency. Forming part of the Dublin Mid-Leinster region, it encompasses two geographical local authority catchment areas, namely South Dublin County Council and Dublin City Council. The Dublin South Central Area provides services to areas in Dublin South City and Dublin South West, including Dublin South Inner City, Rialto, Inchicore, Ringsend, Rathmines, Rathfarnham and areas to the south west of the city including Ballyfermot, Cherry Orchard, Clondalkin, Rowlagh, Palmerstown and Lucan.

The total population of the area is 305,278. Of that figure, 65,564 (21.5%) are children under the age of 18 years of age. Please see (Figure 1) breakdown of age profiles and totals:

Figure 1 - Age profile of children under 18 in Dublin South Central area Age:	Total
Under 1 years	4,016
0-4	19,949
5-12	29,358
13-17	16,257

(Data taken from 2016 census)

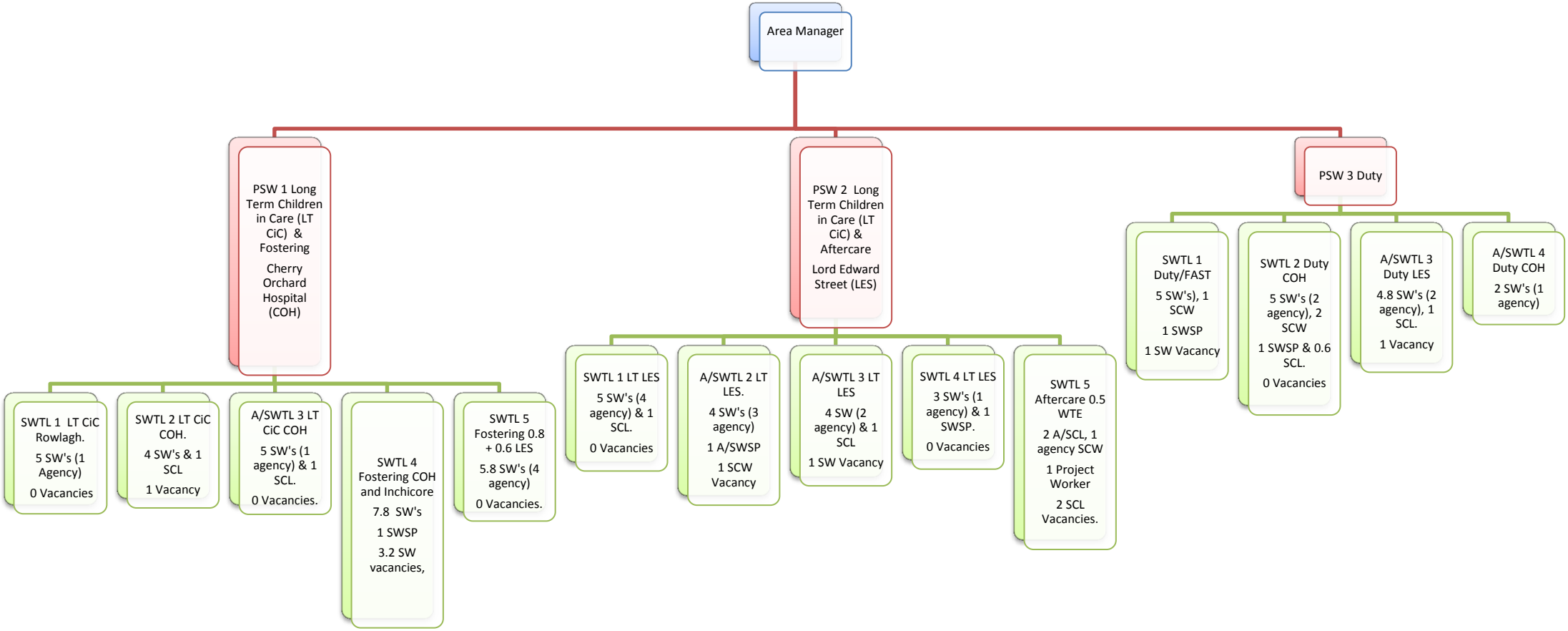
The Pobal 2016 deprivation index cited some areas within the catchment as being 'very disadvantaged' and 'extremely disadvantaged'. The area is under the direction of the regional service director for the Child and Family Agency Dublin Mid-Leinster region and is managed by the area manager.

Between January and September this year, the area received on average 220 child protection & welfare referrals per month. The Section 3 team received on average 15 retrospective referrals per month.

At the time of inspection, the Dublin South Central child protection & welfare service comprised of two duty teams, one intake team, one F.A.S.T (further assessment) and Section 3 team. These teams were line managed by four social work team leaders who reported to one principal social worker. The team had offices in two parts of the area Lord Edward Street and Cherry Orchard Hospital.

As a result of the inspection, immediate changes were made to the makeup of the duty/child protection teams in the area with the creation of a dedicated intake team based in Ballyfermot. From January 2019, a dedicated principal social worker will take up post to manage an intake pillar, separate to child protection, and there will be intake teams in both Cherry Orchard Hospital and Lord Edward Street.

Figure 1: Organisational structure of the Child Protection and Welfare Service, Dublin South Central Service Area* ***(Provided by Tusla, Child and Family Agency)***



3. Summary of inspection findings

The Child and Family Agency has the legal responsibility to promote the welfare of children and protect those who are assessed as being at risk of harm. In order to achieve this, child protection services need to act in a timely and proactive manner in order to effectively safeguard children. This inspection found that Dublin South Central (DSC) Child Protection and Welfare Services failed to achieve this and the service that existed at the time of inspection did not have the capacity or capability to ensure a timely and safe service for all children in receipt of its services. The majority of findings of this report do not come as a surprise to the management team of Dublin South Central child protection and welfare service. They had identified deficits in practice prior to the inspection and had put a service improvement plan in place since September 2017. Despite this, the management team was unable to successfully implement timely changes to provide a safe and effective service and this placed children at risk.

In this inspection, HIQA found that of the six standards assessed, major non-compliances were identified in five and one standard was found to be substantially compliant.

This was the first inspection of Dublin South Central Child Protection and Welfare service since the establishment of Tusla in January 2014. The decision was made to undertake this inspection in response to risks identified by HIQA through:

- On-going monitoring of the foster care service of Dublin South Central Foster Care Service since November 2016 and the continued findings of non-compliance in a number of standards including: safeguarding and child protection.
- Review of available performance and activity data – indicating an increase in unallocated cases within the child protection and welfare service, from 136 in March 2018 to 619 in July of 2018 (450% increase in six months).
- Analysis of unsolicited information received by HIQA in relation to the child protection and welfare service in Dublin South Central, and
- Concerns relating to governance and management within the service area in particular with regard to an absence of effective measures to address known risks.

Significant failings in the provision of a quality service existed at the screening and preliminary enquiry stage of the CPW management process. Two hundred and thirty-two referrals of all levels of priority were placed on a waiting list, some for significant periods prior to basic preliminary enquiries being completed. Checks in the form of internal system checks for details of any previous contact with the service; contact with the referrer; network checks with other professionals and appropriate contact with parents were not routinely undertaken as part of the screening process. Analysis of potential risks through screening of referral information was poor and the risk ratings that were applied to the child were based on limited information, resulting in delays and inadequate responses to some children at risk.

In addition to the above delays, the area also operated a waiting list for children and families who had undergone the screening and preliminary enquiry process and were awaiting allocation to a social worker for the purpose of completing an initial assessment. At the time of inspection data provided by the area manager indicated that there were 77 cases on a waiting list for initial assessment and 184 cases awaiting further assessment. However, there was no effective system in place for reviewing cases awaiting allocation at any stage of the process resulting in continued inaction and long delays in responding to concerns about children. There was no clear plan to address backlogs of referrals awaiting social work intervention. At the end of the inspection the area manager informed inspectors that the structure of the service was being reviewed and that all cases awaiting allocation would be reviewed in order to address the backlog. Waiting lists were also in place for children and families who required the interventions of Protection, Prevention and Family Support (PPFS). In acknowledging this fact the area manager stated that a review of commissioned services was underway in order to ensure that all resources were being used effectively.

Children who were allocated a social worker received a varied service – some received a good quality service where their needs were adequately assessed and necessary interventions including immediate action was taken. Other children received a delayed service, where opportunities were missed to assess their needs in a timely way. When their needs were assessed, through an initial and or further assessment, in some cases inspectors evidenced, through file review sampling, inadequate analysis of home situations,

indicating that the children were not always appropriately safeguarded. It was of concern to inspectors that in five initial assessments reviewed, children had not been seen by the social worker as part of the routine completion of assessments. This indicated poor social work practice and lack of effective oversight by management.

The system in place for ensuring that all allegations of suspected abuse were notified by social workers to An Garda Síochána was not robust and there were many examples where notifications had not been sent as required or where there were delays.

There were good formal systems for liaison between the Child and Family Agency and An Garda Síochána in regard to cases where garda notifications were made or received. However, decisions reached at these forums were not readily accessible on children's individual case files.

Appropriate measures were not consistently taken by social workers to protect children. The process of agreeing safety plans with children's family members was not routinely implemented in practice. Inspectors found that in 16 of 27 cases where safety plans were required, these were not in place. Of those that were in place the majority were not comprehensive and did not adequately address potential or known risks to children's safety. Inspectors reviewed safety plans which had been agreed without consideration of all risks to children; which had not effectively assessed the capacity of the adult responsible for its implementation; and which had not involved children in their development.

The governance, monitoring and oversight of the management of child protection and welfare cases in DSC was of a poor quality:

- Inspectors found that the majority of risks identified during inspection fieldwork had been known to the area management team and had been identified through internal audit and review processes prior to this inspection. However, at the time of this inspection appropriate action to address identified risks and to implement actions to ensure the quality and safety of the service had not been taken. Plans to improve the service, identified as being required 12 months prior to this inspection, had not sufficiently progressed and risks escalated in the interim.

- Inspectors found that oversight of social work practice was poor and there was an absence of adequate governance systems to ensure the effective implementation of national policies, frameworks or templates. At the time of inspection, the service area had begun to implement 'Signs of Safety', a strengths-based approach to child protection casework, grounded in partnership and collaboration with children, families and their wider network of support, and Tusla's national approach to practice. The inspection found that this approach to practice was at an early stage of implementation and was not yet embedded in practice within the child protection and welfare team.

- A new integrated national child care information system (NCCIS) had been introduced in DSC in May of 2018 but this was not being effectively used. This system allows social workers to record details of interventions. Inspectors found that there were gaps in information as staff were not routinely inputting information into the system as required. In addition to electronic records about children, paper records were also maintained. Inspectors found that case files were mostly incomplete and the majority were lacking basic information to provide assurances of actions taken to address risks to children.

- Inspectors found that there was an absence of effective communication with regard to risks in the area. Risk management processes were not fully embedded in practice and systems designated to escalate and monitor risks were not effectively used. Of the 128 cases reviewed by inspectors, 16 cases were escalated to the area manager following inspection fieldwork, for assurances as to the safety of children concerned. It is important to note that the cases that were escalated were usually escalated for more than one reason- such as inadequate screening and preliminary enquiry and safety planning.

- The area management team provided a satisfactory response in relation to all 16 cases escalated. The responses included: implementation of robust safety plans in 12 cases, one closed cases was re-opened and in three cases escalated children were referred for child protection conference due to the identification of on-going significant risk following completion of preliminary enquiries by the service area.

- In addition to the 16 cases mentioned above, during the inspection three case files were requested from the social work team, these could not be located. Assurances were sought from the area manager that these files were located and that that appropriate screening, preliminary enquiries and actions were taken. Satisfactory assurances were provided by the area manager.

Following completion of this inspection, HIQA's Head of Children services and regulatory team met with the Child and Family Agency's Chief Operations Officer and the Service Director for Dublin Mid-Leinster Region, including Dublin South Central service area. During this meeting, the Chief Operations officer and Service Director were presented with preliminary findings of risks identified during this Child Protection and Welfare inspection. In addition, the on-going concerns relating to failures to effectively manage risks in the foster care service in Dublin South Central were outlined. A requirement for a full service plan to address continued and escalating risks across Dublin South Central Service Area was notified to Tusla during this meeting.

Details of the planned actions, provided by the Chief Operations Officer, to address the deficits highlighted in this report are referenced under standard 2.10. In summary, the plan outlined the following;

- an organisational review and restructuring of DSC (the restructuring of the child protection service begun immediately following this inspection)

- the development of a performance and accountability framework to ensure better identification, assessment, monitoring and action to optimize individual and organisational performance

- the use of a project management approach to addressing recommendations / actions for service improvement

- actions to ensure timelier and better quality screening and preliminary enquiries and initial assessments, including ensuring improved governance of cases awaiting allocation and the implementation of a defined safety planning process for children who are not subject to a child protection plan and who are awaiting allocation of a social worker

- review of monitoring, auditing, quality improvement, and oversight arrangements to ensure timely and effective identification and management of risk, the continuous evaluation of quality, safety and outcomes of service provision and the enhancement of a culture of continuous improvement through staff learning and development

- increase in workforce resources related to: (i) the intake, screening and preliminary enquiry functions including increased operational oversight and governance of the intake service; (ii) the service improvement function; (iii) additional staff resources for PPFS; and (iv) additional staff resources for foster care services

- improved information management systems

In addition, as with all inspection reports, the Child and Family Agency are required to provide an action plan to address the specific non-compliances outlined within this report. The action plan is published separately to this report.

In conclusion, this inspection identified significant risks within the Dublin South Central service area. The Child and Family Agency have informed HIQA of a number of arrangements which are being established and or reviewed by Tusla to enhance its capacity and capability to deliver a safe and effective foster care and child protection service in Dublin South Central service area (DSC).

The regulation directorate's monitoring and inspection of DSC during 2019 will focus on assessing the progress made in implementing the various elements of Tusla's project plan; and the extent to which these measures have addressed the concerns outlined in this report resulting in a strengthening of systems and processes necessary for a safer, more timely and effective service.

4. Compliance Classifications

We will judge a provider or person in charge to be **compliant, substantially compliant** or **non-compliant** with the regulations and/or standards. These are defined as follows:

Compliant: A judgment of compliant means that no action is required as the provider or person in charge (as appropriate) has fully met the standard and is in full compliance with the relevant regulation.

Substantially compliant: A judgment of substantially compliant means that some action is required by the provider or person in charge (as appropriate) to fully meet a standard or to comply with a regulation.

Non-Compliant: A judgment of non-compliance means that substantive action is required by the provider or person in charge (as appropriate) to fully meet a standard or to comply with a regulation.

Actions required

Substantially compliant means that ***action within a reasonable timeframe*** is required to mitigate the non-compliance and ensure the safety, health and welfare of people using the service.

Non-Compliant means we will assess the impact on the individual(s) who use the service and make a judgment as follows:

- **Major non-compliance:** ***Immediate action***[1] is required by the provider or person in charge (as appropriate) to mitigate the non-compliance and ensure the safety, health and welfare of people using the service.

- **Moderate non-compliance:** ***Priority action*** is required by the provider or person in charge (as appropriate) to mitigate the non-compliance and ensure the safety, health and welfare of people using the service

[1] Where a major non-compliance judgment presents an 'immediate risk' to the safety, health or welfare of people

using the service, the inspector may issue an immediate action plan on the day of inspection.

5. Summary of judgments under each standard

National Standards for the Protection and Welfare of Children	
Theme 2: Safe and Effective Services	**Judgment**
Standard 2:2 All concerns in relation to children are screened and directed to the appropriate service.	**Non-compliant - Major**
Standard 2:3 Timely and effective actions are taken to protect children.	**Non-compliant - Major**
Standard 2:4 Children and families have timely access to child protection and welfare services that support the family and protect the child.	**Non-compliant - Major**
Standard 2:5 All reports of child protection concerns are assessed in line with Children First (2011) and best available evidence.	**Non-compliant - Major**
Standard 2:9 Interagency and inter-professional co-operation supports and promotes the protection and welfare of children.	**Substantially Compliant**
Standard 2:10 Child protection and welfare case planning is managed and monitored to improve practice and outcomes for children.	**Non-compliant - Major**

6. Findings

Theme 2: Safe and Effective Services

Services promote the safety of children through the assessment of risk, learning from adverse events and the implementation of policies and procedures designed to protect children. Safe services protect children from abuse and neglect and follow policy and procedure in reporting any concerns of abuse and/or neglect to the relevant authorities. Effective services ensure that the proper support mechanisms are in place to protect children and promote their welfare. Assessment and planning is central to the identification of children's needs, the risks to which they are exposed and the supports which need to be put in place for each individual child to keep them safe and maintain their wellbeing.

Standard 2.2:

All concerns in relation to children are screened and directed to the appropriate service.

Screening and Preliminary Enquiry

The service area had four child protection teams based in two locations both with different team structures and procedures. The child protection social work team in Lord Edward Street operated as an intake and assessment team in that they managed referrals from the point of receipt of the referral to completion of initial and/or further assessments, where required. The team in Cherry Orchard Hospital was divided into three sections. The first team had responsibility for managing referrals from the point of receipt of referral to completion of screening and preliminary enquiries. The second team managed referrals for the purposes of completion of initial assessments; and a further assessment and screening team (FAST) completed further assessments and on-going work with children as required.

Tusla Child protection and Welfare Services receives referrals from various sources including members of the public, professionals, community organisations, voluntary services, and An Garda Síochána. This inspection found that referrals were received by Dublin South Central Child Protection and Welfare Service from all of the above sources and these were received in many different ways, including: through an electronic portal, verbally, in writing, in person or through a standard referral form which is contained in Children First: National Standards for the Protection and Welfare of Children (2017).

All referrals received through the electronic portal were automatically acknowledged, while there were some delays in other referrals being acknowledged.

Screening and preliminary enquiries were not being completed in line with the Child and Family Agency's standard business processes and failings existed at all stages of the process.

Once referrals are received by the service, Tusla's standard business process allows service areas five days for social workers to complete screening and preliminary enquiry. This task along with the reason for the referral should be recorded on a standard form called an intake form. There is an expectation that all referrals upon receipt are initially screened by a social worker who makes a decision whether or not a referral meets the threshold of the service and also whether immediate action is required to ensure the safety of the child.

Inspectors were provided with case lists in which all referrals accepted by the service were listed. Each referral was documented including the date it was received and the priority level of high, medium or low which had been assigned. Social work team leaders told inspectors that they read all new referrals received by the service and priortised them based on the information received. However, upon review of case records, inspectors found that information recorded was minimal and did not include records of action taken by social workers at the screening stage of the process. Intake records were not routinely completed and the application of thresholds was not recorded until cases were allocated for completion of preliminary enquiries therefore, it was not clear how priority levels had been decided nor possible to establish timeliness of screening within the service.

When a social worker completes the screening process and determines that a referral meets the eligibility criteria for the service, they will then proceed to preliminary enquiry stage of the process. At the preliminary enquiry stage the social worker gathers information through, clarifying the details of the referral with the referrer and carrying out internal checks to establish if a child is already known to the services, including whether the child is on the Child Protection Notification System.

At the end of the intake record, the social worker brings together all the information gathered and uses this to inform their analysis and decision making. The intake record should clearly detail the outcome of their preliminary enquiry including the category of abuse or neglect (emotional, physical, sexual, neglect, welfare) and a determination as to a priority level of high, medium or low based on Tusla's national prioritisation system in which children at greatest risk of harm are given the highest priority. In addition, the next steps to be taken will be agreed on. Finally, there is a requirement set out in Tusla's standard business process that each intake record, once completed, is reviewed and signed by a Social Work Team Leader.

The duration of time between receipt of the referral information and completion of preliminary enquiries varied in the area, with the majority being more than five days. The inspection team reviewed 93 referrals for the purpose of assessing the quality of screening and preliminary enquiries. Of these 84 (90%) were not completed within the five day timeframe as required by Tusla and only 61 (65%) were found to be documented on Tusla's standard intake record.

Inspectors found, in addition to the risks associated with delays in completing screening and preliminary enquiries, additional risks existed with respect to the quality of screening and preliminary enquiries completed. Inspectors used Tusla's standard business processes to inform the key quality indicators against which to assess the safety and effectiveness of the completed preliminary enquiries and made a judgement as to the quality of each record examined.

Inspectors reviewed 39 completed intake records which had been signed by a social work team leader and found that they were not being completed within Tusla's standard business processes and 23 (59%) of those completed were found to be of poor quality. Of those that were found to be of good quality 16 (41%) inspectors saw screening and preliminary enquiries completed in line with required standard operating procedures, including appropriate classification and prioritisation of referrals, as well as clearly recorded outcomes, including appropriate closure of referrals, allocation to a social worker for completion of an initial assessment or appropriate diversion to alternative support services.

Screening and preliminary enquiries were assessed as being of poor quality due to a number of reasons including: lack of timeliness, failure to complete internal checks to establish if the child was already known to the service, absence of details and failure to clarify details with the referrer and / or failure to consider all information relating to a child such as previous referrals, when reaching a decision in relation to action required to ensure the child's safety.

In addition, the inspection team found that the current system for the management of referrals coming into the service was inadequate. The area had 232 cases with referrals that were awaiting completion of preliminary enquiries. Children First: National Guidance for the protection and welfare of children (2017) outlines that initial checks are aimed at helping a social worker to understand a child's history and circumstances, identify unmet needs and determine if there is a risk of harm to the child. The cases waiting for a social worker to complete a preliminary enquiry did not have these checks completed. Therefore the absence of completed preliminary enquiries and delay in carrying out appropriate screening and preliminary enquiries meant that children at risk may not be identified for appropriate interventions in a timely manner.

During the course of the inspection, it was necessary at times to seek assurances from staff that action had been taken to protect a child as files were not up-to-date and often without the necessary evidence to provide assurances. In a significant number of cases assurances were provided verbally by social workers or team leaders and information written in diaries or hand written notes were provided to support confirmation of actions taken. However, preliminary enquiries were not completed as required, files were not up-to-date and case notes were not routinely completed. Intake records were not consistently used and, where they were used, did not contain all required information or prompt all necessary actions.

Following the inspection fieldwork seven cases were escalated to the area manager seeking assurances that appropriate screening and preliminary enquiries had been completed and safety arrangements put in place as required. The area manager provided assurances that all seven cases had been subject to review, following escalation, including completion of preliminary enquiries and it was determined that all cases would proceed to initial assessment. Safety plans were put in place for four of seven cases escalated.

The area manager told inspectors that the risks associated with the delays and quality of screening and preliminary enquiries was a priority within the area. He highlighted the progress in relation to the roll out of the signs of safety approach to practice and the training undertaken with staff in relation to screening of cases within this approach, which he believed, will improve both timeliness and quality of practice. However, he highlighted circumstances which have impeded progress within the area in this regard including, a high turnover of staff and prolonged vacancies within social work and social work team leader posts and a delay in assigning a training lead for the implementation of signs of safety within the area.

While acknowledging the deficits, the area manager explained how service improvement planning within the area had led to a better awareness of the priority deficits as well as plans to address these. As part of the areas service improvement plan objectives, the area manager along with the service director had at the time of inspection just appointed a principal social worker with responsibility for service improvement within the area.

The area manager told inspectors that the priority for this principal social worker was to improve practice through mentoring, training and skills development in implementing the screening and preliminary enquiry process within the signs of safety approach to practice. Inspectors were informed by the area manager that he had directed that an audit of all 232 cases awaiting allocation within the duty team be undertaken by the principal social worker as he was not assured that these were being appropriately managed.

Non-compliance - Major

Standard 2.3:
Timely and effective action is taken to protect children.

Immediate Action and Safety Planning

The Dublin South Central service area did not provide a consistent, timely nor effective service to children. The areas response to children who presented at risk of immediate harm was appropriate. It is essential for example where there is an allegation of serious physical abuse of a child by a parent that immediate action is taken to ensure the safety of that child and/or other children within the home. According to data provided to inspectors 51 referrals were identified as requiring immediate action following a preliminary enquiry in the 6 months prior to inspection.

Inspectors found good examples of immediate action taken such as visiting a child in their home, joint home visits with members of An Garda Síochána, taking a child into the care of the state and/or implementation of safety arrangements to keep a child safe. However, inspectors reviewed cases where social workers did not identify children at risk of harm in a timely manner nor when they acted ensured that the safety plans or arrangements that were put in place were adequate to safeguard the child. Inspectors found one example where there was a delay of more than three months in completing preliminary enquiry where physical abuse was being alleged. In another case, there were delays of more than six months in implementing an appropriate safety plan with respect to allegations of physical abuse of a child.

For the purpose of this inspection, safety planning refers to the arrangements put in place by Tusla to ensure children stay safe when there is a risk of harm/abuse. Safety planning involves working collaboratively with families to keep a child safe. In a child protection and welfare service the first consideration for a social worker from the initial screening of a report right through all stages of the management process, is the immediate safety of the child and whether or not action to ensure the safety of a child or children is urgently required in order to keep a child safe.

Staff and management told inspectors that the new signs of safety approach to practice has a clear definition of safety plans and also has a specific template to record these. At the time of the inspection, this aspect of signs of safety was not fully implemented. A template to record safety plans was in place but was not routinely used.

Tusla has a formal system in place for implementing a child protection plan where a child has been assessed at being at on-going significant harm as a result of abuse or neglect and is listed on the child protection notification system. For the purpose of reviewing this standard, the inspection team did not review children who were on the child protection notification system (CPNS) and had a child protection plan. Therefore, the focus of this inspection's review of this standard were children who were either awaiting assessment or those who did not meet the threshold of being at on-going significant risk of harm, but required a plan to be in place to ensure that they were safe.

Inspectors reviewed 27 referrals where it was determined that safety planning was required and found that 11 had safety plans in place. While 11 (41%) had safety plans discussed and agreed with parent(s), only five of these adequately ensured the safety and protection of the children concerned. Those five plans included an assessment of a parent's capacity to ensure the safety of their children, consideration of all potential risks and the safety arrangements were monitored by a social worker to ensure they were being implemented as agreed.

The remaining six of the 11 safety plans sampled for review were found to be inadequate for a number of reasons. Inspectors found three safety plans which had been developed without consideration of all risks and one that had not effectively assessed the capacity of the adult responsible for its implementation to protect the child. None of the six safety plans agreed by social workers were adequately monitored to ensure they were being implemented as required. In addition, inspectors found that in the development of four of six plans children with the capacity to understand had not been involved in their development or informed of the details of the safety and support arrangements in place for their protection.

Of the 27 referrals reviewed by inspectors where a determination had been made that a safety plan was required 22 (81%) did not have adequate arrangements in place.

Throughout the course of this inspection, inspectors sought clarification directly from social workers that appropriate safety arrangements were in place, where evidence of these were absent from files and following this inspection seven cases were escalated formally to the area manager seeking assurances that adequate arrangements were in place to protect children. In all cases escalated safety arrangements were revised and in six out of seven cases safety plans were put in place with involvements of extended family members, network supports and children where appropriate. In one case escalated it was determined by the social work team that a safety plan was not required at this time and a strategy meeting with other professionals was agreed to ensure future risks were appropriately considered. In two of these six cases circumstances indicated potential on-going significant risks requiring referral for child protection conference.

Children, for whom multiple referrals had been made over time, did not receive a consistent response in line with national and local area procedures. Re-referrals occurred on open cases which were awaiting intervention by a social worker and there were a high number of referrals following case closures in the area.

Data provided by the area indicated in the six months prior to inspection there were 170 referrals to the service on cases that were previously closed. Assessments were found to be often lacking appropriate analysis of previous referrals or past harm and cases were closed prematurely or without adequate on-going supports in place for children and families.

Non-compliant – Major

Standard 2.4:

Children and families have timely access to child protection and welfare services that support the family and protect the child.

Cases awaiting allocation

Throughout the course of this inspection as cited above, inspectors found delays in the management of child protection and welfare referrals, resulting in delays for some children, receiving necessary social work interventions and potentially being left at risk. There were waiting lists operating at all stages of the referral process and these wait lists were not managed appropriately.

Data provided by the area manager indicated that at the time of inspection there were 77 cases on a waiting list for an initial assessment. Inspectors reviewed a sample of nine of these cases and found that eight of nine were waiting longer than nine weeks for an initial assessment to commence, three of which were waiting between six and 12 months. The area had 184 cases awaiting further assessment. As already stated, inspectors found 232 cases awaiting allocation for the purpose of completing preliminary enquiries. Additionally, there were waiting lists for children and families requiring family prevention and support services such as parenting supports or behaviour management supports.

Family prevention and support services were accessed through Tusla's own services, as well as external service providers who themselves held waiting lists. Data provided by the area indicated that there had been 52 referrals to such external services in the six months prior to inspection. Inspectors reviewed minutes of referral meetings for these services and found, some cases had been prematurely referred to these services, 10 cases in the six months prior to inspection were not accepted by external services as discussion of case details indicated that further social work intervention was required. In addition, there were a small number of cases accepted by external services but placed on waiting list for intervention.

While DSC had a protocol for managing cases awaiting a service this was not being followed. The system in place within Dublin South Central social work area was inconsistent and varied in approach and methodology. Good waitlist management involves regular review of all available information, including consideration of any new information received relating to a referral. Consideration should be given to duration of time a case is awaiting intervention and the appropriateness of the priority level applied. Tusla's standard operating procedure for receiving a referral requires that a Risk Estimation System (RES) tool is used to review cases awaiting allocation to a social worker for the purpose of completing an assessment.

Inspectors saw the RES tool was being used within the area, but not consistently, the majority of cases that were reviewed using the RES tool related to cases awaiting preliminary enquiries.

Additionally a 'duty team leader action sheets' was a tool seen on a number of files which recorded details of actions required following review of a file by a social work team leader. Duty social work team leader action sheets were used for multiple purposes at all stages of the referral process, in some instances to record priority level and category of abuse following screening of a referral, and in other instances to detail next steps or actions required following a review of a case awaiting allocation.

Social work team leaders and the principal social worker described to inspectors the processes in place for reviewing unallocated cases for the purposed of informing decision making in each case. However, inspectors reviewed samples of these cases and found there was no specific timeframe for review of cases awaiting allocation. Some cases were reviewed regularly while they were awaiting allocation and others were on waiting lists for months without evidence of review.

Social workers told inspectors that they were aware of waitlisted cases however, the responsibility for managing these lay with the local management team. Social workers told inspectors that they were not confident in the system in place to manage waitlisted cases and were therefore not assured that risks to children were being adequately managed.

These comments were reflected in what could be described as a chaotic system for management of wait listed cases. For example, waitlisted cases were allocated to social workers on an ad hoc basis to complete identified tasks, based on the capacity of the social worker on a particular day or week. They were then returned to the waiting list if tasks remained outstanding. There was no effective tracking system in place to ensure identified actions were completed and this was evidenced by the fact that often tasks such as completing network checks, had been commenced (in that messages had been left for relevant professionals), but these were not followed up or completed, some for periods of months.

In the majority of case files which had been subject to review by the areas management team, risks had been appropriately identified. Gaps in practice with respect to completing checks or actions were highlighted. However, there was no evidence that this resulted in remedial or follow-up action. Reviews did not consistently lead to a re-prioritisation or escalation of a case, despite a significant number having identified risks to children which required action to address. Reviews of referrals categorised as welfare cases did not appropriately consider cumulative risks in all cases. Inspectors saw cases which had been the subject of multiple reviews over periods of months repeatedly documenting actions without these actions having been taken to address risks to children.

Inspectors were told by the area manager that a signs of safety intake case prioritisation workshop, involving staff from the area, along with staff from the senior management and national management team, had been undertaken between September 10th and 13th. During this workshop cases open to the child protection and welfare service had been reviewed using the signs of safety framework. Following this workshop a number of deficits in practice had been identified and cases had been escalated for immediate action by social workers. The area manager told inspectors that responses and implementation of required actions, in these cases were being monitored by the principal social workers in the area.

Inspectors did not specifically examine these escalated cases however, through their review of files, found a number of cases which had been subject to this review process the week prior to inspection.

Inspectors reviewed a sample of 23 closed cases and found that the majority had been closed appropriately. Six of these had been closed or were due for closure without evidence of work undertaken available on files, including case notes, assessment records or closure summaries. Inspectors sought information from social workers and social work teams leaders to confirm that appropriate actions had been taken prior to closure and in the majority these were received.

However, one closed cases was escalated following this inspection where further action was required to ensure children's safety. Following review by the area management team the case was re-opened for the purpose of completing an initial assessment including further checks and review of safety planning arrangements.

Non-compliant - Major

Standard 2.5:

All reports of child protection concerns are assessed in line with Children First (2011) and best available evidence.

Initial Assessment

The screening and preliminary enquiry process identifies children who require an initial assessment. The social worker in completing an initial assessment reviews the information gathered through the screening and preliminary enquiry process and gathers further information on the needs of the child. The aim of an initial assessment is to determine the child's needs and to establish if the child is at on-going significant risk and/or requires any further intervention from the social work department.

Significant deficits existed both in the timeliness and quality of initial assessments. Inspectors used Tusla's standard business processes to inform key quality indicators which were used to assess the quality of initial assessments. These quality indicators included the timeframe of 40 days from commencement to completion of an initial assessment, that all relevant people were consulted, pertinent information was gathered and analysed as part of the initial assessment and that all initial assessment were completed with participation of parent(s), children, professionals and extended family/support networks.

Inspectors reviewed 33 files where a determination had been made that an initial assessment was required. Inspectors found that 24 initial assessments had been commenced, 15 of which were completed, all within 40 days of commencement. Six (40%) of the 15 were judged to be of good quality.

Good quality initial assessments demonstrated clear analysis of all risks to children, involved social workers directly engaging with children and lead to positive outcomes with respect to reducing risks to the children and families concerned. However, inspectors found that this level of good practice was not evident in the majority of cases examined, as nine (60%) of fifteen examined fell short of appropriate and safe practice. Deficits in these 60% included: Initial assessments having been completed and signed off by social work team leaders without consultation with other professionals, without robust analysis of all risks and identification of strengths and existing safety factors.

Inspectors were particularly concerned that five initial assessments were completed without children having been seen. This is not in line with good social work practice.

Further Assessments

A further assessment is a more in-depth examination of a child's needs and analysis of their situation. Unlike previous stages to the management of child protection and welfare referrals the process of further assessment does not have a defined time scale for completion. As with initial assessments Tusla have standard templates for the completion of a further assessment, which include detailed prompts for social workers to ensure that all relevant people are consulted and pertinent information is gathered and analysed as part of the assessment.

Further assessments were not completed in line with standard business processes. Inspectors reviewed 13 examples provided by DSC service areas as cases where the further assessments were completed by the further assessment and screening team (FAST). Inspectors assessed four of the 13 to be of good quality with only two of these recorded on standard templates. The quality of the majority of further assessment work was evaluated through examination of case file records and case notes evidencing work completed with children and families.

Inspectors found that within the nine other assessments reviewed there was significant deficits in practice with regard to the following: analysis of risk, which was absent in seven of 13, the identification of strengths and existing safety factors recorded was absent in five of 13 and in 3 examples, children had not been seen by social workers during the further assessment process. In some examples there was evidence of long delays in commencing further assessments work, resulting in increased risk or deterioration of circumstances for children and families in the intervening time. In addition, some of these cases had received a range of interventions but there was no family support plan on file, despite a range of services being in place. Therefore, it was unclear how the social worker and team leader monitored the plan in an effective manner.

Specialist services are also engaged at times for the purpose of conducting assessments, for example a specialist assessment of an allegation of sexual abuse. These commissioned services often have waiting lists of their own which contribute to the delays in social work interventions for children and families who may be referred to such a service.

The system in place for notifying An Garda Síochána of suspected abuse was not robust and some notifications were not made by social workers as required. Inspectors reviewed 26 files for the purpose of examining whether or not allegations of abuse had been appropriately notified to An Garda Síochána (AGS) by Social workers and found that in 19 cases there was no evidence of notification on file. A tracking system implemented within the area for the purpose of monitoring notifications of abuse received from and sent to An Garda Síochána indicated that 56 notifications had been sent from Tusla to AGS in the six months prior to inspection, suggesting an underreporting of allegations of abuse from the child protection and welfare service to An Garda Síochána.

Non-compliant - Major

Standard 2.9:

Interagency and inter-professional co-operation supports and promotes the protection and welfare of children.

Interagency and inter-professional co-operation

One of the key functions of Tusla is to ensure effective interagency and inter-professional co-operation which promotes the protection and welfare of children. Tusla works with a range of external agencies and professionals who make referrals to the service, as well as those that provide support services to children and families who require them. During the week of the inspection, the local area was involved in a public awareness campaign in relation to its family support services. This inspection examined the effectiveness of interagency co-operation and communication as well as, co-ordination of services between Tusla and external services. This was done through interviews with Tusla staff, review of case records, monitoring systems and minutes of inter-agency meetings supplied by the area manager.

Evidence of inter-agency contact through review of case files was limited to cases which were allocated to social workers and there was on-going social work intervention or assessment. Where inspectors found good quality assessments, it was evident that social workers had sought the views of other professionals and agencies in order to get a better picture of the child's situation. The sharing of information between external agencies and social workers was key and inspectors found that social workers sought consent from parents prior to contacting external agencies where this was appropriate. However, Inspectors found that when professional meetings were held, decisions were not always clearly recorded, and therefore it was not always clear that there was effective inter-agency co-ordination of cases or why particular decisions were made in relation to a family.

Dublin South Central Service Area had access to a range of commissioned external community resources which support their own prevention, partnership and family support services (PPFS) and Meitheal[1].

[1] Meitheal – a Tusla service which enables children and families to receive appropriate support.
Meitheal - A Tusla service model which enables children and families to receive appropriate support

The data provided by the area indicated that four referrals in the six months prior to inspection required a Meitheal response.

All of these services form part of the wider child protection and welfare service in that, children and families referred to the service who did not meet the threshold for a child protection service were often times referred on to PPFS or Meitheal. The principal social worker for child protection and welfare chaired a six weekly inter-agency meeting during which particular cases requiring support interventions were discussed. Inspectors reviewed minutes of these inter-agency meetings and found that they were well attended by external service providers and members of the social work team. Cases were allocated to services based on discussion exploring the most suitable service to meet identified needs as well as capacity of the services at the time.

The principal social worker told inspectors that often cases referred to these services were cases open to the child protection and welfare teams which were identified for closure as there were no longer child protection concerns however; these families required further interventions to sustain progress or ensure risks continued to be managed.

Social workers and social work team leaders told inspectors that the availability of external support services increased confidence in decision making with respect to closing cases as children and families were receiving on-going professional support and intervention.

Also, they told inspectors that when these external services are engaged to provide supports to families who are undergoing a social work assessment or awaiting a social work service, there are good mechanisms which ensure effective inter agency communication and collaborative working in place including, providing progress reports on levels of engagement of children and families and/or attendance at professionals meetings or strategy meetings where required.

The area manager told inspectors that while there was a good level of resources within the area, social workers had difficulties accessing these services at times due to capacity. The Area Manager told inspectors that he, along with the principal social worker for PPFS, had begun a process of evaluation of these services to examine their input including outcomes

for children and families, levels and duration of engagement with services and detailing clear expectations for each service provider. The Area Manger explained that the intention of this evaluation was to ensure value for money as well as improving timeliness and availability of suitable support services for children and families who require them. This evaluation was on-going at the time of inspection.

An Garda Síochána

Joint working between Tusla and An Garda Síochána forms an integral part of the child protection and welfare service. Regular communication between both agencies through information sharing and notification of suspected abuse of children forms the basis of their shared responsibility for the protection of children. Children First National Guidance for the protection and welfare of children (2017) clearly outlines the requirements on both agencies to notify child protection concerns and/ or allegations of abuse as well as detailing the requirements to work together to ensure the safety of a child, where required. In December of 2017 a protocol (Tusla and An Garda Síochána Children First – Joint working protocol for liaison between both agencies) was introduced within the area but, was not fully implemented at the time of inspection. This protocol details how both organisations cooperate and interact when dealing with child protection and welfare concerns.

Inspectors reviewed cases in which joint working between both agencies was evident. These included details of strategy meetings held between social workers and members of An Garda Síochána assigned to a particular case as well as, details of joint home visits to children and families where necessary, to ensure children's safety where an allegation of abuse warranted such a response.

Through examination of case notes there was evidence of regular communication in relation to referrals between individual social workers and Gardaí including, clarifying details with a referring Garda and/or seeking further information on a particular adult or family through telephone conversations with local Gardaí. The principal social worker told inspectors that there is regular information sharing through both formal and informal mechanisms. Strategy meetings can be held over the phone for example and regular exchange of information is common practice amongst social workers.

Inspectors reviewed minutes from June and August 2018 of two liaison meeting with An Garda Síochána and member of the local management teams including principal social worker and social work team leaders from child protection and welfare. Minutes of these meeting recorded details of discussions on particular cases involving both organisations and references to the completion of joint action sheets detailing actions agreed at the meeting to be taken both individually and collaboratively by members of both organisations. However, inspectors did not find joint actions sheets on any files reviewed.

In addition, senior members of An Garda Síochána from relevant garda divisions within the DSC areas met with the area manager four times in the last six months. This forum was used to discuss interagency sharing of information including processes in place for timely responses to notifications, procedures for closing cases, timeliness of invitations to Gardaí requesting their attendance at child protection conferences and notification of release of adult offenders who may pose a risk to children in the area were discussed and plans agreed to address identified gaps in processes or procedures.

The Area Manager told inspectors that while some recording deficits remained, communication between both agencies had improved and the process for recording information sharing as well as agreed actions for each agency individually and collaboratively had improved.

Substantially compliant

Standard 2.10:

Child protection and welfare case planning is managed and monitored to improve practice and outcomes for children.

Leadership, Governance and Management

The local and regional management team responsible for the Dublin South Central service area did not have robust, proactive management systems in place to ensure that child protection and welfare cases were appropriately monitored or managed to ensure a quality and safe service. Prior to this inspection, senior management with responsibility for the service area were aware that there were significant shortcomings in the management of the service but incremental service improvement had not occurred in a timely manner.

Systems implemented throughout 2018 which are designed to ensure a safer and more effective service were not embedded in practice. The governance arrangements in place included a defined management structure, a governance group, reporting procedures, risk management processes and quality assurance systems. Despite the existence of a defined management structure, these governance arrangements had not adequately ensured the implementation of national frameworks, policies and processes; a consistent approach to child protection practice; or strong managerial oversight and accountability.

There was a defined management structure with clear lines of accountability and responsibility. The area was managed by an area manager who was in post since 2017 who reported to the service director for the Child and Family Agency Dublin Mid-Leinster region. A principal social worker had responsibility for the day-to-day management of the child protection and welfare service and four team leaders managed four individual teams.

Over the course of the previous 12 months, the service had staff vacancies at both social worker and social work team leader grade, which had impacted on service delivery. One duty office had operated for a period of months without a social work team leader and had with only a third of its staff complement. This meant that resources had to be applied to the highest risk cases and children and families identified at medium and low risk waited significant periods for a social work service.

The management structure was clear to all staff and they were aware of their roles and responsibilities. However, there was low morale amongst the majority of social workers and some social workers told inspectors that they lacked confidence in senior management. It was of particular concern to inspectors that a number of staff members said that they did not have confidence in the protected disclosure process. Staff told inspectors that they had concerns in relation to the service's ability to provide a safe service to children and also the lack of adherence to policies and procedures. Staff regularly met with their line managers and discussed cases or shared information, which included staff sharing their worries about the service. Some members of two social work teams within the area had requested to meet the area manager, one since February 2018 to discuss their experiences of the service and while some dates were arranged, these meetings had not happened.

Management systems required further development and improvement. There was a service improvement plan in place which arose from the identification of risks within the service. In 2017 the area manager along with the regional service director created a service improvement governance group within the area to address non-compliances within their foster care service identified through HIQA inspections. In September of 2017 a decision was made to include child protection and welfare services as part of this service improvement plan due to the identification of significant risks within this service. This plan detailed many of the risks that were identified during this inspection. However, progress in implementing the plan was slow and actions were not effective at ensuring risks to children referred to the service were managed in a timely and safe way.

Priorities identified by this service improvement plan for the child protection and welfare service, which were to be completed by July 2018, included that:

1. The National quality assurance directorate to would review area data and implementation of standard business processes
2. Implement the revised business standard processes in line with signs of safety would be implemented and provide training provided on thresholds, including a / review of duty action sheets of all referrals which were are not meeting criteria for IR

3. Ensure robust tracing systems to be developed for all Garda Notifications into the area
4. Data cleansing project to be implemented to ensure system changeover to the national child care information system (NCCIS), to go live by the end of June 2018
5. Creation of front door teams to ensure robust screening of referrals, including past harm and ensuring risk is identified and safety plans implemented

This inspection found:

1. The review of data had not lead to implementation of appropriate actions to address presenting risks, and deficits with respect to implementation of standard business processes were not targeted effectively to ensure progress.
2. The Signs of safety approach to practice had been implemented in the area. However, as cited delays in assigning a training lead to the service area, coupled with vacancies in a number of posts, had impeded progress with respect to training staff members in this approach thus delaying implementation.
3. The system for ensuring notifications to An Garda Síochána was not robust
4. NCCIS was not fully implemented within the area and
5. Poor quality systems as well as social work practice related to screening and preliminary enquiries did not ensure safe, timely and effective responses to child protection and welfare concerns.

Measures were taken to address concerns in relation to the integrity of the data collated by the Dublin South Central Area. The area manager had to collate and return a monthly report of data called 'measuring the pressure' to the national office of Tusla. This included the number of high, medium and low priority cases within the service which were awaiting allocation to a social worker.

The absence of good quality validated data impedes good strategic management planning and decision making to ensure appropriate child protection and welfare case management.

The Service Director of Dublin mid-Leinster instigated a quality assurance audit in February 2018 of the systems in place to validate the accuracy of metrics and prioritisation levels within child protection and welfare service. The audit found that there were inconsistencies in how the area collated data relating to cases awaiting allocation and that clear guidance was required in relation to the allocation status of cases. Inspectors reviewed the most recent metrics from March to July 2018 and found that following this audit in February, there was an increase in the number of unallocated cases of more than 450% in this four month period. Despite the significant increase in the reported number of unallocated cases during April, May, June and July measures to manage these were not put in place.

In August of 2018 as part of phase 2 of the areas service improvement plan, an audit of unallocated cases was undertaken by the Area Manager to assess compliance with the standard business process. Thirty six files were randomly selected from three teams including files containing open referrals as well as those recently closed. This audit found significant failings similar to those identified during this inspection of the service. Of the 36 files reviewed, nine were completed within five days, none of the 36 files contained appropriate safety plans; 35 without appropriate evidence of analysis or reference to past harm in assessments. In 33 cases children were not met with by a social worker and it was unclear if children were met by social workers in the remaining 3 case files.

Recommendations from this phase 2 audit included the requirement for more analysis of past harm, the need to conduct network checks at intake stage, increase participation of families and other professionals to ensure expectations are clear, for example with respect to safety planning; ensuring participation of children; and the need to implemented the signs of safety model into practice.

Risk management processes were under utilisted and did not ensure effective management of identified risks. It was not until September 2018, that the area's risk register recorded risks within the child protection and welfare service, despite risks within the service being identified during 2017. In September 2018 two risks specifically relating to the child protection and welfare service were introduced to the areas risk register.

These were: 1) high number of cases awaiting allocation on child protection and welfare teams, and 2) non-compliance with standard business processes. The measures identified to mitigate against these risks were all related to implementation of the signs of safety approach to practice which included training on this approach, some of which had been completed in June and September 2018. These measures were not effective at reducing the immediate risks within the service.

Other systems such as 'need to know' reporting to the area manager were in place. Need to know reports are intended to highlight risks requiring action to senior management within the area but, they were rarely used and when made, appropriate responses to address risks were absent. In May of 2018 the area manager escalated a risk through the service director relating to critical vacancies within the area and their inability to progress recruitment of new social workers in a timely way through this system.

The area manager noted that the impact of vacancies meant that cases requiring assessment remained on waiting lists and referrals through duty/intake had been priortised for action by social workers. However the service was unable to implement safety measures to manage risk due to the vacancies within the area. Inspectors found that while staff vacancies had been reduced, the management of risks within the duty / intake team had not been effectively addressed.

Social workers told inspectors that they frequently spoke to their managers informally about cases and their managers were accessible to them. There were some more formal monitoring systems in place such as team meetings and supervision but follow up on agreed actions was ineffective. These systems did not adequately ensure progress or improvement where required.

Supervision was not routinely provided in line with policy. Tusla's supervision policy requires that staff are supervised on 10 occasions over 12 months. Supervision did not effectively monitor progress and address performance deficits. Indeed, no performance management plans were in place where skill deficits or required improvements had been identified.

The recording of decision making within supervision records and separately on case records varied greatly – with some decisions clearly recorded with a clear rationale, while this was absent in other cases.

The Child and Family Agency has a caseload management system in place nationally but this was not integrated into practice within this area. The principal social worker for child protection told inspectors that the caseload management system was implemented by the FAST team but this system was not workable for cases at duty/intake. The area were due to be involved in the development of a new system which would be more suitable to the duty and intake teams. Inspectors did not find any evidence that the caseload management policy was implemented and the principal social worker for child protection confirmed that no caseload management reports were created. Therefore, the service area's management team had no system in place to track the efficient allocation of cases. This was not in line with Tusla's caseload management policy.

The area had developed a forum to discuss complex cases, this was a positive development. The area managers, Principal Social Workers and Social Work Team Leaders from child protection and welfare, foster care and children in care teams met and discussed complex cases arising within all services in the area at this forum. Inspectors reviewed a sample of the records of these meetings, and found that this forum was rarely used to discuss child protection and welfare cases, where cases were presented, there were clear actions agreed in order for the individual cases to progress. The minutes of these complex case meetings documented that actions in relation to training were also identified as a result of the discussion of complex cases.

Information governance with respect to oversight and general management of cases required significant improvement. The service area maintained electronic and paper records on all cases. During the course of the inspection, 3 case files could not be located by the service area. Assurances were sought from the area manager that these files were located and that appropriate interventions were provided to children. The area manager assured HIQA inspectors that all three files were located. Overall, inspectors found that case files were largely incomplete and in the majority, basic information was absent. Therefore, case records could not provide assurances of actions taken to address risks to children.

Tusla's new integrated information system- the national child care information system (NCCIS) was not fully implemented in practice in the area. The system was introduced into Dublin South Central in May 2018 and significant work was completed in relation to the cleansing and transfer of data to the new system. NCCIS enabled all records relating to a child's case information to be held within this system. It also provides a mechanism for managers to have oversight on cases. However, electronic systems are reliant on staff keeping the system updated. This was not the case in Dublin South Central. Inspectors found that there were gaps significant gaps in the information recorded on the system. The area manager acknowledged to inspectors that there was some information not on the system such as intake records and assessments and he had developed a separate electronic tracker to monitor these.

In addition to individual case escalations which have been referenced throughout the report, due to the significant concerns in relation to the management and monitoring of the child protection and welfare service of Dublin South Central, HIQA's regulation directorate's head of programme regional manager and inspector met with the Tusla Chief Operations Officer and the Service Director for Dublin Mid-Leinster Region, with responsibility for the Dublin South Central service area. During this meeting the Chief Operations officer and Service Director were presented with preliminary findings of risks identified during this inspection including concerns in relation to the overall governance of the area and the on-going concerns relating to failures to effectively manage risks in the foster care service in Dublin South Central.

Tusla was requested to provide a service area plan to address continued and escalating risks across Dublin South Central Service Area, to include both the child protection and welfare service and the foster care service.

In advance of providing the project plan for Dublin South Central the Chief Operations Officer outlined in writing a detailed series of measures that had been or were in the process of being established or reviewed in order to enhance the capacity and capability of DSC to deliver a safe and effective foster care and child protection service.

Those related to child protection and welfare services included:

- A review of the structure of the child protection service has taken place - a new intake team has been established in Lord Edward Street and the purpose and function of the FAST team is due to be reviewed
- An additional principal social worker post has been assigned to the child protection and welfare service, to be in post by December 2018
- A principal social worker with responsibility for service improvement is in post since 17 September 2018
- Additional staff resources have been assigned to PPFS pillar within the area to increase capacity
- On-going training on the signs of safety approach to practice, including safety planning is planned
- A review of all open child protection and welfare cases is being undertaken to be completed by 30 November 2018 to ensure that interim safety plans are adequate
- In December 2018 an audit of the quality of further assessments will be completed
- Quarterly audits of safety planning will commence in January 2019
- Additional training will be provided to regional and area teams with regard to greater governance in managing performance issues
- A review of the areas governance and oversight group has taken place
- A project management approach is being used to track, monitor and report risks to the chief operations office
- A social work team leader post for NCCIS has been recruited to focus on insuring quality assurance and integrity of data inputted on NCCIS by all social work teams
- The regional quality, risk and service improvement manager (QRSI) will provide mentoring sessions with social work team leaders and social workers in relation to risk management policies and procedures
- A follow up review meeting with each manager by QRSI will be undertaken in quarter two 2019. A report will be provided to the area manager and service director in regard to key issues, trends and analysis of risks
- An audit of supervision files will be completed by the quality assurance directorate in quarter four 2018

- The QRSI manager and child care information officer for the area will meet in November 2018 with the view to ensuring greater governance on the reporting of metrics and risks
- The area manager will issue a memo to staff advising the need for children to be met / interviewed as part of initial assessments. Where this is not in the interest of the child this must be notified to the principal social worker

In conclusion, this inspection identified significant risks within the Dublin South Central area. Tusla are implementing a plan to improve the quality and safety of the service. HIQA's regulation directorate's monitoring and inspection of DSC during 2019 will focus on assessing the progress made in implementing the various elements of Tusla's project plan; and the extent to which these measures have addressed the concerns outlined in this report resulting in a strengthening of systems and processes necessary for a safer, more timely and effective service.

Action Plan

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

Provider's response to Inspection Report No:	4416_CPW_DSC_17
Name of Service Area:	Dublin South Central, Child Protection and Welfare Service
Date of inspection:	17, 18, 19 and 20th September 2018
Date of response:	December 4th 2018.

These requirements set out the actions that should be taken to meet the *National Standards*

Theme 2: Safe and Effective Services

Standard 2.2

Non-Compliant Major

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

Screening and preliminary enquiries process was not robust and was not completed in line with the Child and Family Agency's standard business processes.

The oversight of screening processes was poor and ineffective at ensuring consistency and quality.

The application of thresholds was not routinely recorded

Action required:
Under **Standard 2.2** you are required to ensure that:
All concerns in relation to children are screened and directed to the appropriate service.

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

1. Restructuring of the child protection pillar in Dublin South Central is taking place with the creation of separate intake pillar from the child protection pillar, with a dedicated Principal Social Worker post for intake. This new PSW post for intake was approved in November 2018 in addition to 2 dedicated team leader posts for the intake pillar and 2 senior practitioner posts. Other requests for business posts in respect of the restructuring of the intake/child protection pillars were submitted to National Office during November 2018. Three additional network coordinator posts assigned to PPFS were submitted to COO office during Q4 2018 by the Service Director.

2. The restructuring of the intake pillar with separate intake teams will allow greater attention to screening of preliminary enquiries, checking past referrals and past harm and compliance with the standard business process. The PSW post and additional senior practitioner posts will be dedicated to the robust screening of enquires at the 'front door' and ensuring intake records (IRs) and initial assessments (IAs) are completed in a timely manner. In the interim, a service improvement plan/project team has been created, led by the principal social workers for child protection and service improvement, with a remit to review all open cases, including both allocated and unallocated within the child protection pillar using the Signs of Safety (SoS) screening tool to ensure that all open cases are robustly screened and that no identified risk is present on open cases within the intake/child protection pillar.

The review of all open cases in the child protection teams based in Bridge house teams was completed on November 27th 2018 and the remaining open cases in the Lord Edward street Child protection teams are currently taking place.

3. The application of thresholds using the SOS screening tool being implemented for all new referrals received since Sept 30th 2018 is being implemented and also retrospectively for all open cases in child protection. Oversight by the PSW for intake of referrals through sample monthly audits will take place with the Team leader for QA who will audit sample of completed screening tools. In addition an SOS quarterly case prioritization workshop will review all screened referrals over the preceding 3 months to ensure compliance with thresholds and implementation of the SOS screening tool.
4. Quality assurance (QA) of screened cases and completed IRs is part of this project review and is subject to ongoing monthly QA checks of completed IRs.
5. Four additional training dates for all social workers on thresholds/interim practice guide and screening are scheduled for December 2018 led by the PSW for child protection and the regional Training development officer (TDO) for SoS implementation.

Proposed timescale:	**Person responsible:**
1. Some approved posts made by National office: November 27th 2018.	COO/SD/AM/HR
Additional PPFS posts awaiting approval.	AM/PSW/Project review team
2. January 30th 2019 (as HR recruitment processes allow).	PSW intake and Team leader for QA
3. From January 30th 2019.	Project review team PSW/TL for QA
4. In place by January 7th 2019	PSW
5. By December 22nd 2018.	

Standard 2.3

Non-Compliant Major

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

Some children did not receive timely interventions.

Safety planning was not embedded in practice and action taken to support families and protect children through good quality safety planning was not consistent.

The service did not respond appropriately in all cases where multiple reports of concerns for children who were already known to the service were received.

Action required:
Under **Standard 2.3** you are required to ensure that:
Timely and effective actions are taken to protect children.

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

1. A new dedicated principal social work post for intake and two dedicated intake teams (for Bridge House and Lord Edward Street) with two additional senior practitioner posts will ensure that all referrals are screened robustly, and that where risk is identified that immediate responses are put in place. The restructuring of the intake/child protection teams will allow for a clear daily duty rota to be put in place for immediate responses to children and families where screening indicates immediate concerns or assessments are required.

2. The restructured intake/child protection pillars will include a principal post for intake with two dedicated intake social work teams. The child protection pillar will include a principal post for child protection with three child protection teams (two in Bridge House and one in Lord Edward Street). This will give the area greater capacity to respond to identified risks and provide more timely interventions to families.

3. The principal social worker, as part of the project review of all open cases (including allocated and unallocated case lists), is ensuring that a more balanced case load is in place as per the Agency's case load management tool. This will ensure that social workers can respond immediately to any identified risks. The restructuring of the child protection/intake pillars and robust front door screening will allow social workers to respond on their reduced allocated cases to ensure that timely interventions are being provided to families where case prioritization deems them of high priority. Cases which are deemed to be of low/medium priority will be managed by the three child protection team leaders on a duty rota system and will be reviewed by the team leaders on a monthly basis. All high priority cases will be allocated with a restructured duty system of all other cases managed by team leaders and PSW's, ensuring regular review.

4. The intake pillar will routinely review patterns of referrals on each case using the National Child Care Information System (NCCIS) and ensure that where multiple referrals have been received that an alert system is activated using the SoS screening

tool to robustly review these cases. SoS case prioritization workshops will be held every quarter to review all screened referrals into the intake/child protection pillar over the previous three months.

5. Safety planning training is being provided to all teams during quarter one of 2019 under SoS practice model. This training is part of the national implementation of the 'Child Protection & Welfare Strategy 2017 – 2022' and will be led out by the regional training and development officer for SoS implementation. In the interim, the area has devised its own safety planning template using SoS to ensure that all support networks involved with families are identified and are part of robust safety planning in the area.

6. The PSWs for intake and child protection will robustly and routinely review safety planning for children and families. Team leaders will also use supervision process to ensure that safety plans are robust. Training is being provided during December 2018 to all social workers within the intake and child protection pillars.

7. The new intake principal social worker will review the operation and frequency of R.E.D (Review, Evaluate, Direct) team meetings in the area to ensure that funded agencies are available to take more frequent child welfare referrals and provide interventions for families which are not deemed to be child protection concerns.

Proposed timescale:	**Person responsible:**
1. January 30th 2019 for new intake PSW and other posts as recruitment processes allow.	SD/AM/Regional HR
2. By January 30th 2019	As above.
3. December 22nd 2018.	PSWs for child protection and intake.
4. From December 3rd 2018 with SoS case review workshops every 3 months.	PSWs for child protection and intake/TL QA.
5. March 30th 2019.	
6. In place by January 30th 2019 and SOS reviewed each quarter.	National & Regional TDO for SoS implementation.
7. January 30th 2019.	Area Manager with PSWs & TLs for child protection and intake.
	PSW intake for intake and PSW PPFS.

Standard 2.4

Non-Compliant Major

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

Children and families who were placed on a waitlist for preliminary enquiries, initial assessment, further assessment and those awaiting access to external services or PPFS did not receive a service in a timely manner.

The local protocol for managing cases awaiting a service was not being implemented and the systems in place to monitor waitlists were ineffective.

Reviews of referrals categorised as welfare cases did not appropriately consider cumulative risks in all cases.

There was no plan in place to systematically reduce waitlists in the service.

Some cases were closed inappropriately.

Action required:
Under **Standard 2.4** you are required to ensure that:
Children and families have timely access to child protection and welfare services that support the family and protect the child.

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

1. A revised protocol for managing cases on a waiting list for preliminary enquiries, initial assessments and further assessment will be implemented in the area following completion of the project currently taking place which is reviewing all open cases within the intake and child protection pillars, including both allocated and unallocated cases. This review will be completed by January 2019. Following this review, all open cases within the area will have been screened using the SoS prioritization tool and follow up actions determined. The cases awaiting allocation for preliminary enquiry are being prioritized and any backlogs will be cleared by the end of Q4 2018. A revised protocol based on the above screening of cases awaiting allocation for IAs/FAs will be in place in the area by January 2019.

2. Cases awaiting referral to PPFS following completion of preliminary enquiry will be prioritized by PPFS allocation using the R.E.D team meetings.

3. The revised area protocol for managing cases on a waiting list will include details on the frequency and process for review, including how cases will be escalated for PSW's attention. Waiting lists will be monitored continually by intake and child protection team leaders with oversight by the principal social workers. A team leader post for quality assurance in the area will be filled in January 2019 and this person will have responsibility for reporting directly to the PSW for intake and child protection to ensure that cases on waiting lists are also screened for quality assurance on a regular and ongoing basis.

Monthly quality assurance reports will be provided to the PSW's and Area Manager by the quality assurance team leader. The purpose of these monthly reports will include a sample audit of completed screenings of referrals and also of completed Intake records, initial assessments and closed cases.

4. Completed intake records which refer to PPFS will have the assistance a PPFS social worker who will ensure/quality assure that cumulative risks have been considered as part of the recommendations for diversion to child welfare interventions. The PSW for intake & team leaders will ensure that cumulative referrals/risks have been considered prior to singing off these intake assessments.

5. The project team currently in place in the area which is reviewing all open cases within the intake/child protection pillar using the learning from the SoS case prioritization workshop held in September 2018, will determine which cases can close, divert to PPFS or be allocated within the area. A revised case waiting list following this process will be monitored within the three newly structured child protection teams within the area. The principal social worker for child protection is currently reviewing overall case allocations to ensure that optimum allocations across all child protection teams is taking place to reduce overall waiting lists.

6. A briefing document on overall numbers of social workers and administration staff within the area, details regarding increased referrals to the area and numbers of children in care, in addition to socioeconomic deprivation levels using research based upon the 2016 census is being prepared for the service director and national office by the area manager. The purpose of this briefing document to the Service Director is to ensure that the area has sufficient social work and administration resources based on improved data collation systems, such as NCCIS, which indicate a trend of increased referrals into the area.

7. A standard operating procedure (SOP) is in place for all referrals in the area. This includes quality assurance review of all cases deemed appropriate for closure by the local area quality assurance team leader. This SOP is being reviewed by the area in light of the re-structuring of intake/ child protection pillars. The Quality assurance Team Leader post is due to be filled in January 2019 and will independently report audits of closed cases to the principal social workers for intake and child protection. Learning from these audits will be provided to the team leaders and teams within both pillars. This will also be incorporated into the revised SOP.

8. Training on case closures will be provided to all team leaders within the intake and child protection pillars during Q1 2019 by the principal social workers.

Proposed timescale:	**Person responsible**:
1. January 30th 2019.	AM and PSWs
2. February 28th 2019.	PSW intake/PPFS
3. January 30th.	As above and TL for quality assurance.
4. January 30th 2019.	PSW for intake/PPFS.
5. January 30th 2019.	PSWs for intake/ child protection
6. February 15th 2019.	AM and business support manager.
7. January 30th 2019.	TL for QA reporting to PSWs for intake and child protection.
8. March 15th 2019.	PSWs as above

Standard 2.5

Non-Compliant Major

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

The quality of some initial and further assessments was inconsistent and there were delays in the commencement and completion of assessments. Child protection concerns were not address in line with Children First.

Some children were not seen as part of initial and further assessments.

Not all allegations of suspected abuse were notified to An Garda Síochána.

Action required:
Under **Standard 2.5** you are required to ensure that:
All reports of child protection concerns are assessed in line with Children First (2011) and best available evidence.

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

1. The quality of initial and further assessments will be reviewed by the principal social worker for child protection with the child protection team leaders in respect of their quality assurance processes prior to signing off of these assessments. The PSW's for intake/child protection and service improvement will have oversight of the quality assurance audit process in the area and will receive monthly audit reports from the quality assurance team leader. The monthly reports from the quality assurance team leader will audit a sample of completed intake records, initial assessments, further assessments and closed files to ensure that the quality of assessments is of a good standard. Feedback to the team leaders and teams at training workshops will be provided in respect of improving the overall quality of assessments in the area. Further training will be provided to all intake and child protection team members in respect of quality assurance processes for when they are completing initial assessments and further assessments in line with children first guidelines.

2. Further training will be provided to all intake and child protection team members in respect of quality assurance processes for when they are completing initial assessments and further assessments in line with children first guidelines.

3. The dedicated quality assurance team leader post in the area will review and complete audits of completed initial and further assessments as part of this role and provide feedback to the principal social worker on completed audits on a quarterly basis. This feedback will also be provided to the child protection teams.

4. The area manager issued a memo to all social worker staff in November 2018 stating that in line with good practice, all children must be met and a screening interview completed for all initial assessments and further assessments. Exemptions to this rule where such interviews are not in the child's interests must be escalated to principal social worker level. This memo will also be reiterated by the area manager at a

presentation to the large team meeting of social workers taking place at the end of November 2018. This will also be part of induction training for all new social workers to the area.

5. A memo to state that all allegations of suspected abuse must be notified to the Gardaí will be issued to all staff by the principal social worker and area manager in November 2018 as part of their statutory and mandated role. This will also be reiterated at a large team meeting during December 2018. The project review being led by the PSW for child protection of all open cases within the intake/child protection pillars will ensure that all notifications of suspected abuse to An Garda Síochána have been made. Ongoing monthly sample audit reports of intake/child protection case files by the QA TL will ensure compliance with this action.

6. The newly appointed principal social worker for child protection will continue to chair the Garda child abuse review meetings to have continued robust oversight of all notifications to/from the Gardaí. The PSW will have oversight of the area Garda notification meetings.

Proposed timescale:	**Person responsible:**
1. January 30th 2019.	PSWs for intake/ child protection & service improvement
2. February 28th 2019.	
3. January 30th 2019.	PSWs for intake/ child protection
4. From November 2018.	
5. December 15th 2018.	TL for quality assurance and PSWs for child protection and intake.
6. Ongoing from November 2018.	Area manager.
	Area manager and PSW for child protection.
	Principal social worker for child protection.

Standard 2.9

Substantially Compliant

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

Recording of decisions from professional and strategy meetings was poor.

Joint action sheets were not routinely maintained on children's files.

Action required:
Under **Standard 2.9** you are required to ensure that:
Interagency and inter-professional co-operation supports and promotes the protection and welfare of children.

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

1. File recording of decisions from strategy meetings requires comprehensive training and support to the intake/child protection pillars. A presentation/training will be provided to all the social work teams by February 2019 detailing the importance of same and also guidance regarding templates to be used to record strategy meetings and decisions made. This includes recording of joint action sheets on files.

2. Social work teams will be asked to ensure that all professional and strategy meetings are clearly recorded on case files and scanned onto NCCIS. Admin support will be provided to social work teams to ensure that these records are scanned onto NCCIS and an admin project team set up to ensure that all documents are recorded on NCCIS.

3. The principal social worker for child protection will continue to chair the Garda notification meetings and will ensure that all teams and team leaders are fully aware of action recording of joint action sheets on case files and that these are also scanned onto NCCIS with admin support.

Proposed timescale:	**Person responsible:**
1. February 28th 2019. 2. By February 28th 2019. 3. Dec 15th 2018 and ongoing into 2019.	Principal social workers for child protection and intake and service improvement. Area Manager, Principal social workers and Business support manager. Principal social worker for child protection.

Standard 2.10

Non-Compliant Major

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

Governance arrangements were not robust

National frameworks, policies and processes were not consistently implemented.

Monitoring systems such as supervision, caseload management systems were not robust The national guidance on caseload management was not implemented across the area.

Deficits identified in audits carried out in the area were not acted upon in a timely manner.

The areas service improvement plan had not been effectively implemented within defined timeframes.

Information governance was inadequate, NCCIS was not fully implemented.

Action required:
Under **Standard 2.10** you are required to ensure that:
Child protection and welfare case planning is managed and monitored to improve practice and outcomes for children.

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

1. New governance arrangements have been implemented within the area's child protection pillar since September 2018 to ensure robust oversight. A new principal social worker for child protection has been appointed. A new intake pillar under a dedicated principal social worker has been created to ensure robust front door screening of referrals and business cases have been submitted to the regional service director and COO in relation to these new structures. A dedicated quality assurance team leader will also provide audits/reviews of completed assessments and closed cases as well as provide regular reports to the principal social workers for both intake and child protection.

2. The area oversight committee will continue to be chaired by the service director and attended by national quality assurance. The Service director has asked the National project management office to co-ordinate a project response called 'project vision' for all action plans and service improvement plans in the area. This will be lead out by the PSW for service improvement in the area and will form the basis of the oversight progress meetings chaired by the Service Director.

3. The quality assurance lead for the area will ensure that all national policies, processes and frameworks are presented to large team meetings and training provided to all social work teams on same.

Team leaders and principal social workers will ensure that all teams are aware of same.

4. A supervision audit is taking place during early 2019. Caseload management training is being provided to all staff during Q4 2018 and will continue into 2019. The purpose of these is to ensure that effective and regular supervision meetings are in place in the area and that all social workers receive same. Caseload management tools are to be used to ensure case-loads are manageable and commensurate to experience levels.

5. The area audits which have identified deficits, as well as the signs of safety screening review of all open cases within the intake/child protection pillar are being tracked on a database to ensure tracking of decisions and actions are being made.

6. The area's service improvement and HIQA action plans are being formulated into a project management plan for the area. The regional service director will have oversight of tracking implementation of this plan at the oversight meetings she is chairing.

7. The area has a dedicated team leader post for NCCIS due be filled in Q4 2018. An admin project team for NCCIS is being created in the area. The area also has a full time data information/NCCIS officer. The TL posts will ensure auditing / full compliance by the area with NCCIS, cleansing of legacy data and working with regional child care information officer and improving information systems and data within the area.

Proposed timescale:	**Person responsible:**
1. January 30th 2019. 2. December 19th 2018 and throughout 2019. 3. January 30th 2019. 4. February 28th 2019. 5. December 22nd 2018. 6. December 15th 2018 and meetings throughout 2019. 7. February 28th 2019	Service director/area manager/PSWs intake/ Child protection & service improvement. SD/AM/PSWs QA TL/PSWs As above. PSWs and TLs. SD/AM AM/Business support