



Report of an inspection of a Child Protection and Welfare Service

Name of service area:	Mayo
Name of provider:	Tusla
Type of inspection:	Thematic
Date of inspection:	01 – 04 October 2019
Lead inspector:	Ruadhan Hogan
Support inspector(s):	Grace Lynam, Lorraine O'Reilly, Eva Boyle

About this inspection

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.

This inspection report, which is part of a thematic inspection programme, is primarily focused on defined points along a pathway in child protection and welfare services provided by Tusla: from the point of initial contact or reporting of a concern to Tusla, through to the completion of an initial assessment.

This programme arose out of a commitment made by HIQA in its 2018 *Report of the investigation into the management of allegations of child sexual abuse against adults of concern by the Child and Family Agency (Tusla) upon the direction of the Minister for Children and Youth Affairs*. This investigation was carried out at the request of the Minister for Children and Youth Affairs under Section 9(2) of the Health Act 2007 (as amended) and looked at the management by Tusla of child sexual abuse allegations, including allegations made by adults who allege they were abused when they were children (these are termed retrospective allegations).

Thematic inspection programmes aim to promote quality improvement in a specific area of a service and to improve the quality of life of people receiving services. They assess compliance against the relevant national standards, in this case the *National Standards for the Protection and Welfare of Children* (2012). This thematic programme focuses on those national standards related to key aspects of quality and safety in the management of referrals to Tusla's child protection and welfare service, with the aim of supporting quality improvement in these and other areas of the service.

How we inspect

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

The key activities of this inspection involved:

- the analysis of data
- interview with the area manager and two principal social workers
- speaking with children and families

- the review of local policies and procedures, minutes of various meetings, staff supervision files, audits and service plans
- the review of 69 children's case files
- observing duty staff in their day-to-day work
- observing team meetings and peer supervision.

The aim of the inspection was to assess compliance with national standards related to managing referrals to the point of completing an initial assessment, excluding children on the child protection notification system (CPNS).

Acknowledgements

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

Profile of the child protection and welfare service

The Child and Family Agency

Child and family services in Ireland are delivered by a single dedicated State agency called the Child and Family Agency (Tusla), which is overseen by the Department of Children 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 service areas.

Service area

Mayo is one of the 17 service areas in the Child and Family Agency, forming part of the West Region and is the third largest geographical county in Ireland. Mayo is a

predominantly rural county with larger populations based in Ballina, Castlebar and Westport.

The population of Mayo reported at the 2016 census was 130,507 with 31,968 (24.5%) under the age of 18. Mayo has a deprivation score of -7.7 compared to the national average of -3.6 and records the 9th highest deprivation score when compared to other counties.

In the six months prior to the inspection, the intake service received 659 referrals of Child Protection and Welfare.

The Mayo intake service is managed by a principal social worker, one social work team leader who managed one intake screening team based between three offices in Ballina, Castlebar and Swinford. The duty intake part of the service carried out the majority of screening, preliminary enquiries and initial assessment; the focus of this inspection. Three long term child protection teams are also based in each of these offices and they completed a smaller proportion of the related to the focus of this inspection.

Compliance classifications

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

Compliant	Substantially compliant	Partially compliant	Non-compliant
The service is meeting or exceeding the standard and is delivering a high-quality service which is responsive to the needs of children.	The service is mostly compliant with the standard but some additional action is required to be fully compliant. However, the service is one that protects children.	Some of the requirements of the standard have been met while others have not. There is a low risk to children but this has the potential to increase if not addressed in a timely manner.	The service is not meeting the standard and this is placing children at significant risk of actual or potential harm.

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

1. Capacity and capability of the service:

This dimension describes standards related to the leadership and management of the service and how effective they are in ensuring that a good quality and safe service is being provided to children and families. It considers how people who work in the service are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

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

This inspection was carried out during the following times:

Date	Times of inspection	Inspector	Role
01 October 2019	09:00 – 17:00	Eva Boyle Lorraine O Reilly Grace Lynam Ruadhan Hogan	Regional Manager Inspector Inspector Inspector
02 October 2019	09:00 – 17:00	Eva Boyle Lorraine O Reilly Grace Lynam Ruadhan Hogan	Regional Manager Inspector Inspector Inspector
03 October 2019	09:00 – 17:00	Eva Boyle Lorraine O Reilly Grace Lynam Ruadhan Hogan	Regional Manager Inspector Inspector Inspector
04 October 2019	09:00 – 14:00	Eva Boyle Lorraine O Reilly Grace Lynam Ruadhan Hogan	Regional Manager Inspector Inspector Inspector

Views of people who use the service

HIQA inspectors met with four children in one of the social work offices and spoke to a fifth over the telephone. Inspectors also had telephone discussions with eight parents whose children were in receipt of a child protection and welfare service.

Children were largely positive of social workers and said that they understood that they were there to help them. The majority of children spoke very positively about the work that social workers did with them, one child commenting that “it was brilliant and more helpful than she imagined”. Children said they were given leaflets about the service and they got very clear information about supports that were available.

All the parents whom inspectors spoke with were very complimentary of the service they received. For example, parents said that social workers managed their situations very well, were very professional and very courteous. One parent told inspectors “social workers were straight down the line and there was no beating around the bush” which was very much appreciated and valued. Parents said they were constantly spoken with and kept up-to-date with developments and everything was explained in detail as things happened. Other parents said that while social workers were professional and put them at ease, they felt that Tusla’s involvement was “dragged out” and Tusla could shorten the time that they were involved in their lives.

Capacity and capability

At the time of the inspection, a proactive and responsive child protection and welfare service was delivered in the Tusla Mayo Service Area from the point of initial reporting of a concern to Tusla, through to the completion of an initial assessment. Management ensured there were no children waiting for a service and assured themselves that social workers undertook good quality and child centred work with children and families. The leadership and management of the service had a strong focus on service improvement and inspectors could see that this led to children and families receiving a better service. However, further developments in quality assurance were required. These developments would help identify and implement small but significant changes regarding adherence to timeframes for assessments and recording practices.

As part of the methodology for this inspection, a self-assessment had been completed by the service area's management team prior to the announcement of the inspection and submitted to HIQA. The self-assessment required the area management team to assess and score their compliance with the five standards relating to leadership, governance and management, and workforce. Inspectors largely agreed with the management team's judgments and found that the evidence identified by the self-assessment to support these judgements were in place.

Arising out of the area management team's self-assessment, a service improvement plan was developed prior to the inspection fieldwork. It was noteworthy that the first draft of this plan reflected some of the findings of the inspection, indicating that the management team had an accurate understanding of the areas of practice where improvements were required and were proactive in identifying steps that would lead to service improvements.

The Mayo service area was managed by a stable and experienced management team that ensured staff were well supported and held to account. There were clear lines of accountability. The area manager had held the role for five years and prior to that had held a number of roles in the Mayo service area. He was very experienced, and

had a strong and well defined vision for how the service should be delivered. He supervised the principal social worker for the child protection and welfare service who in turn, oversaw the work of and supervised one social work team leader from the duty intake service and three social work team leaders from the long term child protection teams. Each social work team leader managed a team of social workers ensuring appropriate oversight of decision making. The stability in this management team ensured a consistent service was delivered enabling both a focus on, not just delivering, but improving the service.

A clear and strong vision for the service was outlined by the management team during inspection fieldwork. Service planning was of good quality and the service plan reflected the vision as set out by the area manager during interviews with inspectors.

It was clear to inspectors the service was well led. The management team provided strong leadership to staff. During interviews with inspectors, the senior management team advocated professional values such as child centeredness and set expectations that high quality interventions were to be provided to children and families in line with Tusla corporate values. Initiatives had been set up in the area to implement these values. For example, the area developed the concept of the 'Mayo child' which recognises that each child is the responsibility of the whole service, irrespective of the specific part of the service that is working with them at a particular time.

At the time of the inspection, the area manager was in the process of developing a customer charter with staff to set out to children, families and other stakeholders, the behaviours, attitudes and actions they can expect during their day to day interactions with Tusla staff. The area manager also emphasised the value of recognising good quality work, for example, when quality assessments were completed, or when positive feedback was received through 'Tell Us'- the Tusla feedback forum.

The child protection and welfare service was very well resourced. Mayo is a large geographical area and the duty intake service had been appropriately structured to ensure enough social workers were located throughout the service area so that they could respond to concerns as they were referred to Tusla. Each of the three offices had two senior social work practitioners who were responsible for responding to referrals up to the completion of an initial assessment. Staff on the child protection

teams had the necessary skills, competencies and had a wide range of experience including experience gained outside the jurisdiction enhancing the overall competency of the team. Inspectors found that staff presented as highly motivated and confident in their decision making, ensuring there were no waitlists in operation and that children received a timely service.

Management systems were effective at providing assurance to the area manager that the service was safe. Senior management team meetings were held regularly where members of this team, including the principal social worker for child protection and welfare, and the business support manager, produced and presented reports on the performance of various functions including staffing, complaints, risk escalations and the number of open referrals.

Systems of communication were well established. The staff told inspectors that communication was open and they could approach members of the management team if they had any issues to raise. Staff also told inspectors that they knew how to make a protected disclosure and were confident they would be protected if they needed to do so. Team and management meetings were held regularly and well attended. Day to day matters such as staffing issues and policies and procedures were addressed at these meetings along with feedback from other forums that focused on service improvement. Additional quarterly meetings were held with representatives from the entire service that monitored the planned improvements to the service. Minutes of all meetings were structured under the headings of the National Standards for the Protection and Welfare of Children (2012) as were the service plans, governance reports and quality assurance meetings, thus, ensuring that work undertaken at the various levels of service delivery was consistently aligned with the overall vision for the service.

Risk management systems were in place and were effective at identifying, assessing and escalating risk. Individual case management and staffing issues were appropriately escalated to the area manager and, if required, to the service director and chief operating officer in Tusla. The area recorded internal risk escalations as 'Need to knows'. On review by inspectors, these showed that timely and effective measures were put in place to address the issues raised. The area operated a service

risk register which also fed into to the regional risk register. All risks were being proactively addressed, reflecting a proactive approach to minimising the impact of identified risk before it became a more significant problem.

The National Child Care Information System (NCCIS) was used to monitor service provision. Quarterly updates on the completion of and adherence to timeframes for preliminary enquiries and initial assessments were provided to the area manager by the NCCIS support coordinator. These figures, by comparison with the previous year's performance, showed that that the area had made incremental improvements.

Quality assurance systems in the service were under developed and were not used as effectively as they could have been to identify areas for improvement in service delivery. This was known to the management team and plans were in place to address it. During interviews, the management team acknowledged that audits were quantitative and there needed to be a greater focus on the quality of service that was delivered to children and families. While a detailed local audit of the service was completed against the national standards, the follow up to address identified actions was poor. In addition, the area also identified that learning from audits needed to be embedded into practice. As stated earlier, the service improvement plan had already identified audits the focus of which was on the management oversight of records related to intake records and assessments.

Improvements were required in safe recruitment practices as inspectors found gaps in some staff files. Seven out of 13 staff files sampled by inspectors were of staff recruited in the last 5 years. Of these seven, five staff members had all requirements in place and two staff members recruited within the last five years had gaps such as no copies of curriculum vitae and references on files. Inspectors found that staff recruited greater than five years ago also had similar gaps such as no copies of qualifications, curriculum vitae and photographic identification on file. The management team of the service area maintained a copy of social worker's current professional registration.

Overall, staff supervision was of good quality. It was held regularly and provided both guidance and direction in relation to casework and also focused on the wellbeing of the staff member. During supervision meetings, managers reviewed staff's caseloads

in line with the caseload management policy. Records showed that appropriate action was taken to address unmanageable caseloads. Some of the records required improvement as actions and decisions were not always clearly stated. Staff told inspectors that they received regular supervision and were satisfied with the support they received. Overall, inspectors found supervision was both child and staff centred and provided the necessary support to staff, ultimately helping to retain social workers in the area.

A variety of initiatives were in place to support staff. These initiatives included team development days, specific supports for individual staff members and a mentoring system for newly recruited/promoted staff. A number of staff were engaged in Tusla's 'Empowering Practitioners and Practice Initiative' (EPPI), a program where staff researched specific practice areas. Literature reviews were presented to senior management and listed on Tusla's national EPPI forum where all Tusla employees could access it.

A particularly significant support for staff was the establishment of a forum, chaired by managers in the service, where social workers could present a complex case with the aim of exploring and identifying possible future steps to take in the interests of the child. In addition, personal development plans and staff appraisals were used to further develop the competencies of individual staff.

Training was in place to provide staff with the right skills to deliver the service. Individual training needs analysis had been completed which helped the area identify staff's training needs. For example, 'direct work with children' for new social work staff and leadership training for managers were provided by the service. Staff attended training on Tusla's national approach to child protection and team days were scheduled to provide training and updates on local service developments. Staff also completed other training in areas such as 'Meitheal' and 'Children First in Action'.

All of the above training initiatives informed the quality of service delivery which is set out in the next section of this report.

<p>Standard 3.1</p> <p>The service performs its functions in accordance with relevant legislation, regulations, national policies and standards to protect children and promote their welfare.</p>	<p>Judgment</p> <p>Compliant</p>
<p>A proactive and responsive child protection and welfare service was delivered in the Tusla Mayo Service Area. The management ensured there were no children waiting for a service and assured themselves that social workers undertook good quality and child centred work with children and families. Leadership and management in the service had a strong focus on service improvement and inspectors could see that this led to children and families receiving a better service.</p>	
<p>Standard 3.3</p> <p>The service has a system to review and assess the effectiveness and safety of child protection and welfare service provision and delivery.</p>	<p>Judgment</p> <p>Substantially Compliant</p>
<p>Further developments in quality assurance were required in order to identify and implement small but significant changes in adherence to timeframes and recording practices. This in turn would improve the service that children and families received.</p>	
<p>Standard 5.1</p> <p>Safe recruitment practices are in place to recruit staff with the required competencies to protect children and promote their welfare.</p>	<p>Judgment</p> <p>Partially Compliant</p>
<p>There were gaps in documentation on staff personnel files. For example, records of staff curriculum vitae and verification of references were not held for all staff. For this reason it was judged partially compliant.</p>	

<p>Standard 5.2</p> <p>Staff have the required skills and experience to manage and deliver effective services to children.</p>	<p>Judgment</p> <p>Compliant</p>
<p>The service had staff with the right mix of skills and experience to meet the needs of children. Risk management plans were used effectively to manage staffing shortages. Managers in the service were suitable experienced, qualified and competent to undertake the role.</p>	
<p>Standard 5.3</p> <p>All staff are supported and receive supervision in their work to protect children and promote their welfare.</p>	<p>Judgment</p> <p>Substantially compliant</p>
<p>Staff were well supported. Supervision of staff was generally of good quality. However, some supervision records had gaps in recording and documentation. For this reason it was judged substantially compliant.</p>	

Quality and safety

Overall, the service appropriately managed child protection and welfare referrals in line with Children First 2017: National Guidelines for the Protection and Welfare of Children.

Inspectors agreed with the self-assessment completed by the area management team in relation to the theme child centred services (standard 1.3), and found that the area was compliant with this standard. Areas for improvement were identified reflecting a commitment to continuous service improvement.

There was a culture of child centeredness in the Mayo service area which could be seen in how social workers interacted with children and families. Bright, colourful and child friendly booklets had been developed in the area and these were given to families when allocated a social worker. If a child had a disability, records showed that their disability support worker accompanied social workers on visits. Translators were utilised by social workers during visits with children and parents, when English was not their first language. Social Workers observed children in their homes and recorded this in case records. They described how children's needs were met by their parents and described how parents were in a position to parent to a good enough level, despite observed risks. This created a solid foundation for assessments and highlighted how the needs of children were at the centre of the assessment.

In relation to the theme of safe and effective services (standard 2.1) inspectors agreed with the area's self-assessment and found that it was substantially compliant with the standard. Areas for improvement were appropriately identified.

Child protection and welfare referrals were made to Tusla, in writing, over the phone or through the Tusla Portal. Inspectors observed social workers on the duty team in each of the three offices and overheard courteous, well informed and confident interactions with members of the public. In addition to responding to referrals, social workers consulted and offered advice on child welfare matters to members of the public where such enquiries did not constitute a specific child protection referral.

However, there were no records kept in relation to this work and therefore it was not known how much time was spent doing this. Nonetheless, it's value cannot be underestimated as educational professionals, medical professionals and other concerned members of the public had an avenue in which they could seek advice so they could work out what was the right course of action to take to promote a child's welfare.

In the Mayo service area, inspectors found that as soon as referrals were received, they were entered onto NCCIS by business support. Referrals were then immediately allocated to a social worker and therefore no waitlists were in operation. Overall, the level of resources allocated to the duty intake team along with the significant experience of social workers meant the service was proactive and responsive to children and families in responding to referrals.

Screening is undertaken so that Tusla can ensure that children who need a service get it in a timely manner. Of the 45 referrals sampled by inspectors for screening, 15 or 35% of cases had recorded evidence of screening within 24 hours. Inspectors found it was recorded in a variety of ways. For example, through case notes, direct work with families or intake records (IRs) that were completed within 24 hours. Inspectors also observed detailed screening discussions in the duty offices between social workers. In these cases, social workers checked if a child was previously known and categorised the referral as physical abuse, sexual abuse, neglect, emotional abuse or a welfare concern. However, 30 out of 45 or 65% of intake records reviewed by inspectors could not evidence that screening took place within 24 hours as per Tusla's requirements.

Tusla's intake record does not lend itself to evidencing that screening was completed within 24 hours. The area management team had already identified this as an issue to be addressed in their service improvement plan, in consultation with the national office.

While preliminary enquiries were not always completed within five days, good quality work had been undertaken by social workers. Tusla recorded preliminary enquiries on a

document called an intake record (IR). Fifty five percent of preliminary enquiries sampled by inspectors were completed within five days. The remaining 45% had delays of between a few days to 4 weeks prior to the intake record being completed and signed by the social work team leader. However, the lack of timely recording and completion of intake records did not accurately reflect the work that was being completed on individual cases. Inspectors found that all cases were allocated to a social worker and timely and good quality work with children and families was happening. In the majority of cases, details on referrals were clarified with the referrer. Network checks with professionals such as schools, medical professionals and Gardaí were appropriately completed. Where required, children and families were visited in their homes and safety plans were completed at this stage. Referrals were categorised and prioritised correctly within IR's. Despite the delay in completing some intake records, records contained good quality analysis of available information, including past involvement with the service, to inform decision making and any potential next steps.

Inspectors found that the area consistently and accurately applied thresholds in decision making. Referrals that needed social work involvement remained allocated to a social worker for an initial assessment and intervention. Where it was decided that a step down response was more appropriate, children and families were diverted to early intervention and preventative support agencies with their consent. Additionally, inspectors found that referrals closed following the completion of preliminary enquiries, were done so appropriately when children and families were assessed as not requiring a service. This meant that only the children who required a child protection service, received one and the social work response was proportionate to the level of risk identified. In almost every case reviewed, families were informed on the progress of referrals including whether the referral was closed or allocated for initial assessment.

The area took immediate action where required to ensure children were safe and protected from abuse. Inspectors found evidence on case files of social workers putting effective and timely arrangements in place to safeguard children. For

example, children were met with on the day of the referral, an appropriate safety plan was put in place and arrangements were made for the child to stay with relatives while social workers conducted their assessments. Records also showed there was good quality collaboration between Gardaí and external professionals in cases such as these.

In cases where immediate or urgent intervention was not required, good quality safety planning was in place. Safety planning arrangements were recorded in a variety of places including case notes and assessments. Formal safety plans were also recorded on files and records showed parents and other members of the community had signed these plans. Where appropriate, children were involved in the plan and protective persons identified had on-going assessments of their capacity to protect. The work undertaken with families helped them to recognise and manage the concerns. For example, parents told inspectors that a safety plan was useful to them as they knew what they had to do when social workers were not available.

The area routinely notified An Garda Síochána of suspected crimes of wilful neglect or physical or sexual abuse against children. Of the eight referrals reviewed by inspectors where a Garda notification was found to be required, six were timely and two were late by three and four weeks respectively. There was no recorded rationale for these delays.

While the timeframes of 40 days for completion of initial assessments were not adhered to, they were of good quality. Forty-seven percent of initial assessments reviewed by inspectors were completed within 40 days. The remaining 53% had delays of between one and four weeks with evidence of delays explained in some of the assessments. Social workers met children on their own, in their home, and spoke to them in child-friendly language. Where required, assessments were informed by good quality sharing of information from relevant professionals. Written assessments reflected the voice of children and, for the most part, reflected the individualised needs of children, particularly when there was a number of brothers and sisters being assessed. There was a good quality analysis on assessments that balanced risk with the impact on the child. Outcomes were reached during the assessments with clear recommendations

recorded. Action was taken where children were assessed as being at significant risk. For example, a child protection conference was scheduled or legal advice was sought if care proceedings were required. In other cases, following the outcome of the assessment, children’s cases were closed to the child protection and welfare service. The area was also proactive at communicating the outcome of assessment with families where appropriate.

Standard 1.3

Children are communicated with effectively and are provided with information in an accessible format.

Judgment

Compliant

There were initiatives in place to implement a culture of child centeredness within the service. Assessment and other work completed by social workers was largely child centred. Parents and children told inspectors that they were communicated with promptly.

Standard 2.1

Children are protected and their welfare is promoted through the consistent implementation of Children First.

Judgment

Substantially compliant

Children who required immediate action were dealt with appropriately and good quality safety planning was in place. The content of assessments was of good quality. There was a correct application of thresholds and cases were closed appropriately.

The standard was judged substantially compliant as the completion of intake records and timeframes for assessments were not consistently adhered to in line with Tusla’s own requirements.