



Report of an inspection of a Child Protection and Welfare Service

Name of service area:	Dublin South West, Kildare, West Wicklow
Name of provider:	Tusla
Type of inspection:	Focused CPNS
Date of inspection:	5-7 April 2022
Lead inspector:	Sue Talbot
Support inspector(s):	Jane McCarroll, Pauline Clarke-Orohoe, Hazel Hanrahan
Fieldwork ID	MON-0036389

About monitoring of child protection and welfare services

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

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

The Authority monitors the performance of the Child and Family Agency against the *National Standards for the Protection and Welfare of Children* (2012) and advises the Minister for Children, Equality, Disability, Integration and Youth and the Child and Family Agency (Tusla).

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 they can develop action plans to implement safety and quality improvements
- **inform** the public and **promote confidence** through the publication of the Authority's findings.

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

Theme 1: Child-centred Services	<input type="checkbox"/>
Theme 2: Safe and Effective Services	X
Theme 3: Leadership, Governance and Management	X
Theme 4: Use of Resources	<input type="checkbox"/>
Theme 5: Workforce	<input type="checkbox"/>
Theme 6: Use of Information	<input type="checkbox"/>

How we inspect

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

The key activities of this inspection involved:

- the analysis of data
- interview with the area manager
- interview with two principal social workers
- interview with two independent child protection conference chairs
- interviewing a focus group of eight social work team leaders
- interviewing two focus groups of frontline staff comprising 14 social workers
- review of local policies and procedures, minutes of various meetings, staff supervision files, audits and service plans
- observation of a child protection conference
- the review of 24 children's case files
- phone conversations with six parents
- phone conversation with one child.

The aim of the inspection was to assess the service area's compliance with national standards delivered to children who are subject to a child protection case conference and whose names are listed on the Child Protection Notification System.

Acknowledgements

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

Profile of the child protection and welfare service

The Child and Family Agency

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

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

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

Child and family services are organised into 17 service areas, each led by an area manager. The service areas are grouped into six regions, each with a senior manager known as a regional chief officer. The regional chief officers report to the national director of services and integration, who is a member of Tusla's executive management team.

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

The service area

The Dublin South West, Kildare, West Wicklow service area spans the county boundaries of Kildare, Wicklow, South Dublin and Dublin South City. The service area is diverse and includes rural communities and large rural and commuter belt towns. The overall population of the service area is 402,436 people; with 27% of the population under 18 years of age.¹ Dublin South West, Kildare, West Wicklow is the second largest in size of Tusla's service areas and has the third highest level of deprivation. There were 11,788 people living in areas rated as most disadvantaged nationally, comprising 10.8% of the local population.² Of this group, 29.2% (3446 children) were under age of 18 years. Unemployment rates for the area exceeded the national average; with 13% of the area's population unemployed at the time of the 2016 census.

¹ Census data 2016.

² Pobal HP Deprivation Index 2016

The service area is under the management of the Regional Chief Officer for the Dublin Mid-Leinster region, and is managed by an area manager. Twelve senior managers directly report to the area manager. These include principal social workers for the intake and assessment teams, child protection and welfare teams and child protection conference chairpersons. At the time of this inspection, the service area had four intake and assessment teams and four child protection and welfare teams covering the localities of Tallaght North and Dublin 12, Tallaght South, Kildare North and Kildare South. Each of the teams is managed by a social work team leader. A social work team leader for service development and another for quality, risk and service improvement provided additional support to managers, including undertaking audits to provide assurance of social work practice.

The intake and assessment teams are responsible for the management of child protection and welfare concerns from the point of referral through initial assessment to the initial child protection conference. The handover to the child protection and welfare teams takes place at the child protection conference following the decision being taken to place a child on the child protection notification system (CPNS). The named child protection social worker then has lead responsibility for the ongoing monitoring and review of the effectiveness of safety plans including making regular visits to children and supporting the development of safety networks to help strengthen parental capacity. The outcome of such work and evidence of progress, informs future decisions made at review child protection conferences.

A total of 75 children were on the CPNS on 1 March 2022. Of these, 62 children were listed for neglect, 12 for emotional abuse, and one child for physical abuse. The CPNS register included nine children had been on the CPNS for longer than 12 months, three children for longer than 18 months, and one child for longer than 24 months. A total of 31 children were made inactive since September 2021. The active CPNS database also included 11 children who were previously listed at an earlier point in their childhood.

Compliance classifications

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

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

This inspection was carried out during the following times:

Date	Times of inspection	Inspector	Role
05/04/2022	09.00-17.00	Sue Talbot Jane McCarroll Pauline Clarke-Orohoe Hazel Hanrahan (remote)	Inspector Inspector Inspector Inspector
06/04/2022	09.00-17.00	Sue Talbot Jane McCarroll Pauline Clarke-Orohoe Hazel Hanrahan (remote)	Inspector Inspector Inspector Inspector
07/04/2022	09.00-17.00	Sue Talbot Jane McCarroll Pauline Clarke-Orohoe Hazel Hanrahan (remote)	Inspector Inspector Inspector Inspector

Views of people who use the service

Inspectors spoke to one child and to six parents about their experiences of child protection arrangements. Most feedback given was positive. Parents said that their social workers worked closely with them and their children and helped them. They said they had been given their social worker's direct contact number and that they had been told what was happening. Parents valued knowing when their social worker was on leave and who to contact in their absence.

The young person said:

- *'I like my social worker. They are nice'.*

They also told the inspector they felt safe, and that their social worker helped them to do the activities they liked and to attend school.

Comments made by parents included:

- *'The social worker is very involved, very caring and very professional'.*
- *'We can ring them and ask for feedback and guidance at any time'.*
- *'Meetings are well chaired'.*
- *'I feel heard. My point of view has been taken on board and is part of the plan'.*
- *'I am fully aware of next steps, actions, and who needs to complete them'.*
- *'Support has been good, but suppose coming from difficult circumstances that social worker doesn't get full picture of what I am going through'.*

One parent spoke of the challenges of having to work with three different social workers over the past six months:

- *'It is frustrating to keep explaining our story all over again. I don't understand why there are so many changes of social worker. Lose faith in social workers coz of changes'.*

All parents spoken to said they were given the opportunity to speak at meetings, and felt that their views were heard and included within the agreed safety plan actions. All commented that they felt that the actions taken had helped to keep their children safe. One parent, however, felt they had not been given enough information about the legal processes that may follow if there was not enough improvement in the level of care they were able to provide to their children.

The next two sections of the report detail how the service was managed, and the systems and processes the service area had in place to protect children at risk of abuse or neglect.

Capacity and capability

The focus of this inspection was on children subject to a child protection conference (CPC) and listed on the CPNS, and the aligned service leadership and governance arrangements. The inspection considered the service area's compliance with *Children First 2017: National Guidelines on the Protection and Welfare of Children* and the *National Standards for the Protection and Welfare of Children (2012)*. The scope of the inspection included children 'active' on the CPNS and those made 'inactive' six months prior to the inspection. Children became inactive either following a decision taken at a review child protection conference (RCPC) that they were no longer at ongoing risk of significant harm, or following their admission to care.

Overall, inspectors found strong leadership, governance and performance management of child protection practices within the service area. The area benefited from having an experienced and stable senior management team who demonstrated a shared focus on driving continuous service improvement. The culture of the organisation promoted strong child-centred practice, with effective engagement of families and partner agencies. All children on the CPNS had an allocated social worker. Case handover between teams was closely monitored by managers to prevent delays in case transfer, and ensure ongoing scrutiny of risks.

However, inspectors also identified areas for improvement where the service area's governance and capacity had not been sufficiently resourced or effective in achieving a consistently high standard of child protection practice. Local procedures and practices for safeguarding and meeting the needs of children, identified at ongoing risk of significant harm due to their own behaviours, required development. While audits were undertaken, these were not always effective as timely actions were not taken to address findings in all cases. Inspectors were told, by senior managers, that the service was not appropriately resourced to consistently respond to demands for their child protection service.

Senior managers reported that all child protection and welfare teams had vacant social work posts at the time of this inspection; with particular pressures in one team given the numbers of children it had on the CPNS. This meant that some children did not always receive a consistent standard of support. Inspectors found that some case records did not provide evidence of regular child protection home visits or network meetings in line with the schedule agreed at the child protection conference and within children's safety plans. Some frontline staff described having high and complex caseloads that required intensive intervention; but said that their capacity was over-stretched given the ongoing challenges and delays in recruiting to vacant social work posts.

Senior managers had been working to address this risk and had systems in place for monitoring the pressures staff were working under. They, together with the regional HR team, had plans to ensure levels of resource better matched demand and addressed ongoing challenges in recruiting staff to some of its localities.

The service area's governance systems promoted effective communication and sharing of expertise between different management and practitioner roles and functions. A range of child protection broadcast bulletins, training, practice workshops and case audits complemented individual and group supervision and team meetings to inform ongoing practice development and learning.

The child protection co-ordinator maintained a management tracker that provided a detailed picture of trends and the effectiveness of child protection activity including benchmarking of team's performance. This ensured routine reporting of timeframes from sign-off of a CPC request by the team leader to approval by the CPC chairperson. It also identified any child protection conferences that were overdue and the reasons for this, the length of time children were listed, whether they or their parents had attended, and any feedback they or partner agencies had given about their experience of the CPC. It enabled ongoing monitoring and review of progress against strategic objectives and organisational risks.

Inspectors found that senior managers had a sound grasp of organisational strengths and areas for further improvement. They demonstrated a clear commitment to learning from adverse events, complaints and from previous inspection reports. Areas for improvement actively informed the agendas of senior management meetings and were used to inform priorities within service plans.

National Guidance for the Protection and Welfare of Children (2017) informed local practice which set out agreed criteria to support decision-making about whether children's circumstances and exposure to harms met the threshold for inclusion on the CPNS. The guidance also recognised there were other circumstances where children may be at ongoing risk of significant harm that were not attributable to parental abuse or neglect. In these cases, the agreed action was for a child protection conference to be applied for, but declined, by the CPC chairperson. Practice guidance encouraged the use of family welfare conferences, strategy meetings and safety plans to manage risk. Inspectors found, however, that these arrangements did not effectively address the vulnerability of children where the complexity of their needs and behaviours remained an ongoing significant concern. Alternative processes had not been effective in reducing harms or preventing the recurrence of crises in their review of one child's case record. Delays in access to suitable alternative accommodation added to the challenges in keeping children safe.

Tusla's interim guidelines for child protection conferences and the CPNS (July 2018) were under review at the time of this inspection. They had been due for full review in April 2019, but remained unavailable at the time of this inspection. In the absence of up to date national guidance; the area had developed their own standard operating procedure for child protection and welfare teams (July 2021). This clearly set out the process and timescales for the management of ongoing significant risk of harm to children from the point of referral, through CPNS listing and the development and review of child protection safety plans. Inspectors found that CPNS arrangements for listing, and where required, de-listing of children; were securely and effectively implemented in line with *Children First* guidance. The child's name and type of abuse they had experienced was entered onto the CPNS within 24 hours of the child protection conference in line with statutory guidance.

The transfer of children on the CPNS into and out of the service area, including the management of review child protection conferences was appropriately followed up. Records reviewed by inspectors had effective involvement of key professionals from both service areas to ensure smooth handover of ongoing child protection work.

The service area had reviewed and strengthened its standard operating procedures for the management of child protection conferences (September 2021). These provided clear direction to support professional accountabilities and the required actions prior to, during, and following case conferences. Child protection conference (CPC) chairpersons had adapted their practice over time to strengthen the participation of key stakeholders. Their approach included a strong emphasis on planning and preparation of parents, and engagement of all relevant partner agencies. CPC chairs together with the Principal Social Workers for Intake and Assessment and Child Protection and Welfare; were actively involved in regional and national working groups to support implementation of Tusla's national child protection development programme. These meetings provided opportunities for peer challenge, sharing of learning, and ongoing review of the effectiveness of policies and procedures.

The service area's child protection service plans provided a clear strategic direction to support implementation of Tusla's Child Safeguarding Statement and operating principles. The Child Protection Service Plan (2022) set out clear goals to promote a high quality and consistent standard of organisational performance. This included ensuring timely and effective planning of child protection conferences; with good attention paid to increasing the levels of participation of parents and children. The service area was in the process of developing a parental peer support programme to help strengthen levels of parental confidence and participation.

The Child Protection and Welfare Service Plan (2022) prioritised workforce recruitment and retention and had a strong focus on continuous professional development. It sought to promote greater consistency in the use of safety plans and records of network meetings. Neither service plan however, took sufficient account of the particular needs of children with complex needs and behaviours mentioned in the earlier section of this report.

Senior managers reported effective communication with and support from their regional chief officer. Inspectors found there was good management oversight and communication between key roles and functions within the service area. Inspectors reviewed a range of management documentation and meeting minutes including; strategic senior management meetings, area management meetings, principal social worker meetings, child protection and welfare team meetings and CPC chairpersons meetings. Meeting minutes provided updates of progress against HIQA compliance plans; with evidence of regular checks of organisational performance, capacity and challenges.

Managers effectively used their performance data to ensure early identification of risks and encouraged shared approaches to problem-solving and strengthening of organisational learning. Child protection and welfare pillar meetings, held every three weeks; ensured updates to policies, procedures and practice were discussed to help embed a consistent standard of practice. Follow-up actions and accountabilities for service development activity were clearly recorded.

The service area's risk register appropriately reflected organisational challenges and was regularly reviewed and updated by the area's senior management team. The highest area of risk on the risk register related to the lack of suitable care placements for some children. Risks relating to the shortage of care placements were escalated to the regional chief officer via Tusla's *'Need to Know'* process³. This included children on the CPNS who remained at home, but who required an alternative care placement. There had been no such notifications for children on the CPNS since February 2021; and managers reported there were no children on the CPNS awaiting placement at the time of this inspection. The *'Need to Know'* process ensured senior managers were aware of and kept up-to-date in relation to children where there were ongoing difficulties in finding an appropriate placement.

³ Internal Tusla system for alerting senior managers to significant concerns about the safety and welfare of children.

Inspectors found overall, that the threshold for admission to care for children listed on the CPNS was appropriately identified and managed. Where there remained uncertainty about, or evidence of a lack of progress in parents' ability to protect their children from ongoing risk of significant harm; inspectors found that social workers had recognised this, and were exploring other care options. Two out of 24 case records reviewed by inspectors, indicated growing concerns about the safety of children who were in the care of their parents or placed as a private arrangement with their extended family. Follow up discussion with case holders indicated that care proceedings were being considered; although this had not been clearly evidenced on the children's records. Managers told inspectors they were alert to drift and delay for children who required alternative care, and ensured regular discussion of children on the CPNS within supervision.

The area manager delegated the responsibility for the management of CPCs to two principal social workers. They fulfilled the role of child protection conference chairpersons, and were supported by a child protection co-ordinator in maintaining and updating the CPNS. They reviewed all requests for CPCs and determined if the threshold for a child protection conference had been reached. Where there was insufficient evidence of ongoing risks of significant harm to children, the application was not approved. CPC chairpersons provided feedback to case holders and team managers about gaps in the provision of relevant information or in their analysis of risk. Inspectors found effective challenge by a CPC chairperson in one case record where the '*Me and My Meeting*' booklet had not been completed in advance of the CPC. Review of case records, indicated such feedback was acted on and used to support ongoing learning and improvements to practice.

The service area had reviewed levels of demand for child protection conferences, its workforce capacity and ability to consistently meet conference timeframes. The review indicated the need to strengthen co-ordinator capacity so that more than one conference could be held each day; and to provide back-up for those occasions when a conference chairperson or co-ordinator was not available. An additional chairperson and conference co-ordinator were recently appointed to help address peaks in demand to provide for a flexible organisational response.

The quality of the area's accommodation for hosting child protection conferences had also been highlighted as a barrier to the delivery of a high quality service. The service area had addressed this through investment in information and communication technology and conference facilities that provided for improved management of both virtual and face-to-face participation.

The area manager delegated oversight of the implementation of child protection safety plans and monitoring of children on the CPNS to two principal social workers and their respective social work teams. Arrangements for case transfer between the intake and assessment and long term child protection and welfare teams were well-managed. All children on the CPNS had an allocated social worker; with strong oversight and routine reporting of capacity challenges to the area manager.

Inspectors reviewed the supervision records of child protection and welfare principal social workers and CPC chairpersons undertaken by the area manager, and found they were timely and detailed. One-to-one supervision was regularly held and supported good governance of the service area. Senior manager supervision records evidenced a strong focus on children on the CPNS, other children with high and complex needs, and workforce capacity. The agendas routinely covered workforce performance and progress being made against the service area's inspection and service development plans. This meant the area manager was well-informed about organisational challenges, capacity and capabilities. They were also aware of children living in the service area where there were ongoing significant concerns for their safety. A service-wide supervision tracker supported effective monitoring of supervision activity at all levels.

The service area had recently completed a supervision audit of the area's compliance with Tusla's guidance. The findings of this third annual audit found steady progress had been made in addressing areas for improvement highlighted in previous audits. The audit findings, coupled with feedback from frontline staff and managers, evidenced informal and formal supervision was easy to access and regularly undertaken. Frontline staff and managers told inspectors they valued the additional support they received when managing complex cases. Case supervision notes however, were not always available on all children's records to provide assurance that routine checks had been made of risks to children on the CPNS and of management direction and decision-making. This had been recognised as an area for further improvement by service managers. Information feedback sessions was being planned for May and October 2022 to share the supervision audit findings and reinforce messages about organisational commitments and accountabilities as set out in Tusla's guidance.

Additional support and development opportunities were provided for newly qualified social work staff. Newly appointed team leaders benefited from a peer network and mentoring support. Senior managers reported these supports had a positive impact on staff wellbeing and retention.

The service area had prioritised its use of case audits to provide assurance of the quality of child protection practice. Records reviewed by inspectors found that audits recognised practice strengths and areas where further improvement was required. However, actions from audits were not always implemented in a timely manner as required. The programme of audits included Garda notifications (externally undertaken as part of Tusla's national programme) and local audits of child protection records and safety plans undertaken by CPC chairpersons, the social work team leader for Service development, and the quality, risk and service improvement (QRSI) team leader. Team leaders and principal social workers were also engaged in auditing the standards of child protection practice. Audit findings had been used to inform learning events and to shape service development priorities. Themes for improvement related to social worker's availability to visit children as often as required and ensure effective monitoring, regular review and updating of their safety plans; including provision of support for the child's safety network.

Following completion of case audits, all social workers and team leaders received feedback on the quality of their child protection practice, and audit notes were uploaded onto children's case records. Practice strengths and the need for improvement were discussed in supervision. However, inspectors found that not all priority actions identified through audit had been addressed at the time of inspectors' review of case records. Ongoing delays and gaps in completing and uploading key records dated back six months in three cases, and five months in another. Social workers told inspectors they were aware of audit findings; but advised that workload demands meant they often needed to prioritise other child protection activity and had not been able to keep their records up-to date. This issue had not been effectively addressed in supervision, and carried additional risks in that information on children's care and social work interventions was not up to date.

The service area's complex case review panel was chaired by the area manager. Inspectors found the approach taken was effective in reviewing the experiences of children, the quality of child protection practice, and the impact of local arrangements to keep children safe. The case review process encouraged the development of other strategies for cases that appeared to be 'stuck' in order to improve outcomes for children. This included children on the CPNS for longer than 18 months. Case discussions included exploration of the need for specialist interventions to address children's experience of trauma and for additional assessments; including of parental capacity.

There were gaps in provision of support services for children and families in the service area. Additional funding was generally approved in a timely manner by senior managers. However, the required services, (including those commissioned or provided by partner agencies); were not always available, or there were delays in specific pieces of work starting for some children. The varying levels of resources and availability of specialist services in different localities meant that children and their parents in Kildare were more likely to have to travel out of their local area to access the help they needed. These inequalities had been recognised by senior managers, and there were plans in progress to address gaps in provision.

Child protection conference chairpersons sought feedback from children, parents and partner agencies on their experience of attending CPCs to identify how the process could be further improved. However, frontline staff said they were not aware of the details of such feedback and would welcome having a better understanding of the issues highlighted. Service managers advised that this would be addressed in future learning events.

The service area had clear processes for encouraging children over 12 years of age to attend their conference and complete the *'Me and My Meeting'* booklet. The numbers of young people who attended part of the conference or whose written feedback informed discussions was closely tracked. The CPC service plan aimed to strengthen the participation of children; recognising the potential to more effectively engage with children under 12 years of age. Case audits also sought to reinforce and embed the use of words and pictures to present the views and experiences of younger children.

There had been one appeal of the decision to place children on the CPNS in the six months prior to inspection. Inspectors reviewed the appeal documentation alongside case records and found that the process and plans to safeguard children had been effectively managed. While the grounds for appeal were not in line with Tusla's criteria; there was evidence of organisational openness to learning; with prompt follow-up discussion by senior managers with the person making the appeal. Learning from such feedback was being used to inform future communication and checks of parental understanding of child protection and care proceedings.

There had also been one complaint from a young person in the last six months. Review of the complaint alongside the child's case record found sensitive management of a challenging situation. Social workers and managers worked to improve their understanding of the young person's experience and to prioritise their safety, whilst ensuring additional support for family members.

<p>Standard 3.1 The service performs its functions in accordance with relevant legislation, regulations, national policies and standards to protect children and promote their welfare.</p>
<p>Managers and staff recognised their accountabilities for protecting children and promoting their welfare, and had taken appropriate action to improve the service area’s compliance with relevant legislation, regulations, policies and standards. However, interim national guidelines on child protection case conferencing and the child protection notification system (2018) were over-due review, and required updating by the Child and Family Agency. Child protection and welfare procedures and practices for safeguarding and meeting the needs of children identified at ongoing risk of significant harm due to their complex needs and behaviours, required further development.</p>
<p>Judgment</p> <p>Substantially Compliant</p>
<p>Standard 3.2 Children receive a child protection and welfare service, which has effective leadership, governance, and management arrangements with clear lines of accountability.</p>
<p>The service area had clear plans and well-defined governance arrangements and structures in place to support the delivery of its child protection services. However, systems and levels of support for children with high and complex needs at ongoing risk of significant harm were not sufficiently developed to address major risks to their safety and welfare. There were ongoing challenges in the service area’s capacity to consistently deliver the required levels of support to all children on the CPNS. There were gaps in the availability, reviewing and updating of some children’s case records; with evidence of inconsistencies in the levels of support and oversight of children. Lengthy delays, in a few cases; in addressing priority actions highlighted in case audits, detracted from the quality of social work practice including ongoing analysis of risks to children. Supervision case notes were not always available on children’s records to provide assurance of management oversight and decision-making.</p>
<p>Judgment</p> <p>Not Compliant</p>

Standard 3.3

The service has a system to review and assess the effectiveness and safety of child protection and welfare service provision and delivery.

The service area had clear and effective systems in place for the identification and management of risk that ensured timely alerts to senior managers about children at ongoing significant risk of harm. The risk register was well-maintained and regularly reviewed. The culture of the organisation was one that promoted organisational learning and challenge. Audits were effectively used to provide assurance of the quality and safety of services and inform service development activities.

Judgment

Compliant

Quality and safety

Overall, inspectors found the service area had clear systems and processes to protect children at risk of harm or neglect and to promote their welfare. Child protection conferences were effectively facilitated by independent chairpersons. They enabled good analysis and shared recognition of risks; and of 'bottom lines' in relation to what parents needed to do to keep their children safe and meet their health, development and wellbeing needs. Child protection arrangements encouraged a multi-disciplinary approach to child protection; with evidence of strong and effective joint working with partner agencies. Child protection safety plans reviewed by inspectors were mostly of a satisfactory standard, with some examples of effective child-centred practice. Areas for improvement primarily related to the frequency of review and updating of safety plans, ongoing support for children's safety networks, and ensuring all child protection records were kept up-to-date.

Inspectors found the service area had good performance overall in ensuring timely initial child protection conferences (ICPC) in line with Tusla's standard operating procedures and practice guidance. A request for a CPC was generally made within three working days from the date of team leader sign-off of an initial assessment which identified children were at ongoing risk of significant harm. Review child protection conferences were generally timely, and planned well in advance.

The CPC chairperson sought to convene the ICPC usually within three weeks of receipt of the request. The process recognised the need to ensure parents and professionals were given ten days' notice of the conference. This allowed time for the social worker to discuss their safety mapping report with parents; and for other professionals to prepare relevant reports, or re-schedule their commitments to enable them to attend. It also provided essential planning time to ensure specific issues and risks in relation to the management of the conference had been recognised and addressed. This included strategies for managing parental conflict, or need for interpreting support. Pre-birth conferences for unborn babies were sensitively and appropriately scheduled.

Inspectors found child protection conference planning overall was well-managed; with inclusion of relevant people and co-ordination of reports and activities. Notifications and reports were received in a timely manner to inform analysis of risk and conference discussions. Information-sharing with parents was prioritised, with evidence that safety mapping work undertaken by social workers had been shared in advance of the conference. CPC chairpersons ensured they met with or spoke to parents in advance so that they understood what to expect, recognising the difficult nature and content of the meeting for them. Chairpersons routinely advised parents about the need for confidentiality balanced with statutory requirement for information-sharing; and how to use the complaints and appeals processes. Good attention was paid to seeking and using feedback from conference participants about their experience of the meeting to inform practice improvements. For example, ensuring a refreshment break was built into conference proceedings, (which was introduced in response to feedback received), was seen to be working well, and provided important space for reflection.

Inspectors observed an initial child protection conference. The conference was effectively and sensitively facilitated by an appropriately trained professional who was not directly involved in the assessment or management of the case. The meeting atmosphere was respectful; and encouraged collaborative working between Tusla, the family and external professionals. Parents' views were sought and valued. Additional support was provided for children who were too young to attend. This helped ensure parents were able to fully engage in the conference discussions.

Review of case records found conference chairs were appropriately supportive and challenging; and enabled open discussion about the nature, levels and impact of harm on children. This helped to build a comprehensive picture of risk and of existing safety networks and parental capacity. Decisions and judgments were based on analysis of all available evidence obtained through initial and ongoing assessments; alongside other relevant information from professionals, safety networks, parents and children.

Records evidenced an inclusive approach in the use of safety scaling scores to inform the development of the child protection safety plan and assessment of progress. Social work practitioners and their managers demonstrated a good understanding of the impact of cumulative harm and neglect on the health and development of children. Most social work assessments were holistic and considered past, current and future harms on the safety and wellbeing of children. Due weight was given to the quality of relationships and attachment within families. Conference chairpersons clearly outlined the 'bottom lines' for parents; setting out clearly that further action would be taken, including seeking legal advice about removing children from their care, if there was not sufficient evidence of change in parental behaviours and risks to their children.

Review child protection conferences (RCPC) were generally held in a timely manner, within six months of the previous conference. Data provided by the service area indicated that at the time of this inspection, there were seven overdue RCPCs; the longest was six days outside the expected timeframes. All had dates planned for re-scheduling. The service area closely monitored such delays and recorded the rationale for this.

Review conference discussions provided an effective check of the family life and experiences of children. Records contained good analysis of changes in parental motivation, circumstances and capacity, and the impact for children. Conference chairpersons also ensured earlier review where there was evidence of steady and sustained progress in the safety of children with a view to de-listing children at an earlier point than the routine six month timeframe.

Review of child protection records indicated a mixed picture in the quality of case records. Better quality records indicated social workers were proactively responding to the management of child protection concerns; with evidence of regular checks and safety network meetings in line with the agreed actions set out within children's safety plans. These records contained a good mix of announced and unannounced child protection home visits; with details recorded of observations of children in the care of their parents and of the conversations children had with them.

Inspectors found however, there were gaps in the availability and maintenance of essential documentation on seven of the 24 case records reviewed. These did not contain evidence that children had been visited by their social worker in line with the frequency set out in child protection safety plans. Records did not always indicate if children were seen, or spoken to alone. Inspectors sought assurances from case holders and managers that child protection plans were being overseen and regularly reviewed for their impact in reducing risks of harm to children.

Follow-up discussions provided assurance of their awareness of current risks, and that relevant child protection activity was taking place; albeit this was not at the frequency recommended within the child protection safety plan. Delays and gaps in case records detracted from the delivery of a consistently high standard of safeguarding practice. The service area was working to strengthen its case recording to ensure the naming convention for CPNS-related home visits was embedded in practice and enable effective management tracking of the frequency and quality of direct work with parents and children.

A high standard of direct work with children was evidenced on eight out of 24 child protection records. Such records clearly captured children's views and worries and demonstrated strong advocacy by social workers to ensure they felt safe, reached their full potential, and experienced ongoing improvement in the care they received. The approach recognised the impact for children subject to high levels of risk and some social workers ensured daily checks-ins for children, for example, by safety network members, or with a trusted teacher at school.

Initial child protection safety plans reviewed by inspectors overall were of a satisfactory standard, and contained clear actions to address risks and recognised children's individual needs. Conference chairs clearly set out the priorities parents needed to address and the support they could expect from relevant agencies at the conclusion of the meeting to inform the development of the child protection safety plan. However, in one case reviewed, while the expectation of the conference was that the safety plan be completed within two weeks; this had not been achieved a month later. Safety plans were routinely shared with parents and reviewed within safety network meeting members.

Parents told inspectors they had been involved in shaping their child protection safety plan, and discussion of relevant issues was evidenced in most records of contact/home visits. Case records also indicated some older children had been actively engaged in developing their safety plan. Social workers were mindful of the vulnerability of children's situations, and their feelings about and ability to talk to wider safety network members about ongoing parental concerns and risks to their safety.

Arrangements for the ongoing monitoring and implementation of safety plans, including regular review and analysis of risk and support for safety network meetings were areas of practice which required strengthening on some case records. Better quality child protection safety plans contained up-to-date information; were proportionate and child-centred, and included clear direction about how children's short and longer term needs would be met. They focused well on the complicating factors that impacted on parents' capacity to keep their children safe. This included relapse indicators in relation to parental mental health or substance misuse. However, two of six records where parental substance misuse remained a significant concern indicated the need for stronger scrutiny of 'hidden harms.' This included the need for regular checks of substance use and recording of safe storage of drugs to inform child protection safety plans.

The service area had clear processes in place for the management of data in relation to children entering, remaining or being removed from the CPNS. This included children transferring between service areas. There was also an effective alerting process in place for the management of data in relation to young people who reached 18 years of age.

Seven case records reviewed by inspectors had been closed in recent months. Inspectors found that decisions to close these cases were well-considered and appropriate. One child's case record, in error; indicated they were still active on the CPNS. This was brought to the attention of the service area. The issue was found to be a record cloning failure, and was promptly addressed. Inspectors found that prior to the decision to de-list children, due consideration had been given to the ongoing assessment of progress made in reducing risk, including the effectiveness of children's safety networks and to the length of time children had been listed on the CPNS. Inspectors also sampled two case records of children that had been re-listed and found that decision-making was both appropriate and proportionate.

Children remained listed until such time as there was evidence of sustained improvement in the levels and quality of parental care. Cases that had been de-listed, but where children remained open to the child protection and welfare teams had evidence of clear decision-making in relation to the continuation of additional supports where this was required. While there was evidence of parents routinely receiving letters to advise them their children were de-listed from the CPNS; some children's case records did not evidence that An Garda Síochána or general practitioners (GPs) had been routinely informed of children no longer listed.

Strong multi-disciplinary and inter-agency working was evident at all stages of the child protection process in all case records reviewed. Child protection practice was in line with joint working policies and supported effective partnership working. The approaches taken made good use of the expertise of partner agencies and community networks. A wide range of agencies were involved in providing a shared response to meeting children's needs and monitoring risks to their safety. For example, joint visits made with public health nurses helped strengthen the focus on the health risks and development needs of younger children including recognition of the impact of neglect. Child protection safety plans provided for additional counselling and rehabilitation support, parenting courses and family support workers to help parents with the development of child-centred routines and boundaries. Social workers advocated strongly in key areas such as re-housing and the provision of additional 1:1 support to help build children's self-esteem and promote their engagement in a range of social and leisure activities.

Service managers and frontline practitioners prioritised information-sharing and joint working with An Garda Síochána at a number of levels. This included active participation by senior managers within joint liaison meetings and the promotion of a partnership approach that supported regular sharing of information about children on the CPNS through strategy meetings, joint visits and out-of-hours welfare checks. Good joint working with An Garda Síochána (AGS) and domestic violence support agencies enabled targeted support and ongoing monitoring of risk to children exposed to violence within their family home.

Senior managers had also strengthened their networks with locally-based public health directors and frontline nursing, disability and allied professionals. There was, for example, established meetings Health Service Executive (HSE) managers to promote shared understanding of each other's individual and joint accountabilities. This supported a wider shared response in line with the national safeguarding approach. This had, for example, led to stronger scrutiny of risks to unborn babies and younger children.

<p>Standard 2.6 Children who are at risk of harm or neglect have child protection plans in place to protect and promote their welfare.</p>
<p>Child protection conferences overall were timely and well-managed and provided an open and transparent framework for discussion about risks to children and of parental motivation and capacity to change. The quality of child protection safety plans overall was of a satisfactory standard; and social workers and their managers had a good understanding of current risks. However, in some cases, safety plans had not been sufficiently reviewed and updated, and home visits and network support meetings had not taken place in line with the expected frequency set out within child protection safety plans.</p>
<p>Judgment Substantially compliant.</p>
<p>Standard 2.7 Children’s protection plans and interventions are reviewed in line with requirements in Children First.</p>
<p>Review child protection conferences (RCPCs) occurred at regular intervals in line with <i>Children First</i> guidance. Where delays existed, these were clearly documented and effectively recorded. RCPCs provided a clear structure for monitoring the safety and welfare of children listed on the CPNS; with additional support provided in response to escalating risk or changes in the circumstances of children and their families. Decisions to de-list children from the CPNS were appropriate, and cases were closed or redirected effectively. While parents were routinely informed of their children being made inactive on the CPNS; children’s records did not always evidence that An Garda Síochána and GPs had been formally advised.</p>
<p>Judgment Substantially compliant</p>
<p>Standard 2.9 Interagency and inter-professional cooperation supports and promotes the protection and welfare of children.</p>
<p>The service area’s child protection service had strong multi-agency and multi-disciplinary information-sharing and joint working arrangements at all stages of child protection processes. This helped ensure a shared response to meeting children’s needs and monitoring risks to their safety.</p>
<p>Judgment Compliant</p>

Compliance Plan for Dublin South West, Kildare, West Wicklow Child Protection and Welfare Service OSV – 0004419

Inspection ID: MON-0036389

Date of inspection: 5-7 April 2022

Introduction and instruction

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

This document is divided into two sections:

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

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

A finding of:

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

Section 1

The provider is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk

rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Standard Heading	Judgment
Standard 3.1	Substantially compliant
<p>Outline how you are going to come into compliance with Standard 3.1: The service performs its functions in accordance with relevant legislation, regulations, national policies and standards to protect children and promote their welfare.</p> <ul style="list-style-type: none"> ➤ The area will continue to ensure that Tusla led safety plans are developed for these children/young people using the safety planning approach that Tusla undertake in abuse cases but reference as a child welfare response in Children First. Such planning involves the development of networks of both informal and professional support people and a high level of interagency collaboration. Quarterly audits on safety planning will continue across the area; ➤ KWW/DSW are part of a national pilot project currently underway in 5 areas which is focused on 'low harm/high need referrals'. The first step of this project is to review these cases to identify the key themes and issues with a view to engaging other disciplines that could potentially support safety and support planning with these families. Involvement of the area is at the planning stage with the review work to be completed by the end of June 2022; ➤ CPC chairs will continue to be actively involved in regional and national working groups to support the implementation of Tusla's national child protection development programme. These meetings provide opportunities for peer challenge, sharing of learning, and ongoing review of the effectiveness of policies and procedures; ➤ The area's Child Protection Service Plan (2022) sets out clear goals to promote a high quality and consistent standard of organisational performance and this will continue to be monitored throughout 2022; ➤ Children/young people that present with complex needs and behaviours will continue to be referred to Case Reviews for discussion with senior managers and chaired by the Area Manager. 	
Standard 3.2	Not Compliant
<p>Outline how you are going to come into compliance with Standard 3.2: Children receive a child protection and welfare service, which has effective leadership, governance and management arrangements with clear lines of accountability.</p> <ul style="list-style-type: none"> ➤ Capacity within the Child Protection and Welfare Pillar will be reviewed by Quarter 3 2022 with a view to the informing the Areas Service Plan for 2023. This work will be completed in conjunction with the Regional Chief officer; ➤ The QRSI Social Work Team Leader will complete quarterly audits in relation to the monitoring of safety plans and the evidencing of this work on NCCIS. The outcome of these audits will be monitored by the CPC Chairs and the PSW for Child Protection and Welfare; 	

- Quarterly CPC workshops will continue to be provided to Children Protection and Welfare staff and will include CPC Safety Planning;
- CPC Chairs and QRSI team leader will collate information on all cases due for a RCPC at the 2 monthly point i.e. 3 months prior to their review being due, to audit the file and establish if the CPC Safety Plan is being monitored and progressed in line with the ICPC. The CPC coordinator will pull the list of these files each quarter and send the list of these cases to the CPC Chairs and PSW for Child Protection and Welfare and the QRSI Team Leader. The outcome and actions required following this audit will be uploaded to NCCIS and sent to the PSW for Child Protection and Welfare, the Team Leader and the Social Worker. The cases identified as requiring action by a Team Leader and Social Worker will be discussed in supervisions.
- An area wide Supervision audit was completed in January 2022 and feedback sessions on the findings of the audits have been scheduled for all staff in May 2022 and October 2022.

Standard 2.6

Substantially Compliant

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

- KWW/DSW will be involved in a Safety Planning Learning and Development Programme. The programme is designed to deliver in-depth understanding of what is required in practice to ensure that Safety Planning as a process in case work is applied. The target audience are teams who are working with families who are post-IA and the decision has been made for either safety planning or child protection safety planning. The aim is to improve child protection and welfare practice, to promote rigorous and robust safety planning that increases safety for children. A two day 'Safety Planning in Action' workshop has been scheduled for June 2022. Virtual training will also be available to staff on Safety Planning/Roadmap workshop and Building Safety Plans with families & their network, delivered by Tusla Learning and Development.
- The CPC Chairs and QRSI team leader will look at all cases due for a RCPC at the 2 monthly point i.e. 3 months prior to their review being due to audit the file and establish if the CPC Safety Plan is being monitored and progressed in line with the ICPC. The CPC coordinator will pull the list of these files each quarter and send the list of these cases to the CPC Chairs and PSW for CPW and QRSI who will agree who will audit the cohort of files pulled. This will be monitored through supervision
- When signing off on minutes CPC chairs will ensure that the safety plan has been launched and uploaded onto NCCIS. This action has already been put in place in the area;
- Safety plans are to be included as a standard item in supervision. Supervision records will note any changes/amendments to plan, including the rationale for these and the fact that the discussion took place between the worker and the line manager.

Standard 2.7	Substantially Compliant
<p>Outline how you are going to come into compliance with Standard 2.7: Children’s protection plans and interventions are reviewed in line with requirements in Children First.</p> <ul style="list-style-type: none"> ➤ The new CPC templates have developed a standardised letter to send to An Garda Siochana when a child is listed/delisted from the CPNS. The area will continue to inform Gardaí after a child is listed and de-listed from the CPNS; ➤ The decision to de-list is recorded in the CPC record and in line with the CPC Guidelines, a copy of the record is sent to the Gardaí, PHN if the child is under 6 years and the child’s GP, regardless of their attendance at the CPC. While there is no requirement in the CPC Guidelines for GP’s to be informed of a child being de-listed from the CPNS, the area will develop a standardised letter to be sent to the child’s GP outlining if a child is de-listed. This communication will take place in writing and a copy of same will be uploaded to the child’s record on NCCIS. This will be in place from June 2022 	

Section 2: Standards to be complied with

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

The provider has failed to comply with the following standards(s).

Standard	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Standard 3.1	The service performs its functions in accordance with relevant legislation, regulations, national policies and standards to protect children and promote their welfare.	Substantially Compliant	Yellow	Ongoing throughout 2022
Standard 3.2	Children receive a child	Not Compliant	Orange	30/09/2022

	protection and welfare service, which has effective leadership, governance and management arrangements with clear lines of accountability.			
Standard 2.6	Children's protection plans and interventions are reviewed in line with requirements in Children First.	Substantially Compliant	Yellow	Ongoing
Standard 2.7	Children's protection plans and interventions are reviewed in line with requirements in Children First.	Substantially Compliant	Yellow	Ongoing