Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

14 June 2018

Safer Better Care

About the Health Information and Quality Authority

The Health Information and Quality Authority (HIQA) is an independent authority established to drive high-quality and safe care for people using our health and social care services in Ireland. HIQA's role is to develop standards, inspect and review health and social care services and support informed decisions on how services are delivered.

HIQA aims to safeguard people and improve the safety and quality of health and social care services across its full range of functions.

HIQA's mandate to date extends across a specified range of public, private and voluntary sector services. Reporting to the Minister for Health and engaging with the Minister for Children and Youth Affairs, HIQA has statutory responsibility for:

- **Setting Standards for Health and Social Services** — Developing person-centred standards, based on evidence and best international practice, for health and social care services in Ireland.
- **Regulation** — Registering and inspecting designated centres.
- **Monitoring Children's Services** — Monitoring and inspecting children's social services.
- **Monitoring Healthcare Safety and Quality** — Monitoring the safety and quality of health services and investigating as necessary serious concerns about the health and welfare of people who use these services.
- **Health Technology Assessment** — Providing advice that enables the best outcome for people who use our health service and the best use of resources by evaluating the clinical effectiveness and cost-effectiveness of drugs, equipment, diagnostic techniques and health promotion and protection activities.
- **Health Information** — Advising on the efficient and secure collection and sharing of health information, setting standards, evaluating information resources and publishing information about the delivery and performance of Ireland's health and social care services.

Note on terms and abbreviations used in this report

A full range of terms and abbreviations used in this report is contained in a glossary at the end of this report

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Introduction and background to the investigation

On 9 February 2017, RTÉ television broadcast a Prime Time programme which revealed that the Child and Family Agency (Tusla) had sent a notification to An Garda Síochána (the Irish police force) containing a false allegation of child sexual abuse against a garda* whistle-blower, Sergeant Maurice McCabe. Tusla is the State's child protection and welfare agency, set up in 2014, with around 4,100 employees. In 2017, over 50,800 referrals were made to it.

In light of these circumstances and a concern about more systemic issues that may potentially require a response at a national level, the Minister for Children and Youth Affairs believed that the apparent poor handling by Tusla of information in this case indicated a possible 'serious risk to the health and welfare' of children who were the subject of child sexual abuse referrals to Tusla, including adults alleging abuse during their childhood where the alleged abuser may pose a risk to current children.

As a result, on 2 March 2017, the Minister of Children and Youth Affairs wrote to the Chairperson of the Health Information and Quality Authority (HIQA), formally instructing, in line with the Health Act 2007, [(1)] that HIQA carry out a statutory investigation under the Act. Furthermore, the Minister instructed HIQA to draw on its existing work in the monitoring of child protection and welfare services. On 8 March 2017, the HIQA Board approved the start of an investigation.

This report presents the findings of the HIQA investigation into the local, regional and corporate arrangements provided by Tusla to ensure the effective management of child sexual abuse referrals involving adults of concern, including allegations made by adults who allege they were abused when they were children (these are termed retrospective allegations). The report makes recommendations to improve the safety, quality and standards of services provided by Tusla in relation to referrals of allegations of child sexual abuse involving adults of concern.

HIQA's role in monitoring child protection and welfare services

Between 2014 and 2016, HIQA had conducted 12 inspections of Tusla child protection and welfare services, against the *National Standards for the Protection and Welfare of Children*, including child sexual abuse referrals.** These National Standards were approved by the Minister for Health and the Minister for Children and Youth Affairs in 2012.

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* Garda — the term for a police officer in Ireland.

** This investigation report refers to 12 inspections carried out by HIQA between 2014 and 2016, while HIQA's governance review in Appendix 10 reports on 14 inspections in a different time period during these years.

While there was evidence of good practice, particularly around responding to children who were at immediate risk of significant harm, HIQA inspectors found areas of significant concern which demonstrated inconsistencies in how Tusla ensured safe and effective child protection and welfare practice.

Examples of poor practice included high levels of unallocated referrals (where a named social worker has not been assigned to a case), unmanaged retrospective referrals, poor record-keeping, inconsistent risk management arrangements and difficulties with retention and recruitment. There were also inadequate quality assurance arrangements to effectively detect, manage and learn from deficiencies in practice identified during HIQA's monitoring and inspection programme.

Despite being brought to the attention of Tusla service areas during each inspection, these common shortfalls continued to emerge in inspections carried out throughout 2014 and 2015. Therefore, HIQA was not assured that the national governance arrangements within Tusla were adequately addressing these deficiencies in a systematic way. Because of this, in December 2015, in line with its powers under the Health Act 2007, HIQA started to review the governance arrangements in Tusla.

During the 2015–2017 review, there was evidence of a wide-ranging transformation programme within Tusla and abundant evidence of the considerable financial investment in terms of staff recruitment and training. Tusla had also indicated that it had significantly improved its governance structures. It also found the Child Protection Notification System, introduced in 2015, was accessible on a 24-hour basis across all service areas.

However, the 2015–2017 review also found a large number of child protection and welfare referrals that did not have a named social worker allocated to their case. There were inconsistencies in the identification, reporting and escalation of risk; inadequate managerial oversight at a local level, with poor practice and inconsistencies potentially not being actively addressed; and good practice was not being identified and shared.

The absence of an integrated information communications technology (ICT) system remained a significant risk to Tusla. There had been inconsistencies in the gathering and storage of data, and social worker recruitment challenges. It is in the context of the findings of HIQA's earlier governance review of Tusla that the Investigation Team looked at the governance and management structures during its 2017-2018 investigation.

Findings in relation to the management of referrals of child sexual abuse and referrals of retrospective child sexual abuse

In conducting this investigation, the HIQA Investigation Team was acutely mindful that the pathway that Tusla uses for managing child sexual abuse referrals is identical to its pathway for managing all child protection and welfare concerns. Therefore, these findings provide an insight into the governance and operational arrangements in place for all child protection and welfare concerns referrals and retrospective cases.

The Investigation Team found many examples of good practice by committed Tusla personnel in how they manage allegations of child sexual abuse and retrospective abuse. Similar to earlier inspection findings, Tusla appropriately responded to children who were judged to be at immediate and serious risk of harm. In these situations, there was good cooperation between Tusla and An Garda Síochána in taking protective action to ensure that children were safe. Furthermore, Tusla has strategically developed service-area-based dedicated teams and one regional-based team for retrospective cases and there was evidence to show that this approach is helping to increase the effectiveness of how retrospective child sexual abuse referrals are managed.

In line with the Terms of Reference of this investigation and in response to the Minister's concern as to systemic risk to children, the Investigation Team reviewed the systems in place in six of Tusla's geographical service areas and in one Sexual Abuse Regional Team (SART) in the Tusla Dublin North East Region to ensure Tusla effectively and safely manages all child sexual abuse referrals, including retrospective referrals. The investigation identified three defective points in Tusla's system of managing such referrals, which Tusla must now address as a matter of urgency:

a. screening and preliminary enquiry

b. safety planning

c. management of retrospective cases.

A. Screening and preliminary enquiry

This investigation found inconsistencies in practice around the screening of allegations and making preliminary enquiries, which meant that not all children at actual or potential risk were being assessed and where necessary, protected by Tusla, in a timely and effective manner.

B. Safety planning

Inconsistencies in safety-planning practice meant that while some children were adequately safeguarded, others at potential risk were not. Even for children who had a safety plan, these plans were not always reviewed to ensure the continued safety and wellbeing of the child.

C. Management of retrospective cases

While there was a policy on managing allegations made by adults of abuse during their childhood, it did not include a standardised approach to direct and guide staff in case management, leading to variation in practice and delays. Some people were not told that an allegation of abuse had been made against them and others were given only limited information.

The Investigation Team found that while Tusla focused on examining current risks to children, this often resulted in a lack of urgency in responding to retrospective allegations of abuse against adults of concern. This meant that children who are potentially at risk — from adults who are alleged to have abused children in the past, and or who were convicted of child sexual abuse in the past, and who now have access to other children — may be missed.

Omitting and or not fully completing any stage in the management of child sexual abuse referrals will invariably impact on the adequacy and or timeliness of any intervention put in place to mitigate risk to vulnerable children. This systemic risk is increased when the child protection and welfare staff who are operationally responsible are unclear about the steps they need to take or fail to adhere to them and or there is no formal guidance in place to begin with.

Keeping clear, contemporaneous and accurate records for each child ensures that there is a documented account of decisions taken to protect children. The child's or adult's record is an essential source of evidence for investigations and enquiries, and may also be required to be disclosed in court proceedings. Good quality records help with continuity of social work support whenever individual social workers are unavailable or when the named social worker on a case changes, and they provide an essential tool for managers to monitor work practices or for peer review.

The Investigation Team found that the quality of record-keeping varied widely in those service areas reviewed and, therefore, could not assure HIQA about the quality and effectiveness of Tusla's child protection and welfare service. For example, the Investigation Team reviewed 164 cases reported as closed in the six service areas and could not establish if some of the cases reviewed were actually closed. Furthermore, the Investigation Team found cases which were inappropriately closed as there were outstanding child protection concerns.

A central principle of the Child Care Act, 1991 is that the child's welfare and protection is paramount and is at the core of all child protection and welfare practice. Tusla staff frequently cited ongoing criminal investigations by the Gardaí for some of the delays in starting and completing assessments of child sexual abuse allegations, including retrospective allegations. It is imperative that Tusla ensures its own operational arrangements and cross-agency working practices do not allow criminal investigations to impede its statutory duty to safeguard children.*

Tusla has a duty from the outset to act fairly, proportionately and in line with the principles of natural and constitutional justice. The Investigation Team found that in the majority of cases, Tusla told persons subject of an abuse allegation whether or not the allegation against them was established or not at the end of the process. However, there were inconsistencies in the level of detail about the allegation communicated to these people, and delays to the start of the assessment, the assessment itself and the conclusion. Such delays could affect a person's ability to respond to their case adequately and this could present challenges for Tusla.

In October 2017, midway through this investigation, in line with the Terms of Reference and as a result of its findings, HIQA wrote and subsequently met with the Minister for Children and Youth Affairs, officials at her department, Tusla's senior management team and a Tusla board representative. These meetings were to highlight that the findings at that juncture concurred with the view that there were systemic risks to children which Tusla should address to ensure the effective management of allegations of child sexual abuse against adults of concern. In addition, HIQA highlighted evidence that this systemic risk may potentially extend across the wider child protection and welfare service, given the identical referral pathways involved.

* In May 2018, the Investigation Team received a copy of Tusla's Policy Submission to the Department of Children and Youth Affairs in respect of Section 3 of the Child Care Act, 1991, dated 9 October 2017.

Findings in relation to governance, leadership and management

The Investigation Team does not underestimate the amount of work that Tusla's board and executive have undertaken and achieved to embed the organisation during its four years in existence, particularly in the areas of corporate governance and management structures. There is now a clear strategic direction, and a long-term vision of what Tusla wants to achieve. The quality of its public and internal documentation, policy papers, information and communications is of a very high standard.

Tusla's governance structures are underpinned by a quality improvement framework, risk management policies, business planning processes, and many supporting policies and processes. However, they are not comprehensively and consistently embedded in front-line practice in the services areas visited by the Investigation Team. In those areas, there was evidence that staff neither fully understood Tusla's standardised processes or policies, or implemented or adhered to them. At the time of the investigation, potential poor performance was not being detected or corrected.

At a regional and corporate level within Tusla, there was evidence of insufficient oversight to assure its executive and board that staff are adhering to these corporate-wide procedures. Therefore, there is a system-wide risk in delivering a consistent and sustainable child protection and welfare service. While Tusla is moving towards a more responsive service to children and their families, this will only be achieved whenever the governance arrangements ensure clear accountability and effective managerial oversight.

Streamlined risk and quality assurance processes are also required. Nevertheless, those Tusla staff that the Investigation Team met with were openly committed to child protection and welfare. Indeed in some service areas visited, managers openly took on board the investigation's findings at that time and immediately addressed those risks identified.

The establishment of Tusla in 2014 brought approximately 4,000 staff together from a number of existing agencies, with a range of embedded cultures and long-established operational, performance and management practices. While efforts were being made to develop a culture of working together, the Investigation Team did not find strong evidence to suggest that opportunities to promote a culture of learning through the organisation have been maximised. Neither did the Investigation Team find strong evidence of effective staff training and development or detection of poor staff performance which could address the aforementioned risks.

The Investigation Team welcomes the development by Tusla of its Child Protection and Welfare Strategy. This includes adopting the 'Signs of Safety'* programme as its national approach to practice. Tusla is confident that its full implementation will address some of the risks identified in this HIQA investigation. However, Tusla must now ensure that in the interim, it addresses the systemic deficiencies identified by HIQA in Tusla's governance and support arrangements. This is necessary to ensure the effective and sustainable management of child sexual abuse referrals involving adults of concern, including allegations of retrospective child sexual abuse.

Findings in relation to workforce

The Minister for Children and Youth Affairs initially requested HIQA to include in this investigation an assessment of the number, skill-mix and adequacy of staffing levels. However, a comprehensive workforce assessment was outside the scope and competencies of this investigation. Notwithstanding, in line with the Terms of Reference, the Investigation Team examined how Tusla staff were adequately supported to confidently and effectively manage child sexual abuse referrals involving adults of concern, including allegations of retrospective child sexual abuse.

A shortage of qualified social work staff is undoubtedly contributing to delays in the appropriate management of referrals and the early assessment of children at risk. In response, Tusla had taken a number of steps to try to attract and retain social work staff. Despite this, Tusla only managed an increase of 12 whole-time equivalent social workers nationally between November 2016 and November 2017. The lack of available social work graduates is key to this poor return, but Ireland is not alone in experiencing such a shortage.

The Investigation Team believes the impact on Tusla from a shortage of qualified social workers in a number of jurisdictions are exacerbated by internal factors within Tusla, such as workforce allocation and staff training and development. Its supervision and caseload management systems, while appropriate in theory, were being inconsistently applied in practice in the service areas visited by the Investigation Team. In addition, the quality of personal development plans, a key element of staff supervision, varied widely and were not in place for all staff.

In addition, the Investigation Team believes Tusla's failure to consistently provide training to its front-line child protection and welfare staff on its national policy and procedures on managing allegations of abuse was a serious shortcoming. This was further compounded by the finding that some line managers providing social work practice supervision did not have the appropriate training in managing child sexual abuse referrals, including retrospective allegations.

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* Signs of Safety: national approach to practice within Tusla which provides a range of tools for assessment and planning, decision-making and engaging children and families.

It is evident that some staff feel they are spending too much time on administrative and on overly-bureaucratic tasks, rather than building relationships with people using the service. While HIQA recognises the need for good quality record-keeping for many valid reasons, Tusla needs to develop a workforce environment where social workers and social care workers can enjoy doing the core job they were trained for and are qualified to do. Such an approach should contribute to greater retention of staff and allow others to take on extra responsibilities.

And while Tusla undoubtedly believes it is currently under-resourced in terms of social work staff in particular, the Investigation Team did not find a comprehensive strategic approach to workforce planning within the organisation that was informed by the reality of the global jobs market. Little evidence was found of attempts to identify efficiencies and improvements in work flow or evidence of consideration of upskilling other social care disciplines or formal role enhancements, along with targeted educational strategies with third-level institutions.

Tusla in conjunction with the Department of Children and Youth Affairs has to manage the same workforce challenges faced by other jurisdictions and, as a relatively young organisation, avoid an organisational mind-set that sees such problems as insurmountable due to factors outside its control.*

Findings in relation to use of information

There is no doubt that Tusla was significantly restrained and challenged by the absence of and or poor deployment of information communication technology (ICT) systems. Tusla had made much progress in relation to addressing information communication technology (ICT) deficits previously identified by HIQA, by securing additional ICT funding, the establishment of an ICT directorate within the organisation and the development of an ICT strategy.

These measures should support Tusla to meet its business and strategic needs and will decrease its dependency on assistance from the Health Service Executive (HSE) for the ICT supports that the HSE currently provides to Tusla. At the time of this investigation, the National Child Care Information System (NCCIS) was developed and being rolled out across the service. When fully implemented (Tusla has set a target date of July 2018 for full implementation), the National Child Care Information System should provide an integrated child welfare and protection system that records each stage of referral from first contact through to case closure.

* Tusla reported in June 2018 that it has commissioned an external consultancy to conduct a workforce planning exercise.

The success of this system will be improved through providing essential equipment, such as computers and laptops, and associated training and support, to front-line social work departments without delay.*

Notwithstanding these achievements, Tusla continues to face significant challenges in relation to the quality of its record-keeping and the information that it gathers. The Investigation Team found a number of shortfalls in the management of information about child sexual abuse allegations, including those allegations made by adults about alleged abuse when they were children. Staff were not adhering to Tusla's guidance on maintaining records and there was a failure by Tusla to implement internal audit findings in relation to this.

Because Tusla will continue to use paper records for retrospective and adult cases, following the roll out of the National Child Care Information System, the risks and inefficiencies associated with paper-based records will remain a challenge for Tusla. While the new ICT system and its three-year ICT strategy should contribute to standardising data recording, they cannot alone assure the quality of the records themselves. Therefore, training will be required to ensure child protection and welfare practice is accurately recorded and maintained — a key requisite for effective and transparent decision-making about children's safety.

Findings in relation to bilateral engagement between Tusla and An Garda Síochána and external agencies

This investigation focused exclusively on Tusla's management of child sexual abuse referrals. However, in order to explore how well Tusla worked with An Garda Síochána and relevant external agencies, the Investigation Team held a number of focus group meetings with Tusla staff, members of the Gardaí and external agencies across the six service areas visited. Senior members of the Garda National Protective Services Bureau also met with members of the Investigation Team to discuss cooperation with Tusla.

Tusla has statutory responsibility for child protection and welfare services. In order to do this effectively, Tusla and An Garda Síochána need to work closely together in the best interest of those children who are the subject of child sexual abuse allegations and those adults who allege that they were sexually abused when they were children.

While there was a system in place for the notification of suspected child sexual abuse between An Garda Síochána and Tusla, there was no electronic data transfer interface between the ICT systems in both agencies. Instead, these notifications have to be sent by fax or posted.

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* Tusla reported in June 2018 that the majority of social workers had been provided with laptops, mobile phones and wireless Internet devices.

This is neither efficient, appropriate nor wholly secure given that these notifications relate to allegations or suspicions of child abuse. There are plans for electronic transfer of notifications to start in 2019.

Although there are a number of established forums for interagency working between both agencies, such as strategy meetings and liaison meetings, the Investigation Team found that many aspects of these forums need to improve. Record-keeping to clearly reflect their discussions was inconsistent across the six Tusla service areas visited by the HIQA Investigation Team. In addition, there was no agreed information-sharing protocol to facilitate good sharing of relevant information and which has the confidence of both agencies.

This resulted, in some cases, in difficulties in identifying risks to children in a timely manner. There were also evidence of lengthy delays in responding to requests by Tusla for additional information from An Garda Síochána, which led to delays in creating informed safety plans for children. Conversely, members of the Gardaí reported that requests to Tusla for written reports were often delayed, and when provided, lacked the information which had previously being relayed verbally and which was needed to support criminal proceedings.

Joint-specialist interviewing of children by the Gardaí and Tusla (where a child is jointly questioned at the same time by a social worker and a garda) was acknowledged at interview and group meetings as a key element in assessing an allegation of child sexual abuse. However, very few social workers are trained in specialist interviewing, training for which is coordinated and facilitated by the Gardaí. Joint-specialist interviewing should become standard practice, but can only happen with a significant increase in trained Tusla and Garda interviewers.

In spite of these challenges, it was reported that there are good informal working arrangements between members of the Gardaí and Tusla staff. In addition, it is anticipated that a new Tusla and An Garda Síochána Children First joint-protocol for liaison between both agencies, agreed in December 2017, should formalise these processes.

The Investigation Team found that the arrangements for providing allied support services such as specialist therapeutic and medical services to support the management of allegations of child sexual abuse were not equitable and largely depended on available resources within a particular area or county. Future provision and investment in child protection and welfare services would benefit from an analysis of the availability and capacity of resources accessible to Tusla service areas to support the management of child sexual abuse referrals. This would also highlight the likely impact of resource deficits wherever they may exist.

While the Investigation Team was informed of examples of effective interagency working at local level, it was also informed of concerns about delayed responses in one service area by Tusla to referrals of retrospective child sexual abuse made by external agencies working with children. In addition, the variation in practice with regard to formal service-level arrangements at local, national and or regional level between Tusla and external agencies working for Tusla represents a missed opportunity for enhanced interagency working in the best interests of children.

Conclusion

Concerns about the handling of information by Tusla in relation to a garda whistle-blower led the Minister for Children and Youth Affairs to direct HIQA in March 2017 to carry out a statutory investigation to assess whether there were systemic issues in Tusla that constituted a serious risk to the health and welfare of children. In informing its findings, the Minister expected HIQA to draw on its existing child welfare and protection inspections and its prior governance review of Tusla. The year-long HIQA investigation determined that these risks existed.

There is no doubt that the creation of Tusla as a national agency in 2014 for the protection of children and families at risk is a positive development. It would be remiss to underestimate the national investment, planning, negotiation and coordination required to set up Tusla. HIQA acknowledges that Tusla has had significant hurdles to overcome, none greater than its initial over-reliance on the HSE for information management support and the bringing together of approximately 4,000 staff, often with differing cultures, traditions and work practices.

It is evident that considerable strides have been made by Tusla to become established and to create a governance structure that should provide assurance to the public that children at risk are effectively assessed and protected in a timely and proportionate manner. Without question, this investigation found evidence that the shortage of qualified social work staff within Tusla is contributing to delays in the appropriate management of referrals and the early assessment of children at potential risk.

Notwithstanding evidence of positive strategic developments within Tusla, the evidence of good front-line practices seen in the service areas visited, and the committed Tusla staff that the Investigation Team met with, the shortcomings found in this investigation are a further reflection of HIQA's previous findings in its inspection and monitoring of child protection and welfare services, which includes child sexual abuse referrals, since Tusla was created in 2014.

Some children are being left at potential risk due to failures at operational level to consistently implement Tusla's national policies and business processes; to accurately record important decisions made and actions taken; to monitor the effectiveness of the steps taken to protect children; and to support staff members' personal development, day-to-day practice and skill set. These failings stem from a gap between national Tusla policies and business processes and what is actually happening on the ground.

Given that HIQA has repeatedly identified these risks in its previous inspection and monitoring activity, and given that it raised similar concerns in its previous review of the governance of Tusla, it is of the utmost concern to HIQA that Tusla's corporate governance systems have failed to effectively share learning across Tusla's 17 service areas from adverse findings by HIQA, whose statutory role is to promote quality and safety in these services.

In moving towards providing a more responsive service aimed at supporting and protecting children and families, Tusla must face a number of challenges. These challenges particularly relate to the planning and provision of a skilled and competent workforce to meet service demand, the use of validated information that informs future policy and strategic service planning and the provision of effective ICT systems. While the implementation of the Signs of Safety initiative is at the core of Tusla's strategic direction for child protection and welfare services over a five-year period from 2017, current challenges and systems risks require immediate attention as not all will be addressed by introducing Signs of Safety alone.

In the interim, the deficiencies in the current arrangements that have been identified in this investigation must be addressed to safely manage referrals of allegations of child sexual abuse and retrospective allegations against adults of concern. These referrals follow the same pathway as all child protection and welfare referrals, therefore raising the prospect of these deficiencies being replicated elsewhere in the child protection and welfare system. Concurrently, there was little evidence found that Tusla is systematically seeking out and sharing good practice across its 17 service areas.

In order to ensure that improvements are sustainable in the longer term, it is imperative that such improvements are supported by risk, quality and information management systems which are embedded in practice at all levels throughout the organisation. It is for this reason that the recommendations contained throughout the report relate to the need for Tusla to review, design and implement a nationally consistent approach to effectively managing waiting lists across all 17 service areas.

There must be a shared understanding of and consistent approach to safety planning, and there must be strengthened managerial oversight and accountability structures in place to ensure that Tusla staff adhere to good policy and processes.

The disparity between Tusla policy at national level and local practice on the ground, in addition to almost universal reports in risk registers across the country about inadequate staffing levels, represents a serious ongoing challenge to providing safe and sustainable management of child sexual abuse allegations.

Despite the measures introduced by Tusla to recruit more social workers, the organisation remains beset by insufficient numbers of social work staff. However, Tusla cannot rely on recurring staff shortages as a default reason for failing to deliver a more efficient and safer service to children and their families. In the absence of a strategic approach to workforce planning, such as using other staff disciplines to support the role of the social worker, staff shortages will continue to directly impact on the timely management of child protection and welfare referrals.

Tusla's new integrated information and communications system, while a key positive development, cannot assure the quality of the records inputted into the system. The Investigation Team also remains concerned that Tusla will continue to operate a paper-based system for retrospective and adult cases nationally. This makes it imperative to provide clear guidance and support for staff on the appropriate storage of sensitive information about persons who are the subject of allegation of abuse, in particular when such information is held on the complainant's file.

HIQA acknowledges efforts to improve working arrangements and information sharing between Tusla and An Garda Síochána, introduced in the latter part of 2017. HIQA welcomes the new Tusla and An Garda Síochána Children First joint-protocol for liaison between both agencies. This joint-protocol — along with an improved training scheme for joint-specialist interviewing — should, if fully implemented, address the deficiencies identified by this investigation in the bilateral interactions between Tusla and An Garda Síochána.

However, it must be accompanied by an agreed information-sharing protocol to facilitate the effective sharing of information which has the confidence of both agencies. Similarly, in order to ensure that joint-specialist interviewing of children by Tusla and the Gardaí becomes standard practice nationally, measures must be put in place to significantly increase the numbers of existing social workers trained to conduct joint-specialist interviewing with the Gardaí.

Finally, the impact of this investigation's findings depends on the recognition of those with responsibility at executive and board level in Tusla that management of all allegations of child sexual abuse follows the same referral pathway as child protection and welfare referrals. As such, there is a significant risk that the deficiencies identified during this investigation in the pathway for allegations of child sexual abuse in a sample of the services provided by Tusla may be replicated across the wider child protection and welfare services.

Moving forward

While HIQA acknowledges Tusla's work to date to merge child protection, early intervention and family support services, Tusla now has to address the risk and deficiencies identified within this report. This is necessary in order to improve how child sexual abuse referrals and retrospective cases are managed. Tusla must also ensure that it addresses as a matter of urgency similar risks and deficiencies which may exist in the broader management of all child protection and welfare referrals.

It is vital that Tusla's governance structures to support the implementation of the findings and recommendations of this investigation report are clear, and include a named accountable person within Tusla who has the overall delegated responsibility for implementing these recommendations. The associated implementation and or action plans should include clear timelines against each action and identified individuals in Tusla who are responsible for implementing those actions.

HIQA acknowledges the progress to date by Tusla in its efforts to improve the quality and safety of services. These include:

- the appointment of a director of ICT and chief social worker within Tusla and the roll-out of the National Child Care Information System (NCCIS) and its ICT Strategy
- the planned implementation of its Child Protection and Welfare Strategy
- the project management approach being taken by Tusla to the NCCIS and these strategies
- setting up of an additional three dedicated regional teams to manage retrospective allegations of abuse
- training initiatives with the specific purpose of improving governance and oversight activity at service director, area manager and principal social worker grades
- Tusla plans to improve performance information and reporting; quality assurance and monitoring; and risk and incident management.

HIQA — in consultation with Tusla, the relevant professional organisations and children's advocacy groups — will begin the design in 2018, based on the findings of this investigation, an inspection programme to promote improvement in child protection and welfare services. In addition, in 2019, HIQA will begin to develop revised National Standards for Children's Social Services. The standards should cover all support and protection services from the point of referral until discharge of the child or client from the service.

To inform the development of a regulatory framework for children's social services in Ireland, HIQA will assist the Department of Children and Youth Affairs in reviewing international best practice in the regulation of children's services. Given the significant system-wide recommendations outlined in this report, it will be vital that there is the necessary political commitment to their managed implementation in order to promote sustainable improvements in the quality and safety of all child protection and welfare services.

Therefore, HIQA recommends that the Minister for Children and Youth Affairs should set up without delay an oversight committee in the Department of Children and Youth affairs to ensure the recommendations contained in this HIQA investigation report are implemented. The roll out of this report's recommendations provides an opportunity to build upon the essential work being carried out by Tusla and to learn from adverse events in a meaningful way for the betterment of services to protect Ireland's most vulnerable children.

Recommendations

1. The Child and Family Agency (Tusla) should:

A. review all of the findings of this investigation, including the identified non-compliances with the *National Standards for the Protection and Welfare of Children* as set out in this investigation report

B. review these findings as they relate to all other child protection and welfare referrals, which follow the same referral pathway as all child sexual abuse referrals

C. review all of the recommendations made by the Investigation Team throughout this report

D. publish an action plan on its website outlining in clear language and with clear timelines the measures it proposes to take to implement the actions identified in the recommendations A to C above. This action plan should include a named person or persons with responsibility and accountability in Tusla for implementing these recommendations and actions.

E. ensure it continually reviews and updates this action plan and that updates on progress being made against these recommendations and actions are included in its annual report.

2. As a matter of urgency, Tusla and the Department of Children and Youth Affairs should seek the assistance of the higher education and training establishments to create formal career-path mechanisms for students and graduates to support current and future workforce needs in Tusla, with the aim of providing a sustainable child protection and welfare service.

In the interim, Tusla and the Department of Children and Youth Affairs should review the current operational arrangements in Tusla to identify efficiencies and improvements in workflow. This should include a review of the existing social worker, social care worker and support staff skill-mix, and the development of a workforce strategy.

3. The Department of Children and Youth Affairs, with the assistance of the Health Information and Quality Authority (HIQA), should undertake an international review of best practice in the regulation of children's social services in order to inform the development of a regulatory framework for these services in Ireland. This is with the view to providing independent assurance to the public that the State's child protection and welfare services are safe and effective.

4. The Department of Children and Youth Affairs should establish an expert quality assurance and oversight group to support and advise Tusla and the Department on the implementation of the recommendations of this investigation report and Tusla's Child Protection and Welfare Strategy and Corporate Plan. The Department of Children and Youth Affairs should provide regular updates on its website to inform the public of the progress being made.

Chapter 1
Introduction and methodology

1.1 Introduction

This report presents the findings of the investigation by the Health Information and Quality Authority (HIQA) into the management of allegations of child sexual abuse by the Child and Family Agency (Tusla)* against adults of concern, in line with the investigation's Terms of Reference (see Appendix 1).

1.1.1 Background

On 9 February 2017, RTÉ broadcast a *Prime Time* television programme which revealed that the Child and Family Agency (Tusla) had sent a notification to An Garda Síochána (Ireland's National Police Service, also known as the Gardaí) containing a false allegation of child sexual abuse against Garda Sergeant Maurice McCabe, a Garda whistle-blower.[(2)] The programme raised questions about the role of Tusla in relation to the management of this false allegation, which it had received in August 2013 from another agency.**

While a social worker sought a meeting with the Gardaí within days of receiving the allegation, a formal notification from Tusla containing the false allegation against Sergeant McCabe was not sent to the Gardaí until 2 May 2014, over eight months later, the programme had reported. While Tusla had become aware in May 2014 that the allegation was false, Sergeant McCabe first learned of the allegation in January 2016, when in December 2015 a Tusla child protection social worker wrote to him to inform him that Tusla was investigating him for alleged child sexual abuse.

Prime Time also reported that in June 2016, the same social worker wrote to Sergeant McCabe's solicitor and stated a mistake had been made and that no allegation of child sexual abuse had been made against him. Tusla later wrote to the Secretary General of the Department of Children and Youth affairs on 27 January 2017, acknowledging that an error had occurred in the management of this matter and that an internal case review had been instituted.[(2)]

* The Child and Family Agency (Tusla) was established on 1 January 2014 following commencement of the Child and Family Agency Act (2013). It is mostly referred to hereafter in this report as 'Tusla' or occasionally as 'the Agency'.

** This was reported by the Prime Time broadcast as having being notified by a counsellor.

In light of these circumstances and a concern about more systemic issues that may potentially require a response by Tusla at national level, the Minister for Children and Youth Affairs believed that the apparent poor handling by Tusla of information in the Garda whistle-blower case indicated a possible 'serious risk to the health and welfare' of children in respect of whom referrals have been made to Tusla.

As a result, on 2 March 2017, the Minister wrote to the Chairperson of HIQA, formally instructing in line with Section 9(2) of the Health Act 2007[1] that HIQA carry out a statutory investigation (the 'investigation') under Section 9(1) of the Act. This investigation would be into the management of allegations of child sexual abuse by the Child and Family Agency (Tusla) against adults of concern. A copy of this correspondence is included in Appendix 2.

1.1.2 Establishment of the HIQA investigation

On 8 March 2017, the HIQA Board considered the concerns of the Minister and it approved the commencement of an investigation under Section 9(1) of the Health Act 2007. The Terms of Reference for the investigation were approved by the Board of HIQA on 8 March 2017 and subsequently published on 30 March 2017.

1.1.3 How this investigation report is structured

This report is divided into 9 chapters, as follows:

Chapter 1. Introduction and methodology

Chapter 2. Setting the scene of the investigation

Chapter 3. Findings on leadership, governance and management

Chapter 4. Findings on management of child sexual abuse referrals, including retrospective allegations against adults of concern

Chapter 5. Findings on workforce

Chapter 6. Findings on use of information

Chapter 7. Findings on bilateral engagements between Tusla and An Garda Síochána and other external agencies

Chapter 8. Conclusions and recommendations

Chapter 9. References.

This report is supported by a glossary of terms and abbreviations used and a number of appendices to provide the reader with additional information. In addition, the report contains a number of explanatory footnotes, and contains references that are identified by a superscript number in the body of the report. These references are listed at the end of the report.

1.2 Methodology

1.2.1 Overall approach

In keeping with HIQA's mission and corporate values, the Investigation Team has aimed to ensure fairness and due process throughout the investigation process while fulfilling its mandate under the Health Act 2007 to thoroughly investigate in the public interest the matters set out in the Terms of Reference.

Based on the Terms of Reference published by HIQA on 30 March 2017, this investigation examined the safety, quality and standards of services provided by Tusla in relation to referrals of allegations of child sexual abuse against adults of concern. As directed by the Minister in her letter of 2 March 2017, the Terms of Reference set out that HIQA's investigation should take all necessary steps to avoid the potential for overlap with the Tribunal of Inquiry established to inquire into certain protected disclosures arising from the protected disclosures made by Garda Sergeant Maurice McCabe (the 'Tribunal'). In particular, the Minister directed that any files

> *'relating to allegations of child abuse that come within the terms of reference of the Tribunal and, in particular, files concerning allegations of abuse of children against members of An Garda Síochána, are formally excluded from the Authority's investigations'.*

The findings from HIQA's ongoing programme of inspections of Tusla, carried out against the *National Standards for the Protection and Welfare of Children* (2012) — referred to in this report as the National Standards[3] — helped to inform the lines of enquiry (questions to be addressed) of the investigation. This approach aimed to identify opportunities to improve the arrangements that Tusla has in place locally, regionally and nationally to ensure the effective management of child sexual abuse referrals involving adults of concern (including allegations of child sexual abuse made by adults in relation to when they were children, termed retrospective referrals).

Following this approach and in line with the Terms of Reference of the investigation, the Investigation Team identified relevant lines of enquiry. It also reviewed and evaluated information through documentation and data review, interviews, focus-group meetings and case-record review, as described below.

HIQA established an internal governance and oversight board called the investigation programme board, in line with HIQA policy, to ensure this investigation would be conducted in line with the investigation's Terms of Reference.

In April 2017, HIQA published a guidance document which had been developed to provide information to relevant parties and the public in relation to the HIQA Investigation Team's approach to carrying out this investigation.[4]

1.2.2 Lines of enquiry

Lines of enquiry were developed by the Investigation Team to guide the approach of the investigation and provide a framework for selecting and gathering information. Lines of enquiry represent a series of criteria, informed by documentation and data, interview and case-record review to assess the arrangements in place to ensure the safety, quality and governance of care provided by Tusla.

The lines of enquiry reflected:

- the Terms of Reference for the investigation as approved by the Board of HIQA on 8 March 2017
- the *National Standards for the Protection and Welfare of Children*
- *Children First: National Guidance for the Protection and Welfare of Children* (2011)
- the findings of a HIQA review of the governance arrangements that Tusla had in place in relation to child protection and welfare services, conducted by HIQA during 2016 and 2017
- HIQA's ongoing programme of inspections carried out against the nationally mandated *National Standards for the Protection and Welfare of Children*
- relevant legislation, which includes the Health Act 2007, the Child Care Act, 1991 (as amended) and the Children Act 2001
- performance data published by Tusla including the numbers of open child sexual abuse referrals (these are cases that require an intervention) by service area
- Tusla-specific policies, procedures and guidelines gathered by HIQA, particularly with regard to the processes in place for of the management of allegations of child sexual abuse by adults of concern and retrospective referrals
- returned data and documentation from each of Tusla's 17 service areas
- unsolicited information received by HIQA from members of the public
- a literature review of national and international best practice
- principles of natural justice and adherence to fair procedure.

1.2.3 Investigation Team

The Investigation Team consisted of staff members of HIQA with the relevant qualifications and experience for the development, management and delivery of this investigation. These team members were appointed by the Minister for Health as authorised persons under Section 70 of the Health Act 2007 for the purposes of conducting this investigation in line with Section 9 of the Act.

1.2.4 External Advisory Group

To support the investigation, HIQA convened an External Advisory Group, which met for the first time on 25 April 2017. It brought together expertise in social work, child protection and children's rights from Ireland and the UK. The advice and guidance provided by the External Advisory Group reflected national and international evidence and best practice. As the investigation progressed, two members of the Advisory Group were made authorised persons in line with Section 70 of the Health Act 2007, for the purposes of conducting interviews with Tusla staff during the investigation in line with section 73 of the Health Act. The membership of the External Advisory Group is set out in Appendix 3.

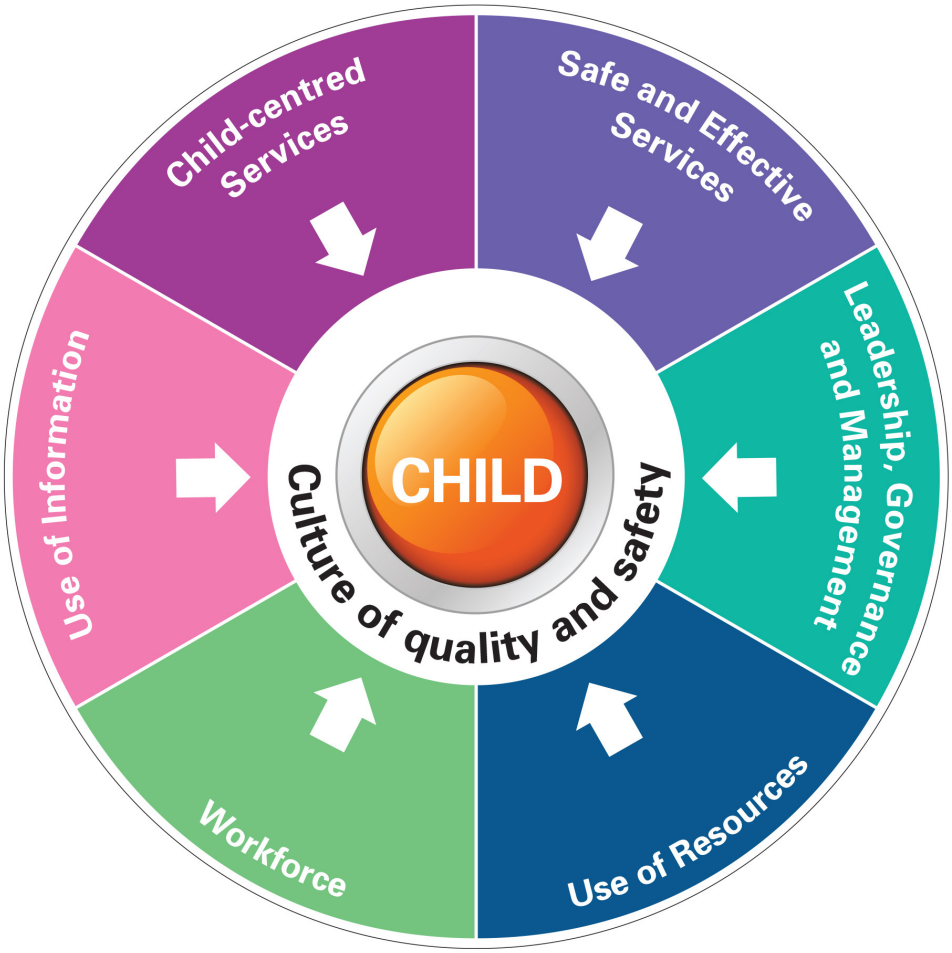
1.2.5 Investigation approach

This investigation's approach paid particular attention to four key areas of HIQA's *National Standards for the Protection and Welfare of Children*, approved by the Minister for Health and the Minister for Children and Youth Affairs in July 2012. The design and development of these National Standards were informed by a review of international and national evidence, relevant legislation, engagement with international and national experts, public consultation and targeted consultation with the Irish child welfare and protection system.

The National Standards are outcome-based Standards. This means that each Standard describes practice that promotes the best outcome for children. They provide a framework for the development of services in Ireland that are centred on the needs of the child, in order to protect children and promote their welfare. There are six themes described in the Standards (see Figure 1).

The first two themes relate to the dimension of quality: the theme of **Child-centred services** is about how services place children at the centre of what they do, while the theme of **Safe and effective services** considers how services deliver best achievable and safe outcomes for children and families, using best available evidence and information. The remaining four themes relate to the key areas of capacity and capability.

Figure 1. The six themes described in the National Standards



The lines of enquiry for the investigation primarily focused on four key themes contained within the National Standards. These reflect the essential components of a high-quality, safe child welfare and protection service and they encompass the capacity and capability required by Tusla to effectively and safely deliver such services.

Three of these four key themes focus on capacity and capability, as set out in the Standards:

- Leadership, governance and management
- Workforce
- Use of information.

The fourth key theme, which the investigation's line of enquiry reflected, focuses on the issue of quality, as described in the National Standards:

- Safe and Effective Services.

1.2.6 Review of literature

The Investigation Team conducted a literature review of national and international best practice. This further informed the lines of enquiry of the investigation and later provided context when reviewing findings and reporting on the findings in this report. The process also supported the resulting recommendations arising from this investigation. References to best practice are cited throughout the report.

1.2.7 Request for documentation and data

In line with section 73 of the Health Act 2007, HIQA issued formal documentation and data requests to Tusla in April 2017. The content of these requests is set out in Appendix 4 of the report. As a result of this request, the Investigation Team obtained in excess of 500 documents and pieces of data from Tusla, relating to:

- policies, procedures and guidance documents reflecting the management of child protection and welfare referrals
- Child Protection and Welfare Strategy 2017–2022, including Tusla's 'Signs of Safety' initiative
- corporate and executive governance structure, management and quality assurance and oversight arrangements
- service-level arrangements with third-party providers and other agencies and services
- workforce learning and development plan, service-area planning reports and implementation plans
- staffing levels
- information systems and information communication and technology (ICT) strategies
- internal quality assurance audits, internal and external review reports and associated action plans
- risk management arrangements in place in Tusla for the escalation of risks that relate to the management of child protection referrals
- performance data and activity reports related to social work.

Later during the investigation, HIQA also obtained a copy of a review conducted by Tusla of a number of risks identified by the HIQA Investigation Team and escalated to Tusla during the investigation fieldwork.

1.2.8 Service users' experience

The Investigation Team recognises:

- the confidential and sensitive nature of allegations of child sexual abuse
- the potential of subsequent and or ongoing criminal investigation
- the range in age of those who may have suffered alleged abuse or were the subject of an allegation of child sexual abuse by an adult of concern at the time of this investigation.

In view of this, the Investigation Team applied a case-record review approach to gain an insight into what service users (children, adult complainants and the persons who are the subject of an allegation of abuse) were potentially experiencing while their case or allegation against them was being managed by Tusla. This case-record review approach enabled the Investigation Team to examine critical aspects of the management of selected cases in line with Tusla's policies and procedures. This provided the Investigation Team with an overview of the extent to which the service user experienced high-quality and timely screening, assessment, and management of child sexual abuse referrals, including allegations of retrospective child sexual abuse (where adults allege they had been abused during their childhood).

In addition, unsolicited information provided by members of the public to HIQA was reviewed by members of the Investigation Team. This information further informed the investigation's lines of the enquiry and where appropriate was reviewed during on-site activity.

1.2.9 Risk management and escalation

During the course of this investigation, the Investigation Team could, at any stage, identify specific issues that it believed may present an immediate and or potential serious risk to the health or welfare of children. In line with HIQA policy, these risks would be assessed and then escalated with the necessary correspondence issued to the service provider and or Minister for Children and Youth Affairs.

1.2.10 On-site fieldwork

The safety and welfare of the child is paramount in all children's services. Safe services for children need to be timely and effective. In assessing the safety, quality and standards of the services provided by Tusla in relation to referrals of allegations of child sexual abuse, the Investigation Team took a risk-based approach to prioritising the on-site visits to Tusla services. This approach aimed to enhance the quality and safety of services in areas where it was potentially needed most, while at the same time, providing a balanced assessment through the identification of good practice.

This approach was informed by the information received from Tusla in response to the formal documentation and data request made by HIQA at the outset of this investigation.

It was also informed by information from other sources, including unsolicited information received by HIQA from members of the public and Tusla's published performance reports. It also drew on the findings of HIQA's inspections carried out against the National Standards and the findings of a HIQA review of the governance arrangements that Tusla had in place in relation to child protection and welfare services, conducted by HIQA between late 2015 and spring 2017.

The Investigation Team initially identified six out of 17 Tusla service areas and one Sexual Abuse Regional Team (SART) in the Tusla Dublin North East Region — which covers four service areas — for an on-site visit. It was agreed between the Investigation Team and the HIQA programme board that should a trend be identified in the service areas visited that these interim findings would be brought to the attention of the Board of HIQA and that the team would proceed to the interview and assurance component of the investigation.

By October 2017, the Investigation Team had completed fieldwork investigations at five Tusla service-area sites and the SART team; had reviewed and evaluated relevant documentation and data; had conducted case-record reviews; and had carried out individual interviews and group meetings at local and regional level. As a result, the Investigation Team believed that its findings up to that point concurred with the belief of the Minister that there was a possible serious risk to the health and welfare of children about whom referrals have been made to Tusla and where allegations had been made to Tusla against adults who may pose a risk to children.

The Investigation Team, together with the Executive of HIQA, through the investigation governance arrangements, decided, at that point that given the nature and consistency of the risk escalations made in the Tusla service area sites visited up to that time, that it would proceed with the seventh Tusla site visit as its final fieldwork site.*

The Investigation Team continued its work and completed a series of interviews with senior Tusla personnel at national level as planned. In October 2017, the Investigation Team communicated interim findings to the Minister, the Minister's officials at the Department of Children and Youth Affairs, the Chairperson of the board of Tusla and the Chief Executive of Tusla.

* This decision was taken in order to facilitate Tusla staff in their preparation for, and attendance at, the Tribunal of Inquiry into protected disclosures made under the Protected Disclosures Act 2014 and certain other matters following Resolutions (the Charleton Tribunal).

This interaction is described in more detail in Chapter 4 (see also Appendix 5).*

By the end of the investigation, the Investigation Team had conducted on-site fieldwork at six out of a total of 17 Tusla service area sites and at the single Sexual Abuse Regional Team (SART). The seven services visited by members of the Investigation Team are set out in Table 1.

Table 1. Tusla service areas and the Sexual Abuse Regional Team (SART) visited by members of the HIQA Investigation Team between June 2017 and January 2018

Tusla service areas or sexual abuse regional team	Tusla regional operational area	Date of on-site investigation visit
Waterford, Wexford	South	12–16 June 2017
Sexual Abuse Regional Team	Dublin North East	26–29 June 2017
The Midlands	Dublin Mid Leinster	10–13 July 2017
Carlow Kilkenny South Tipperary	South	31 July–4 August 2017
Louth Meath	Dublin North East	4–8 September 2017
Galway Roscommon	West	25–29 September 2017
Cavan Monaghan	Dublin North East	15–18 January 2018

* A copy of the correspondence from the Chairperson of the Board of HIQA to the Minister for Children and Youth Affairs is included in Appendix 5 of this report.

1.2.11 Case-record review

The Investigation Team conducted case-record reviews of almost one in three case records (33%)* in the six service areas and one dedicated regional team (SART) visited to assess the operational arrangements in place to ensure the timely screening, assessment and management of child sexual abuse referrals. A case record is any document which formally records a contemporaneous account of specific social work interventions in the management of an allegation of abuse, including their interactions with children and their families.** A review of these records by the Investigation Team aims to gain an insight into what service users (the child, the adult complainant and the persons subject of an allegation of abuse) were experiencing while their case or allegations against them was being managed by Tusla. The Investigation Team sought assistance and or clarification with regard to case records from Tusla staff members when required.

This case-record review sample was determined by performance figures[5] published by Tusla and available at the time of the investigation. These reported the number of child sexual abuse referrals that were open (cases that require an intervention) in each Tusla service area (October 2016) and the approximate national figure of 900 unallocated*** retrospective cases of abuse, recorded in Tusla's corporate risk register**** (as of November 2016). Data submitted by Tusla service areas to the Investigation Team in June 2017***** — much of which related to Tusla figures 'as of 1 May, 2017' — also influenced the sample selection.

* This case-record review included both open and closed cases: those open on the date of the on-site visit by the Investigation Team and those that had been closed within the six-month period (this period was extended in one service area) prior to that date.

** Children First (2011) states that record-keeping is of critical importance in social work and unless accurate records are maintained, the ability to adequately protect vulnerable children may be severely curtailed.

*** Cases awaiting allocation to a named social worker.

**** Provided to HIQA as part of HIQA's review of governance arrangements in place in Tuslas' child protection services carried out between 2015 and 2017.

*****This data was not validated by HIQA.

The case records reviewed included the following:

- children's case records in relation to child sexual abuse referrals (excluding retrospective cases)
- case records on persons who were the subject of abuse allegations in relation to child sexual abuse referrals (excluding retrospective allegations)
- adult complainant's case records in relation to retrospective allegations of abuse
- case records on persons who were the subject of abuse allegations in relation to retrospective allegations of abuse.

1.2.12 Interviews

The Investigation Team interviewed 39 members of Tusla staff including a member of its board.* Interviews took place at local, regional and national level in accordance with the lines of enquiry.

All individuals interviewed were provided with a minimum of 10 working days' advance notification of interview. Where an individual was unavailable on an allocated day, alternative arrangements were put in place to facilitate an interview at a later date.

Following interview, HIQA provided individuals interviewed with an audio recording of their individual interview on CD and they were requested to inform the Investigation Team, within 10 working days, if they wished to provide further information or clarification in relation to the recorded discussions.

1.2.13 Focus group meetings

The Investigation Team also carried out 29 focus-group meetings. These meetings were carried out with Tusla staff and with representatives of relevant external agencies identified by Tusla** and members of An Garda Síochána. The 29 group meetings consisted of:

- 14 meetings with Tusla social workers and social work team leaders
- seven meetings with external agencies***
- one meeting with the regional team of a Tusla assessment service
- seven meetings with members of An Garda Síochána.

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* Individual interviews were conducted with Tusla staff in accordance with their roles and responsibilities as they related to the Terms of Reference for this investigation. These staff were identified by Tusla prior to the investigation fieldwork.

** External agencies were identified by Tusla to the Investigation Team prior to investigation fieldwork. These agencies nominated an attendee.

*** One attendee represented an agency co-funded by Tusla and the HSE at one meeting.

The discussions, facilitated by two members of the Investigation Team, closely mirrored the key questions and topics as outlined in the lines of enquiry. Key points of the discussion were reviewed and agreed by all attendees on completion of the meeting.

1.2.14 Due process feedback

To ensure fair procedure, HIQA provided a copy of the relevant excerpt or excerpts of the confidential draft investigation report, on an individual basis or in a representative role, to relevant senior managers in Tusla and other staff members interviewed by the Investigation Team or whose role or decisions were featured in the draft report. An Garda Síochána also received a copy of excerpts of the draft report. HIQA provided a time frame of 10 working days for the return of any feedback and comments from the date of issue of the draft excerpt of the report. HIQA extended these deadlines to Tusla following a request by Tusla. Every comment received was carefully considered by HIQA prior to publication of this investigation report.

1.2.15 Quality assurance

To maximise the consistency and reliability of the investigation approach, HIQA put a series of quality assurance processes in place. These included:

- designing the investigation methodology and supporting quality controls in line with the Terms of Reference and having these agreed by the Board of HIQA
- setting up the Investigation Team based on the skills, knowledge, experience and competencies required, in line with the Terms of Reference of the investigation
- establishing an internal committee governing the investigative processes
- interviewees being provided, as relevant, with an excerpt or excerpts of the draft report findings to ensure fair procedure.

Upon publication of the Terms of Reference (see Appendix 1) in March 2017, the Investigation Team started to gather information in line with the methodology outlined in this chapter. The Investigation Team began writing the report in January 2018 with review and advice provided by the Executive of HIQA through the investigation governance arrangements, by other internal quality assurance reviewers, the External Advisory Group and the Board of HIQA on 14 June 2018.

1.2.16 Acknowledgements

HIQA wishes to thank the following people and organisations for their cooperation during the investigation: staff of Tusla who met with the Investigation Team during the on-site fieldwork, the external agencies that attended group meetings, An Garda Síochána, the Department of Children and Youth Affairs, members of the external advisory group of the investigation and the staff of HIQA who contributed to this investigation.

Chapter 2
Setting the scene

2.1 HIQA's role in monitoring child protection and welfare services

The Health Information and Quality Authority (HIQA) is an independent authority established in May 2007 with legal power and responsibility for improving the quality, safety and value of health and social care services in Ireland. Under section 8(1)(c) of the Health Act 2007,[1] HIQA has the function to monitor compliance with standards.

The *National Standards for the Protection and Welfare of Children*, published in 2012 (referred to in this report as the National Standards), support continual improvements in the care and protection of children receiving Tusla's child protection and welfare services.

Prior to this investigation, HIQA had been conducting inspections into child protection and welfare services provided by Tusla from the time that Tusla was established in January 2014. A schedule of inspections, against the National Standards, of Tusla-provided child protection and welfare services and resulting published HIQA inspection reports from 2014–2016 is available in Appendix 6.

During these inspections, HIQA identified aspects of these services which were delivered well and in a child-centred way. There were many examples of good quality direct work (effective engagement by social workers to build relationships) with children and families by Tusla staff. During these inspections, responses to children at immediate risk of significant harm were found to be timely in all cases and decision-making in relation to these specific cases resulted in immediate actions to reduce risks to these children.

However, since the inspection of these services against the National Standards began in 2012 — initially when these services had been provided by the Health Service Executive (HSE) — HIQA inspections have found recurring and common issues of concern across multiple service areas. Despite positive findings and evidence of service improvements over time, HIQA remained concerned about inconsistent and varied practice in aspects of the child protection and welfare service, which has been provided by Tusla since January 2014. These impacted on Tusla's capacity to deliver safe, equitable and high-quality services to children and families on a national basis.

Such adverse findings related to:

- high levels of referrals not allocated to a named social worker
- inconsistent allocation of children listed on the Child Protection Notification System (CPNS) to a named social worker
- unmanaged retrospective referrals
- inadequate policy provision
- delayed assessments of referrals
- poor quality record-keeping
- an inability to meet service needs
- unsafe and inadequate information systems
- a lack of dependable data
- insufficient external therapeutic and specialist services
- staff recruitment and retention
- limited quality assurance mechanisms
- inadequate systems of reporting, recording and assessment of risk.

Inspection findings led to a large number of recommendations for service areas as well as for the HSE and Tusla at a national level, which should have been used to inform and improve practice, and promote safer and better services. While action plans submitted by both organisations in response to inspection findings outlined the measures taken or to be taken to address identified deficiencies, HIQA believed the national governance arrangements within Tusla were not sufficiently good enough to systemically address these deficiencies.

Because of this, HIQA started a review of the governance arrangements in Tusla in December 2015 in line with section 8(1)(c) of the Health Act 2007. This review was to specifically assess the effectiveness of the governance arrangements in relation to Tusla's child protection and welfare service. The review also considered whether these arrangements provided corporate and operational assurance about the delivery of a safe, quality service to children receiving child protection and welfare services. When this investigation commenced in March 2017, this governance review was in the process of being completed.

2.2 Statutory investigations by HIQA

Under the Health Act 2007,[1]* HIQA may investigate the safety, quality and standards of social care services if HIQA believes on reasonable grounds that there is a serious risk to the health and welfare of children receiving a service or if requested to do so by the Minister for Children and Youth Affairs ('the Minister'). The seven investigations undertaken by HIQA between 2007 and 2015 related to patient care at HSE or HSE-funded acute hospitals (hospitals that provide care for sudden and severe illness).[6,7,8,9,10,11,12,13]

On 2 March 2017, the Minister wrote to the Chairperson of HIQA formally requesting under Section 9(2) of the Health Act 2007 that a statutory investigation (the 'investigation') be carried out in line with Section 9(1) of the Act. The Minister believed that the apparent poor handling by Tusla of information provided to it in relation to the Garda whistle-blower, Garda Sergeant Maurice McCabe, indicated a possible 'serious risk to the health and welfare' of children.

This request for an investigation was made against the backdrop of significant and intense public, media and political scrutiny of the Gardaí and Tusla during February and March 2017 into the handling of a false allegation, received by Tusla in 2013, made against the Garda whistle-blower and later contained in a Tusla notification to the Gardaí.[2] This had led to the establishment of a tribunal of inquiry to inquire into certain matters; and to other investigations by regulatory bodies into Tusla.

On 9 February 2017, RTÉ broadcast a *Prime Time* programme about the false allegation which raised questions about Tusla's management of this false allegation.[2] A statutory tribunal of inquiry was established by the Minister for Justice and Equality on 17 February 2017 under the Hon Mr Justice Peter Charleton, Judge of the Supreme Court, to investigate, amongst other issues, Tusla's role in the Garda use of this notification.

The Terms of Reference for this HIQA investigation set out the relationship between the investigation and the work of the tribunal. When this HIQA investigation was getting under way, the Office of the Ombudsman was separately investigating the way in which complaints were being handled within Tusla.[14] The Ombudsman's investigation looked in particular at how Tusla had dealt with complaints about the management of retrospective allegations of child abuse, at how current allegations against adults are handled and at interactions between Tusla and foster carers.

In March 2017, the Special Investigations Unit of the Data Protection Commissioner had also started an investigation to examine Tusla's governance of personal data concerning child protection cases.[15]

* Under section 9(1) and section 9(2) of the Health Act 2007 and or as amended by the Child and Family Agency Act, 2013.

In light of these other ongoing investigations, HIQA was conscious that under subsection 3 of Section 9 of the Health Act 2007, it 'must ensure' that a Section 9 investigation does not interfere or conflict with the functions of other statutory bodies. HIQA received legal advice that publishing the report of its governance review of Tusla, while its own investigation was ongoing, could potentially cause a difficulty under the above section of the Act. It was the view of HIQA that it would not therefore be appropriate to publish the governance review report at that point in time (March 2017).

HIQA wrote to Tusla in April 2017 confirming the above decision and stating that it remained open to Tusla to incorporate the learning from the draft report into its governance practices. HIQA's draft governance review report had been shared with Tusla in February 2017 as part of HIQA's due process component of that review, without HIQA's conclusions or recommendations in that draft. Due process is aimed at ensuring fair procedure and allows parties to comment on findings of reviews, investigations and inspection reports.

While a final governance review report was not published at the time, the findings from the governance review, as well as the findings of other relevant investigations where they have been published, were used by the Investigation Team to inform its assessment approach and this report of the investigation. In the interests of public transparency, a copy of the governance review report, which incorporates amendments following due process at the time, is now published as an appendix in this investigation report (see Appendix 10).

2.3 The role of Tusla

The Child and Family Agency (Tusla) was established on 1 January 2014 following commencement of the Child and Family Agency Act (2013). It became an independent legal entity, merging child and family services of the Health Service Executive (HSE), Family Support Agency and the National Educational Welfare Board. For the first time, this legislation provided for the delivery of child and family services by a single agency. Tusla 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
- response to domestic, sexual and gender-based violence.

Of the above services provided by Tusla, the investigation focused on the first of these services — child welfare and protection services (excluding family support services). Child protection and welfare services are responsible for the management of all referrals of child abuse and neglect and, specific to this investigation, child sexual abuse referrals. Therefore, while Tusla provides a wide range of services to children and families, the Terms of Reference of the investigation was limited to the management of child sexual abuse referrals, including allegations of retrospective child sexual abuse against adults of concern.

At the time of reporting, Tusla services were organised into 17 service areas and were being managed by area managers. There were four regional operational areas in place:

- West
- South
- Dublin Mid Leinster
- Dublin North East.

A service director was responsible for each region. Service directors reported directly to Tusla's Chief Operations Officer.

When established, Tusla brought together some 4,000 employees and had an operational budget of €609 million in 2014.[16] In 2016, its budget was reported as €665 million.[17] It is governed by a board appointed by the Minister for Children and Youth Affairs, who has the authority to oversee the development of the corporate strategy, risk policy, annual budgets and business plans.

The chairperson of the Tusla board reports to the Minister on measures taken to achieve priorities and performance targets. The Chief Executive of Tusla is responsible to the Tusla board for the performance of its functions.

2.4 Child protection and welfare: legislative and policy framework

The Child Care Act, 1991 (as amended) is the primary legislation governing child care in Ireland. This legislation identifies the statutory role that Tusla has to identify and promote the welfare of children not receiving adequate care and protection. While there will always be vulnerable children who will need to be protected from the risk of serious harm, Tusla uses a range of services and interventions to support families to adequately care for their children.

The *National Children's Strategy (2000–2010): Our Children – Their Lives* identified a series of objectives to guide children's policy over a 10-year period. In the opinion of the Investigation Team, this was the first time a government had clearly articulated that vulnerable children required and deserved a coherent and integrated sector-wide child protection and welfare approach.

The current framework — *Better Outcomes Brighter Futures: The national policy framework for children & young people (2014–2020)* — sets out the State's agenda and priorities in relation to children and young people over a seven-year period. It emphasises the importance of shared responsibilities in achieving improved outcomes for children and young people.

Children First: National Guidance for the Protection and Welfare of Children (2011) (Children First) aimed to promote the protection of children from abuse and neglect. This national guidance outlined what different statutory and non-statutory bodies, and the general public, should do if they were concerned about a child's safety and welfare. It also set out specific protocols for Tusla and An Garda Síochána for the protection of children from abuse.

Central to the work of Tusla's child protection and welfare services, Children First (2011) highlighted how suspected abuse and or neglect of children should have been dealt with. It also emphasised the importance of multidisciplinary and interagency working in managing concerns about children's safety and welfare.

The Children First Act 2015, which was signed into law on 19 November 2015, puts elements of Children First (2011) on a legal footing. The legislation forms part of a suite of child protection legislation which includes the National Vetting Bureau (Children and Vulnerable Persons) Acts, 2012–2016 and the Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act 2012. Following enactment of this legislation, Children First (2011) was revised in 2017, and at the time of this report, includes information on the legal obligations under the Act in relation to the introduction of mandatory reporting.

This Children First guidance is issued under section 6 of the Children First Act 2015 and replaces all previous editions of the Children First guidance. It also sets out the best practice procedures that should be in place for all organisations providing services to children.

The *National Standards for the Protection and Welfare of Children: For Health Service Executive Children and Family Services*, published in July 2012, provide a framework for the development of child-centred services in Ireland that protect children and promote their welfare. These are referred to as the National Standards in this report.

HIQA monitors child protection and welfare services in a number of ways, including:

- monitoring activity which includes a national monitoring programme for these services against the National Standards
- receipt, review and risk rating of 'unsolicited information' — this is information provided to HIQA by anyone who has a concern or an issue with the care provided
- having the legal power to conduct statutory investigations when it is deemed necessary and appropriate.

While HIQA does not have the legal remit to investigate individual complaints in relation to health and social care services, it reviews and risk assesses all unsolicited information received to establish if there are reasonable grounds to indicate a risk to the safety and welfare of service users.

Whenever concerns regarding the quality and safety of services provided to children and their families are identified, depending on the nature of the information and the level of assessed risk, HIQA may consider a range of interventions. These include seeking assurances from Tusla that any identified risks are being mitigated and managed.

2.5 Tusla performance and activity data

Tusla publishes reports on the performance and activity of Tusla services on a monthly and quarterly basis. The monthly performance and activity dashboard and the quarterly service performance and activity reports are structured around key performance and activity measures included in Tusla's Annual Business Plan.[18]

Tusla has developed a set of key performance indicators (KPIs) — these are used to measure elements of practice which can benchmark the quality of the service being provided and can indicate the effects of the service delivered and its structure.

In the context of this investigation, Tusla's key performance indicators are a valuable source of information on those elements of its child protection service which manage child sexual abuse referrals. These KPIs are described in more detail in Chapter 3.

With regard to child protection and welfare services, Tusla's performance and activity reports include referrals data (which was provisional at the time of writing, with validated data being published quarterly in arrears),* social work activity data and data from the Child Protection Notification System (a computer-based system). These include:

- the number of referrals to child protection and welfare services
- the number of cases:
  - open to the service
  - allocated and or awaiting allocation to a social worker
  - awaiting allocation by priority level
  - awaiting allocation by time waiting
  - children listed as 'active' on the Child Protection Notification System.

1.2 million children (0–17 years) are estimated to live in Ireland.[19] The 0–17 years population accounts for more than one in four (26%) of the total population for 2016.[18] In 2016, Tusla received 47,399 referrals to child protection and welfare services.[17]** That is 38 per 1,000 children and represents a 9% increase in referrals from 2015.

Tusla activity data is reported in the following pages and is based on annual data for the years 2014 to 2016, and more detailed data taken from Tusla's quarterly performance and activity reports for quarter 4 of 2016[20] — as well as those corresponding reports for the same period in 2017.[21]*** As defined by Tusla, these quarter 4 figures relate to referral data at the end of quarter 3, in 2016 and 2017 and activity data at the end of quarter 4, in 2016 and 2017.

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* Tusla Monthly Management Data Activity Report December 2017.

** Child protection and welfare referrals are categorised by child welfare concerns and child abuse concerns. Child welfare concerns are those related to neglect, while child abuse concerns are those related to emotional abuse, physical abuse and child sexual abuse.

*** It should be noted that more than one referral can be received in relation to a specific child (for the same or separate incidents), and as a result, the number of children involved is likely to be fewer than the number of referrals received.

2.5.1 Referrals

Data published by Tusla signals an increasing level of child protection referrals to it in recent years, with a slight dip by the end of 2017.

In 2016, there were 47,399 referrals to Tusla child protection and welfare services in Ireland. Four out of 10 referrals (40%, 19,087 referrals) were related to child abuse concerns, while six out of 10 referrals (60%, 28,312) were welfare concerns. Of these 19,087 child abuse concerns, child sexual abuse concerns accounted for 3,042 referrals (16%).[17] The overall number of referrals to Tusla increased in 2017, when there were 50,811.* Table 2 demonstrates annual figures related to child protection and welfare referrals from 2014 to 2016.

Table 2. Child protection and welfare referrals to Tusla, 2014 to 2016

Referrals to child protection and welfare service (broken down by welfare concerns and abuse concerns)	2014[22,23]	2015[23]	2016[17]	% change (+/-) since 2014
Number of referrals to the child protection and welfare service	43,179	43,596	47,399	+10%
Child welfare concerns	24,638	25,286	28,312	+15%
Child abuse concerns	18,541	18,310	19,087	+15%
Cases open to Tusla social work services	27,651	26,655	25,034	-9%
Open cases awaiting allocation to a named social worker	8,542	6,718	5,413	-37%
High-priority open cases awaiting allocation	2,836	999	801	-72%
Children listed as active on the Child Protection Notification System (CPNS)	1,400	1,349	1,272	-9%

* Provisional; validated data is published quarterly in arrears.

Based on the annual figures reported in Table 2 above, the number of cases open to Tusla at the end of 2016 was 9% lower than it was in 2014 — despite the number of overall child protection and welfare referrals having increased by 10% over the same time period. The number of open cases awaiting allocation to a named social worker had reduced by 37% and the number of high-priority open cases awaiting allocation had reduced significantly by 72% at the end of 2016.

At the time of writing this report, the most recent Tusla figures on the breakdown of the number and type of referrals was available in its quarter 4 performance and activity report for 2017.[21] The figures of this report are compared with the reported figures for the corresponding period in 2016 [20] and are included in Table 3 below. Tusla data at the end of quarter 3 is published in its quarter 4 performance reports. These figures relate to activity for the end of quarter 3, 2016 and 2017.

Table 3. Referrals to Tusla child protection and welfare services at the end of quarter 3, 2016 compared to end of quarter 3, 2017, as published by Tusla

Referrals to child protection and welfare service (broken down by welfare concerns and abuse concerns)	End of quarter 3, 2016 [20]	End of quarter 3, 2017 [21]	% change (+/-) since previous year*
Number of referrals to the child protection and welfare service	11,732 (100%)	12,498 (100%)	+7%
Child welfare concerns	7,145 (61%)	7,732 (62%)	+8%
Child abuse concerns	4,587 (39%)	4,766 (38%)	+4%

** Percentage change is based on the difference between the numbers of referrals (child welfare concerns and child abuse concerns) for the two separate quarters.*

For the end of the third quarter of 2016, published in its quarter 4 performance reports, Tusla had received 11,732 referrals to the service of which 61% (or 7,145) were child welfare concerns and 39% (or 4,587) were child abuse concerns.

A year later, in the third quarter of 2017, Tusla reported that it had received 12,498 referrals to the service of which 62% (or 7,732) were child welfare concerns and 38% (or 4,766) were child abuse concerns. This represents a 7% increase in the number of child protection referrals for 2017, when compared with the same quarter the previous year.

In its Corporate Plan 2015–2017, Tusla reported its key performance indicators for completion of screening within 24 hours of receipt of referral, and completion of initial assessments within 21 days of receipt of referral: with targets of 95% and 80% respectively for referrals at year 3 (2017).

Table 4 below shows that for quarter 3, 2016, 68% of screening and preliminary enquiries had been completed within 24 hours. It shows that 41% of referrals required an initial assessment, while 14% of initial assessments were completed within 21 days of receipt of the referral.

Table 4. Screening and preliminary enquiries and initial assessments, as published by Tusla

Referrals to child protection and welfare service	End of quarter 3, 2016 [20]	End of quarter 3, 2017[21]
Number of referrals to child protection and welfare service	11,732	12,498
Preliminary enquiries completed within 24 hours of receipt of the referral	68% (n=7,755)	Not reported by Tusla
Referrals that required an initial assessment	41% (n=4,712)	36% (n=4,455)
Initial assessments completed within the 21-day target of receipt of the referral	14% (n=644)	Not reported by Tusla

The Investigation Team found that Tusla did not report on the above indicators for completion of preliminary enquiries and completion of initial assessment for 2017 in its quarterly performance reports. The timeliness for completion of preliminary enquiries and initial assessments is discussed in more detail in Chapter 4.

2.5.2 Open cases allocated/awaiting allocation

Table 5 below shows Tusla's social work activity data at the end of quarter 4, for 2016 and 2017 as reported in its quarter 4 performance and activity reports, 2016 and 2017.

Table 5. Open cases allocated or awaiting allocation as published by Tusla

Social work activity data	Quarter 4, 2016 [20]	Quarter 4, 2017 [21]	% change (+/-) since previous year
Total number of open cases to child protection and welfare service	25,034 (100%)	24,891 (100%)	-1%
Number of open cases allocated to a social worker	19,621 (78%)	19,999 (80%)	+2%
Number of open cases awaiting allocation to a named social worker	5,413 (22%)	4,892 (20%)	-10%

At the end of quarter 4, 2016, there were 25,034 cases open to the child protection and welfare services. Of these, 19,621 cases were allocated to a social worker while the other 5,413 cases were awaiting allocation to a named social worker.

A year later, at the end of quarter 4, 2017, there were 24,891 cases open to the child protection and welfare services. Of these, 19,999 cases were allocated to a social worker and 4,892 cases were awaiting allocation to a named social worker.

The number of open cases for quarter 4 had decreased by 1% when compared with the same time the previous year. The number of open cases allocated to a social worker increased by 2% and the number of cases awaiting allocation to a named social worker had decreased by 10%. A downward trend in the number of cases awaiting allocation to named social workers has been observed when the annual figures are observed for the years 2014 to 2016, despite increases in child protection and welfare referrals. This is a welcome development.

2.5.3 Cases awaiting allocation by priority

Published Tusla data indicates that throughout 2016 and 2017, the number of high-priority cases increased. However, this has slowly decreased throughout 2017.

A high-priority case is described by Tusla as including children:

- requiring further child protection assessment and intervention
- involved with child protection court proceedings
- in care for less than six months and
- with high-risk mental health and anti-social difficulties.

Many children whose cases are determined as medium and low priority have welfare rather than child protection needs.[18]

Table 6 indicates the number of 'high-priority' cases open to the service which were awaiting allocation.

Table 6. Open cases awaiting allocation as published by Tusla

Open cases	Quarter 4, 2016 [20]	Quarter 4, 2017 [21]	% change (+/-) since previous year
All open cases awaiting allocation to a named social worker	5,413 (100%)	4,892 (100%)	-10%
Out of the total number, high-priority open cases awaiting allocation	801 (15%)	818 (17%)	+2%

Of the 5,413 cases awaiting allocation to a social worker in quarter 4 of 2016, the data shows 801 (or 15%) were categorised as high priority. For quarter 4 of 2017, the data records that 818 (or 17%) of 4,892 open cases awaiting allocation to a social worker were categorised as high priority. All remaining unallocated cases were categorised as either 'medium priority'* or 'low priority'.**

Throughout 2016 and 2017, the number of high-priority cases increased considerably — from its lowest of 576 cases in quarter 3 of 2016 to 1,062 cases in quarter 1 of 2017, an increase of over 84% in less than six months. However, this slowly decreased throughout 2017 to 818 high-priority cases awaiting allocation to a social worker in December 2017 (a reduction of 23% since quarter 1 of 2017).[21]

* Where an initial assessment or further assessment is required for a child welfare concern.

** Where a child may be on a family support plan following an initial assessment.

2.5.4 Cases awaiting allocation by waiting time

It is not possible to clearly state if overall waiting times for cases to be allocated have improved or deteriorated between quarter 4 of 2016 and quarter 4 of 2017 because Tusla data for quarter 4 of 2017 is incomplete. For quarter 4 of 2016, of the 801 high-priority cases awaiting allocation, 517 cases had been waiting less than three months, with the other 284 waiting greater than three months. In quarter 4 of 2017, the length of time waiting was only available for 15 out of the 17 service areas. In those 15 service areas, 731 high-priority cases were awaiting allocation, with 385 awaiting allocation less than three months and 346 waiting more than three months. Therefore, the numbers of high-priority cases known to be waiting longer than three months in 15 service areas was 28% greater than the same period in 2016 for all 17 service areas.

The breakdown of these figures is provided in Table 7 below.

Table 7. Cases awaiting allocation by priority level and time waiting as published by Tusla

Waiting time for high-priority cases to be allocated to a social worker	Q4, 2016 [20]	Q4, 2017 [21] *
1 week	79	5
1–2 weeks	79	120
2–3 weeks	80	19
3–4 weeks	69	52
1–2 months	116	118
2–3 months	94	71
Greater than (>) 3 months	284	346
Total	801	731

The allocation and management of waiting list cases is discussed in more detail in Chapter 4. Tusla's systems and processes in relation to data capture and validity are discussed in Chapter 6.

* Analysis for this section is based on data returns from 15 out of 17 Tusla service areas (4,360 cases awaiting allocation). The length of time waiting was not available for the remaining 532 cases (as reported by Tusla in its quarter 4 performance report, 2017) in the other two service areas.

2.5.5 Child Protection Notification System

The Child Protection Notification System (CPNS), in line with Children First, is a national record of all children who are the subject of a child protection plan agreed at a child protection conference. These children have been assessed as being at ongoing risk of significant harm.

At the end of 2016, there were 1,272[17] children listed on the Child Protection Notification System. At the end of 2017, 1,304 children were listed as being 'active' on the Child Protection Notification System.[21] This represents a 3% increase from the previous year. Tusla's quarter 4 performance report stated that at the end of 2017, all children listed as active on the Child Protection Notification System had an allocated social worker.

2.5.6 Retrospective cases

Tusla's monthly performance and activity dashboard report for January 2018[24] shows the number of open retrospective cases for the 17 Tusla service areas.* It outlined there were 1,948 open cases of retrospective abuse — of these, 1,465 were allocated and 483 were awaiting allocation. The overall number of open cases had reduced by 37 (or 2%) since January 2017. The number of cases awaiting allocation had decreased by 45% in the 12-month period. Retrospective cases are discussed in more detail in Chapter 4 of this report.

* These figures include referrals of allegations of retrospective child sexual abuse and retrospective physical, emotional abuse and neglect.

Investigation findings

Chapter 3
Findings on leadership, governance and management

3.1 Introduction

This section of the report outlines the Investigation Team's findings in relation to the national, regional and local governance and management arrangements in place in the Child and Family Agency (Tusla) to effectively plan and deliver its service and the assurances Tusla provides to the Tusla board in respect of how referrals of child sexual abuse are being managed.

On 1 January 2014, the Child and Family Agency (Tusla) became an independent legal entity and is now the dedicated State agency responsible for improving wellbeing and outcomes for children. When established, it merged the Health Service Executive's (HSE's) Children and Family Services, the Family Support Agency and the National Educational Welfare Board as well as incorporating some psychological services and a range of services responding to domestic, sexual and gender-based violence.

Effective governance in services for children and families is guided by provisions made in:

- Irish and international legislation
- Children First 2017, National Guidance for the Protection and Welfare of Children[25]
- the *National Standards for the Protection and Welfare of Children*, published in 2012
- and Tusla's policy documents, standard business process and guidelines.

This investigation is the eighth investigation undertaken by HIQA since 2007. This is the first investigation into the management by Tusla of allegations of child sexual abuse referrals, including retrospective allegations — which are allegations made by adults who alleged they were abused when they were children — against adults of concern.

In each of the previous investigation reports, HIQA has emphasised that the sustainable delivery of safe, effective and reliable person-centred care depends on service providers having sufficient capacity and capability in the areas of leadership, governance and management, resources, information and workforce.[6]

In an effective governance structure, overall accountability for the delivery of services is always clearly defined. There are clear lines of accountability at local, regional and national level so that all individuals working in the service are aware of their responsibilities and to whom they are accountable.

In a well-governed service, effective leadership and management arrangements ensure that the service fulfils its remit and achieves its objectives. The deployment of necessary resources through informed decisions and actions facilitates the delivery of effective and safe services to children and families.

A well-governed and monitored service measures its performance across all organisational levels to ensure reliability so that it provides care, support and services that are of a consistently high quality with minimal variation across the wider system. Quality and safety is also assured by complying with legislation, acting on standards, guidance and recommendations from the reports of reviews by relevant statutory and regulatory bodies.

A well-governed service has strong systems in place for the notification and review of serious incidents. The learning from the review of serious incidents is shared with front-line and management staff within appropriate timescales to inform the development of best practice and service improvements. The effectiveness of services sourced externally is monitored through formalised service agreements.

In 2016, there were 47,399 referrals to Tusla child protection and welfare services in Ireland. Four out of 10 referrals (40%, 19,087 referrals) were related to child abuse concerns, while six out of 10 referrals (60%, 28,312) were welfare concerns. Of the 19,087 child abuse concerns, child sexual abuse concerns accounted for 3,042 referrals (16%).

In line with the investigation's Terms of Reference, the Investigation Team examined how Tusla manages child sexual abuse allegations, which follows a pathway identical to that of all referrals to Tusla's child protection and welfare service, which HIQA has been inspecting and monitoring since 2014.

In addition, throughout 2016 and early 2017, HIQA — in line with section 8(1)(c) of the Health Act 2007 — reviewed the governance arrangements that Tusla had in place to ensure the effective delivery of child protection and welfare services. The governance review report — which had been shared with Tusla in February 2017 and which incorporates due process feedback received at the time from Tusla — is published as an appendix within this report (Appendix 10).

The findings of this earlier governance review as they relate to the Terms of Reference of this investigation are discussed here.

3.2 HIQA review from 2015 to 2017 of Tusla's governance arrangements to ensure the effective delivery of child protection and welfare services

3.2.1 Background

Between 2014 and 2016, HIQA conducted 12 inspections against the *National Standards for the Protection and Welfare of Children* (2012) of Tusla child protection and welfare services.* The findings of all these inspections, with the exception of the Midlands,** have been published and are available on HIQA's website (see schedule in Appendix 6).

Throughout these 12 child protection and welfare inspections, HIQA found features within each service which demonstrated a child-centred approach. There were many examples of Tusla providing a quality direct service (effective engagement by social workers to build relationships) and of services working well with children and families. For the most part, Tusla swiftly responded to children who were at immediate risk of significant harm. There was evidence to verify that decision-making in relation to these specific cases resulted in immediate actions being taken to reduce urgent risks to these specific children. However, some priority child protection and welfare cases that were reviewed by HIQA were considered to require further assessment, and as a result, HIQA escalated these cases for action by Tusla at the time of inspection.

During these 12 inspections between 2014 and 2016, HIQA inspectors also found areas of significant concern across several service areas. In summary, these findings showed an inconsistency in child protection and welfare practice. These inconsistencies meant that children and their families could potentially experience a different level of response and service depending on where they lived. The inspectors found multiple reasons for these inconsistencies which included:

- high levels of referrals not allocated to a named social worker
- inconsistent allocation of children listed on the Child Protection Notification System to a named social worker
- unmanaged retrospective referrals
- inadequate policy provision
- delayed assessments of referrals
- poor quality record-keeping

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* This investigation report refers to 12 inspections carried out by HIQA between 2014 and 2016, while HIQA's governance review in Appendix 10 reports on 14 inspections in a different time period during these years.

** The inspection of the Midland's child protection and welfare services was unpublished as it primarily related to a progress report on the action plan of the previous inspection.

- inadequate quality assurance arrangements to effectively detect, manage and learn from mistakes
- inconsistent risk management arrangements
- poor and or absent information management processes and systems
- challenges to effectively meet the service needs within available resources
- and difficulties with staff retention and recruitment.

After each inspection, the relevant service area submitted a satisfactory action plan to HIQA which outlined its response and planned actions to address those areas requiring immediate and longer-term attention. However, notwithstanding these local responses, HIQA was not assured that the national governance arrangements within Tusla were adequate to systematically address these findings or that they ensured a consistent approach for all child protection and welfare referrals across all service areas.

As a result of these inspection findings, HIQA had decided to carry out a schedule of inspections of child protection and welfare services delivered from all 17 Tusla service areas, focusing on the management of all referrals to the service up to the point of completing an initial assessment. However, this schedule of inspections was deferred due to the start of this statutory investigation.

3.2.2 Key findings of the 2015 to 2017 governance review

Throughout the governance review, senior Tusla personnel articulated and produced evidence demonstrating a wide-ranging transformation programme to include the implementation of a child protection and welfare strategy. In addition, there was an increased suite of national policies, procedures and standard business processes available to guide staff in delivering a safe and effective child protection and welfare service, with a particular emphasis on supporting decision-making at the screening and intake stage of processing a child protection and welfare referral.

There was abundant evidence of the considerable financial investment that the Department of Children and Youth Affairs, Tusla's board and executive had made in terms of staff recruitment and training, and developing a more service-demand model of staff allocation across its service areas. There was also evidence to show better and more focused staff training, with Tusla emphasising that this was a work in progress. Implementation of the child protection and welfare strategy had included further staff training.

Furthermore, during the governance review, Tusla had indicated that it had improved its governance structures and arrangements to include better communication processes, clear lines of accountability, an enhanced and improved culture of learning and decision-making and a consistent social work model of service configuration and delivery.

At the time of the governance review, the Child Protection Notification System (CPNS), introduced in 2015, was accessible on a 24-hour basis across all service areas. Tusla reported that the notification system had the appropriate information governance systems in place to secure the information held, and it stated the system had enhanced Tusla's capacity to ensure timely and accurate information sharing internally in Tusla and externally among relevant professionals.

While these service-wide improvements were acknowledged and welcomed by HIQA, the review also found that there remained a large number of child protection and welfare referrals that did not have a named social worker allocated to their case. In addition, inconsistencies remained across service areas, particularly in the context of the identification, reporting and escalation of risk.

In addition, while there had been a reported focus on developing effective quality assurance arrangements — in the form of programmes of audit, review and monitoring against national key performance indicators — quality assurance arrangements had not been consistently embedded at local and regional level. There had also been inadequate managerial oversight at a local level which meant that areas of poor practice and inconsistencies had potentially not been actively detected and dealt with. In turn, areas of good practice had not been formally identified and shared, with the aligned learning not being communicated across services.

At the time of the governance review in 2015–2017, while a new information communication system was being introduced, the absence of an integrated information communications technology (ICT) system remained a significant risk to Tusla. There had been inconsistencies in the gathering and storage of data. Some service areas had a paper-based system and others had different ICT systems, none of which were integrated — this therefore had prevented the accurate and timely sharing of information. Furthermore, the absence of an integrated approach and ICT system meant that data collected could not be validated in a timely way. This in turn meant it could not be used as information to effectively and accurately inform service delivery, design, planning and quality assurance.

At the time of the governance review, there were a limited number of social work graduates for Tusla to recruit into its child protection and welfare service. At the time, Tusla had reported that it had been developing a workforce plan to address its service requirements.

Tusla completed this workforce plan in 2017 after the conclusion of the 2015–2017 HIQA governance review, and this plan was provided to the Investigation Team as part of this statutory investigation. This will be reported on in Chapter 5 of this report.

It is in the context of the findings of HIQA's earlier governance review of Tusla that the Investigation Team looked at the governance and management structures and arrangements in place at national, regional and local level to ensure Tusla was safely and effectively managing allegations of child sexual abuse, including retrospective allegations.

The pathway involved in managing child protection and welfare concerns — as examined in this earlier governance review and in the 12 HIQA inspections of child protection and welfare services — is identical to the pathway for the management of allegations of child sexual abuse. The next section of this report reflects the Investigation Team's findings in relation to the governance and management arrangements in place for the management of child sexual abuse allegations in Tusla.

3.3 Investigation findings for governance and management

3.3.1 The board of Tusla

The board is the governing body of Tusla, consisting of a chairperson, a deputy chairperson and seven ordinary members appointed by the Minister for Children and Youth Affairs (the Minister). The Child and Family Agency Act 2013 sets out the role and function of the Tusla board, which includes the monitoring of corporate performance, the development of corporate strategy in relation to major plans of action, risk policy, annual budgets and business plans and to monitor the implementation of corporate performance.

These roles and functions are achieved through meetings of the board, with reporting of performance through committees of the board and information provided to the board by the chief executive officer of Tusla. The board of Tusla is accountable to the Minister for the performance of its functions. Board minutes are published on the Tusla website.

At the time of the investigation, the Chairperson of the board reported at interview that the nine board members had the necessary skills, competencies and experience to effectively deliver the functions of the board. In addition, while it was reported at interview that the board committee structures were effective, the Investigation Team was also informed that at the time of this investigation, the board was exploring options to enhance its current assurance reporting arrangements.

3.3.2 Tusla executive

The board of Tusla is responsible for appointing the organisation's chief executive officer (CEO), with the postholder reporting to the chairperson of the board. The current CEO is in post since 13 February 2016.

The Child and Family Agency Act 2013 sets out the functions of the CEO and the circumstances in which these functions may be delegated to Tusla employees. The CEO's functions include the implementation of Tusla's corporate plan and to carry on, manage and control generally the administrative business of Tusla.

At the time of the investigation, Tusla submitted to HIQA an organisational chart setting out the structure that it had in place to deliver its functions.

Within this structure, Tusla's senior management team reports directly to the CEO. The senior management team is made up of a chief operations officer, director of ICT, director of transformation and policy, head of legal services, director of finance, director of human resources and a director of quality assurance.

In addition, it was reported by senior management team members that the Tusla board had, in late 2017, approved the appointment of a director of corporate services, a chief governance officer and a chief social worker.* However, none of these positions had been filled at the time of this investigation.

Corporate Strategy (2015–2017)

Tusla launched its first corporate strategy in 2015.[16] In doing so, Tusla identified eight key strategic objectives as follows:

- improve the quality and focus of the delivery of services for children and families
- develop the governance structures, processes and supporting infrastructure to ensure that Tusla is in a position to carry out its functions in an effective and efficient manner
- establish a new and distinct values-based culture that empowers children and families through high-quality services
- develop an organisation that lives within its means and uses its resources in an efficient and cost-effective manner
- develop a workforce that is valued and supported within a learning organisation

* Tusla informed the Investigation Team in May 2018 that the Chief Social Worker had been appointed in April 2018.

- position the Agency as a responsive, trustworthy and respected body with its own unique identity
- build on a research strategy to develop policy and enable evidence-based decision-making and high-quality service delivery
- ensure a strategic approach to quality assurance, information management and risk management that supports continual improvement and good governance.

Although its title suggests a three-year time frame, Tusla's strategy provides an incremental approach spanning 10 years to fully achieve the strategy's implementation. Tusla explicitly identifies key risks that could potentially slow its progress. These include: operational, governance, management, financial and reputational risks. In addition, Tusla identifies a suite of key performance indicators (KPIs — specific and measurable elements of practice that can be used to assess quality and safety of care) and targets for each of these KPIs in the first three years.

In the context of child protection and welfare — of which child sexual abuse referrals are included — Tusla identified the following 2015–2017 key performance indicators and targets (Table 8).

Table 8. 2015–2017 child protection and welfare key performance indicators and targets published by Tusla[16]

Tusla's child protection processes and systems are responding to children at risk in a timely manner			
KPIs	**Year 1 targets**	**Year 2 targets**	**Year 3 targets**
Percentage of referrals of child abuse where a preliminary enquiry took place within 24 hours.	75%	95%	95%
Percentage of referrals of child abuse which required an initial assessment following a preliminary enquiry.	70%	90%	95%
Percentage of these initial assessments completed within 21 days of receipt of the referral.	50%	70%	80%
Targeted reduction of cases previously listed as 'active' on Child Protection Notification System within prescribed timeline.	Baseline to be established in 2015	10%	15%
All processes and systems underpinning children and family policy and services are evidence-informed			
Percentage of functions/ services conducting a full self-assessment against the Tusla quality assurance framework.	60%	95%	100%
A fit-for-purpose organisation to deliver on our strategic intent			
Agency has stand-alone ICT infrastructure.	70%	80%	95%
Organisational structure, roles, responsibilities and capacity aligned to corporate objectives.	70%	80%	100%

At the time of this investigation, Tusla's most recent annual business plans[18,26,27] set out how Tusla would meet its strategic objectives year on year. In order to meet corporate objectives on a national scale, local business plans were developed for the majority of Tusla service areas. The Investigation Team noted that 15 out of 17 service areas had produced a 2017 business plan by June 2017. However, two service areas did not provide a business plan for 2017 to the Investigation Team.

Service area business plans reviewed by the Investigation Team were aligned with national priorities and expected outputs. However, the content and quality of the business plans varied, making it more difficult to accurately and fairly compare and contrast projected performance across service areas. Some, but not all, included implementation timelines and assigned responsibility for actions to specific teams or individuals. Significantly, some local business plans indicated that business priorities for their respective service areas would not be met due to insufficient staffing levels.

At the time of reporting, Tusla had introduced a five-year child protection and welfare strategy (2017–2022). Senior staff reported that this strategy arose out of a review of Tusla's core responsibilities under legislation, including the Child Care Act, 1991 and the Children First Act 2015.

In addition, Tusla reported that the strategy has been informed by Government policy, including *Better Outcomes Brighter Futures: The national policy framework for children & young people (2014–2020)*; *Children First: National Guidance for the Protection and Welfare of Children (2011)*; and the current revision of Children First (2017).

Managers at local, regional and national level reported at interview that Tusla had recently selected 'Signs of Safety' as its national approach to practice, describing Signs of Safety as an innovative, strengths-based approach to child protection casework, grounded in partnership and collaboration with children, families and their wider networks of support.

Tusla's most recent Business Plan in 2017 reported on a significant 'Transformation Programme' to address organisational, cultural and operational risks and required improvements. It was reported to the Investigation Team by a member of the senior management team that this Transformation Programme evolved from the need to connect a number of programmes within Tusla, including, for example, the development and implementation of its Child Protection and Welfare Strategy and its ICT Strategy.

Included in the Child Protection and Welfare Strategy is Signs of Safety (a new national approach to practice), which will be expanded to all of the Agency's service delivery units over a three-year period. To support and monitor the development and implementation of major programmes and projects required by the Agency, it has established a Programme Management Office.

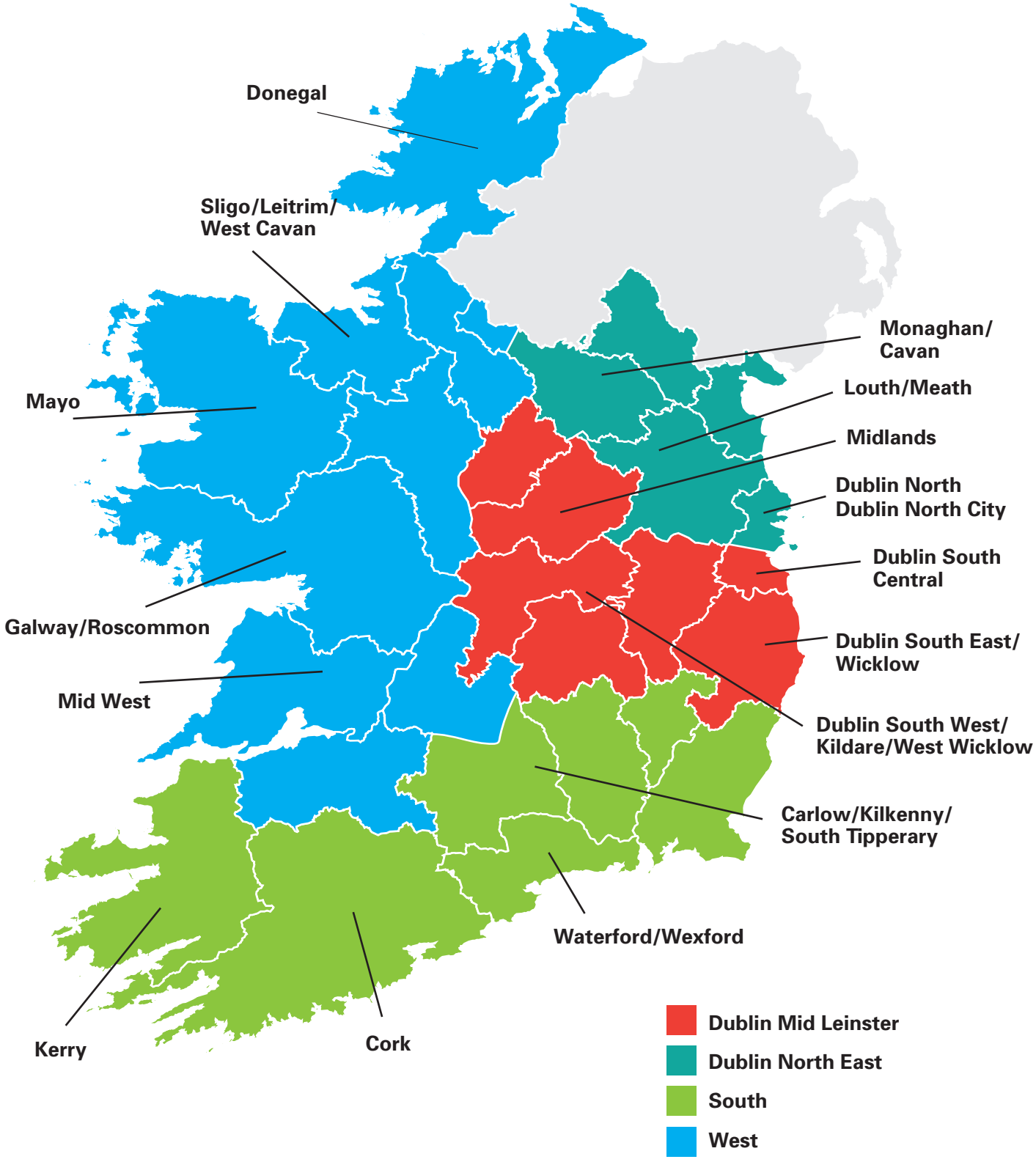
The Investigation Team was informed at interview that a Head of Project Management Office and six project manager posts had been established and filled at the time of the investigation.

The Programme Management Office was new to Tusla, and a member of the senior management team reported that it will play a key role in enhancing governance and management arrangements in place for large and essential projects within the Agency. The development of the Project Management Office is welcomed by the Investigation Team and this initiative should bring a coordinated approach to the implementation of the various strategies and programmes underway within this developing agency.

3.3.3 Tusla's regional and local organisational structure

At the time of the investigation, Tusla submitted its regional and local organisational structure. Tusla has four regional operational areas called West; South; Dublin Mid Leinster; and Dublin North East regions (illustrated in Figure 2).

Figure 2. Tusla's four regional operational areas*



*Source: http://www.tusla.ie/get-in-touch/service-directors/.

A service director leads and is responsible for the effective governance, leadership and operational management of child protection and welfare services, including child sexual abuse referrals within their respective region, with each postholder reporting directly to the chief operations officer based in Tusla headquarters in Dublin. Service directors are supported in delivering their functions by geographically-based area managers who have specific responsibility for ensuring effective day-to-day management of their service areas. The area managers' role includes accountability for the management of service delivery within their respective areas, change management, budgetary responsibility, staff management and health and safety. There are between four and five service areas in each region. (See Appendix 7 for Tusla's organisational chart in relation to regional and local reporting arrangements.)

The next tier of operational management within Tusla is the principal social worker who reports directly to his or her respective service area manager. Through interview and review of the documentation submitted by Tusla, the Investigation Team identified that principal social workers have a wide-ranging remit. Principal social workers manage teams which may include social workers, social care workers, administrative staff and family support workers within their service area. The principal social worker's role includes the oversight and management of staff performance, personal development of staff and providing social work practice supervision to social workers and social care workers. Social work team leaders report directly to principal social workers. Their roles and responsibilities include the management of child protection and welfare teams and oversight of the management of referrals of child sexual abuse, including retrospective child sexual abuse.

At the time of this investigation, there was one Sexual Abuse Regional Team (SART) in the Dublin North East Region. This is a stand-alone dedicated team which was established in the Dublin North East Tusla Region in 2016 to reduce waiting lists for assessing allegations of retrospective abuse cases and also to standardise practice in the region. SART primarily manages retrospective cases and it may also provide support to social work teams within each of the four service areas of the Dublin North East Region in the management of current child sexual abuse allegations against an adult. This team is managed by a principal social worker who reports directly to the service director for the Dublin North East Tusla Region.

The next section of this report explores the current governance arrangements in place to assure the board and executive of Tusla that there is safe and effective management of child sexual abuse referrals including retrospective allegations against adults of concern at a corporate, regional and local level.

3.3.4 Corporate governance

The board is the governing body of Tusla. In line with Section 50 of the Child and Family Agency Act 2013, the Tusla board developed and approved its first code of governance in September 2015. The Investigation Team reviewed the code of governance and identified that the document clearly describes the function, board members' roles, chief executive's role, structures, code of standards, committee structures and the processes, guidelines and reporting requirements of the CEO and board committees.

The Investigation Team, with the Chairperson of the Tusla board, explored the frequency and effectiveness of the board meeting and the holding to account by the board of the senior management team. It was reported by the Chairperson at interview that the board is satisfied that the reporting arrangements are adequate and are effective at holding the senior management team to account for the effective delivery of child protection and welfare services. It was reported that the senior management team provides assurance reports to the board which include progress against the actions Tusla is taking to address findings of monitoring activities, risk and areas of non-compliance with nationally mandated standards.

Senior management team members interviewed described how the board questioned them in this regard. Tusla's corporate risk register was found to contain reference to the risk of reputational damage due to high levels of non-compliance with National Standards as identified through inspections and investigations of Tusla services, the consequences of which included reduced confidence in Tusla's ability to deliver its services appropriately. Senior management team members reported that unallocated cases,* which include current and retrospective child sexual abuse allegations, are discussed routinely at board level. They also reported that the aligned performance reports have been improved by the introduction of an integrated report format which includes data, operational practice and progress updates.

This was further explored at interview with the Chairperson of the board who acknowledged that the current capacity of Tusla to effectively manage the increasing volume of child protection and welfare referrals and to effectively address all unallocated cases is a serious challenge to Tusla. In addition — and as found in this investigation and the previous HIQA governance review — there was an absence of effective data collection by Tusla and the generation of timely and accurate information reports. The Chairperson agreed that this is an additional risk to vulnerable children. This data issue is described in more detail in Chapter 6 of this report.

* An unallocated case is a case open to Tusla social work but is not assigned to a named social worker.

Nonetheless, the Chairperson is assured that the introduction of Tusla's integrated information system, called the National Child Care Information System (NCCIS), is a significant development and that, given time, this will address the risks around poor data capture and access to timely and quality reporting. However, the Investigation Team remained concerned about the lack of immediate measures from Tusla to address poor data capture and access to timely and quality reporting, which the team believes are fundamental risks to the safety of vulnerable children in this State.

3.3.5 Board committees

In line with its code of governance, Tusla's board has created four committees to support its role and function. The four committees are the Audit Committee; Quality Assurance and Risk Committee; Organisational Development Succession and Remuneration Committee; and the Governance Committee.

The Investigation Team verified that each committee has defined terms of reference, and a charter detailing each committee's membership, the frequency of its meetings, the attendees and the committees' reporting arrangements to the board. The Quality Assurance and Risk Committee focuses primarily on quality assurance, service delivery and related risk, and it advises the board on these matters. A member of the board is chairperson of the committee, with two fellow board members and two external persons with the necessary skills and experience in this area appointed by the board to the committee. The committee is required to meet at least four times a year and the committee chairperson has the discretion to meet more frequently if deemed necessary.

In the context of this investigation, two senior Tusla staff identified the Quality Assurance and Risk Committee of the board as the key conduit in providing assurance to the board about the effective management of child sexual abuse allegations, including allegations made retrospectively.

It was reported at interview that the appointed chairperson of the Quality Assurance and Risk Committee at the time of this investigation was unavailable to act in this role from June 2017 onwards. To address this absence, the Chairperson of the board sat on the committee to ensure it had the minimum number of members present in order to make its proceedings valid. However, during this investigation, the Investigation Team noted that the committee had not convened at the frequency determined in its own code of governance.

The Investigation Team reviewed the minutes of a selected number of meetings of the Quality Assurance and Risk Committee from March 2015 to March 2017. The 2017 work-plan for the committee showed that there were standing items which were reported every three months.

These included items on the corporate risk register, protected disclosures* received by Tusla, internal quality assurance reviews, audit reports and risk reports.

Additional quarterly audit reports to the committee included the number of child protection and welfare referrals to Tusla and the number of referrals awaiting allocation to a named social worker. In addition to these reports, the board has access to a national performance 'dashboard' which was established in 2015 by Tusla. Other planned agenda items included learning for the organisation from reports on the deaths of children in care by the National Review Panel.**

In the context of this investigation, it was reported at interview and recorded in the documentation received from Tusla that the information provided to the committee included a national review of cases awaiting allocation which had been carried out by Tusla in 2015 (including retrospective cases). A subsequent internal report was presented to the committee on Tusla's National Assurance Review on Retrospective Cases of Abuse, which it carried out in 2016, the report of which is dated March 2017.

The Investigation Team found that similar risks had emerged in both the 2015 review of unallocated cases and the 2016/2017 review on retrospective cases of abuse. There were specific risks relating to:

- delayed assessments of referrals resulting in unidentified children being at potential risk of harm
- levels of risk to children not being determined and therefore potentially not responded to appropriately
- inadequate staffing levels in child protection and welfare services to meet service needs
- and ineffective data collection.

It was reported at interview that the director of quality assurance attends each meeting of this committee. Committee meeting minutes showed that the Chief Operations Officer attends whenever requested. The Investigation Team acknowledges the importance of the director of quality assurance attending these meetings, particularly in regard to audit results. However, the postholder does not have any direct operational responsibility for delivering services and as a result may not be best placed to provide the assurance the committee requires in the context of the timely response to audit findings and operational risk.

It was evident that the chairperson of the committee provided a report to the board and that reciprocal action was required of the senior management team.

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* Defined in 2014 legislation as protection for people who raise concerns about possible wrongdoing in the workplace.

** This is an independent panel established to review the deaths of children who are or have been in the care of the State.

The Chairperson of the board acknowledged at interview in November 2017 that although the number of unallocated retrospective cases had decreased, risks remained in relation to unallocated cases.

The Investigation Team was surprised to learn that there was no standard business process with defined time frames for managing retrospective child sexual abuse allegations. As a result, Tusla was challenged to assess how effective its performance was in the absence of an aligned set of key performance indicators (KPIs) for these referrals. For instance, the Quality Assurance and Risk Committee was not provided with assurance that adult complainants, who allege they were abused as children, were being met with by Tusla to assess within a required time frame the retrospective allegation of child sexual abuse.

Nor was there information available to assure the efficiency and effectiveness of the management of people against whom allegations of abuse were being made.

3.3.6 Governance arrangements

The CEO of Tusla and members of the senior management team make up the organisation's executive. It is the responsibility of the executive to ensure that the board of Tusla is provided with accurate and timely information. Members of the senior management team are required to report periodically to the board. The CEO can delegate any of the executive's functions to a member of the senior management team.

Senior management team members are accountable for a wide range of services provided by Tusla, which include child protection and welfare services. Child protection and welfare services manage child sexual abuse allegations including retrospective allegations. At the time of the investigation, the CEO reported at interview that since 2014, the senior management team had evolved, and he was satisfied that it was working well. He identified that the appointment of a chief social worker would further enhance its structure and would provide additional oversight, particularly in the context of service delivery.

The senior management team met fortnightly or as required. On a quarterly basis, these meetings were extended and attended by, for example, service directors. Other members of staff attended as requested by the senior management team to present, for example, on specific projects they were involved in. The Investigation Team found evidence of strong reporting structures in place whereby the senior management team is formally held to account by the CEO for their respective functions. There is an action log in place for the senior management team, which aims to ensure all required actions are recorded and progressed.

In addition, a tracking system is in place to record the implementation of actions from internal and external reports and internal audits. The CEO reported to the Investigation Team that, in addition to management team meetings, he separately meets each member of the senior management team.

He reported that at these monthly one-to-one meetings, performance reports (which included reports on finance), staff retention and performance figures for the previous month for each region are discussed and reviewed.

In the context of this investigation, the Investigation Team interviewed a number of members of the senior management team whose particular functions were relevant to the Terms of Reference of this investigation. In response to Tusla's 2016/2017 National Assurance Review of Retrospective Cases, Tusla's Chief Operations Officer developed a service improvement plan that identified the actions required to address the main concerns raised in the 2017 review. These actions included developing local or regional teams to:

- accept and assess retrospective child sexual abuse referrals
- address backlogs of unallocated retrospective cases
- create a standard operating procedure for managing these referrals
- allocate all retrospective cases to a social worker within a three-month period
- high-priority cases were to be allocated at the point of referral.

In order to assure the CEO about the safety and quality of Tusla's child protection and welfare services, strong reporting arrangements between the Chief Operations Officer based in Tusla's headquarters in Dublin, and regional and local operational managers are critical. The Chief Operations Officer and service directors reported at interview that regular face-to-face meetings took place between them on an individual basis. They described these meetings as challenging, supportive and productive. Service directors reported that at these meetings, they were held to account by the Chief Operations Officer on how they managed their services.

Regular face-to-face meetings were also held between the Chief Operations Officer and operational managers on a group basis. The Investigation Team reviewed minutes of a selected number of these meetings and found that they had been held monthly and had been well attended. It was evident that operational managers reported on their respective regions' performance and staffing levels.

3.3.7 Investigation fieldwork activity

As previously described in this report, Tusla's child protection and welfare services are managed and delivered across four regions by four regional service directors. These four areas are subdivided into 17 service areas, with each having an area manager accountable for the effective operational delivery of the service. The Investigation Team visited six service areas and one regional dedicated team.

At the time of this investigation, senior Tusla management stated that the organisation was undertaking an internal strategic review of its current operational management model which they believed would effectively address the organisation's current and future capacity requirements to deliver its services.

The terms of reference for the group assigned to this work were developed in July 2017 and indicated a three-month time frame for reporting on findings and recommendations. However, a draft of this report had not been completed at the time of this investigation for review by the Investigation Team. It is the opinion of the Investigation Team that this demonstrates a lack of urgency within the organisation to reflect on and change, if necessary, how it currently operates.

The Investigation Team noted that a draft commissioning strategy was developed and published in May 2017, and this is a welcome initiative. Tusla's commissioning strategy is intended to support Tusla management, staff, providers and partners to deliver on the short-, medium- and long-term outputs identified in Tusla's Corporate Plan so as to achieve improved outcomes for children. It aims to link resource allocation with assessed current and future needs to achieve best outcomes for children. This was at an early stage of implementation at the time of this investigation.

To gain an understanding and insight into the assurance arrangements in place to ensure the effective management of child sexual abuse allegations, the Investigation Team met with various front-line Tusla personnel and examined numerous documents. It interviewed a number of senior staff in the seven investigation fieldwork sites visited (six service areas and one dedicated team), met with numerous staff working in the areas, reviewed the regional and local governance structures, reviewed minutes of meetings and supporting policy, guidelines and business rules. The Investigation Team noted the high quality of Tusla's public and internal corporate and business documentation, national policy papers, and national corporate information and communications.

3.4 Key findings arising from fieldwork visits

While management structures were similar across the service, the lines of accountability varied in relation to services around child sexual abuse referrals, including retrospective allegations against adults of concern. This variation was in part a response to the 2016/2017 National Assurance Review of Retrospective Cases which had recommended establishing four regionally-based dedicated teams to manage retrospective cases. At the time of this investigation, a dedicated regional team was in place for Dublin North East Region, the Sexual Abuse Regional Team (SART), to manage current and future referrals but was not in place for the other three Tusla regions — contrary to the organisational chart supplied to HIQA by Tusla at the start of this investigation.

In addition, three out of the six service areas visited had a local dedicated retrospective team. In a fourth area, a local dedicated team was due to start operating in October 2017.

In total, the Investigation Team conducted formal one-to-one interviews with 27 front-line staff and managers working in the seven fieldwork sites visited.* In addition, the Investigation Team met a number of additional staff while conducting the fieldwork component of this investigation.

All staff interviewed reported that staff supervision was a key process in place to assure the effective operational management of child sexual abuse referrals, including retrospective allegations against adults of concern. The supervision process is underpinned by an approved staff supervision policy. This policy was first approved in 2012 when child protection and welfare services were provided by the HSE. The policy was adopted by Tusla in 2014 when it took over the child protection and welfare function on its establishment. However, this policy has not been reviewed since 2012 to reflect the introduction of Tusla's National Strategy for Continuing Professional Development** in 2016, which is implemented during the supervision meetings. This will be further discussed in Chapter 5 of this report.

This 2012 policy was reviewed by the Investigation Team, and it was found to clearly define supervision, its objectives and core principles. These included putting the needs of children first, that supervision should have a direct bearing on the quality of service delivery and outcomes for children, and that it contributes to the management of risk in relation to children, families and Tusla.

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* The Investigation Team carried out 39 formal individual interviews with members of Tusla staff and its board. Of this total number, 27 interviews took place at the seven fieldwork sites visited.

** Continuing professional development (CPD) is the means by which health and social care professionals maintain and improve their knowledge, skills and competence, and develop the professional qualities required throughout their professional life. CPD is an integral component in the continuing provision of safe and effective services for the benefit of service users. CPD requires engagement by the health and social care professional in a range of learning activities on an ongoing basis.

The policy states that staff members have individual responsibility for the quality of their own work; and that supervision should ensure the effective management of staff practice, staff development and addressing issues of under-performance. This policy document states that staff should be provided with regular formal supervision: at a minimum at four- to six-week intervals and that it should be recorded in writing. A supervision contract should be in place for all staff.

However, the Investigation Team found a disparity between this policy and practice on the ground. Through a review of a selected sample of 132 staff supervision records during the on-site fieldwork, interviews with service directors, area managers, principal social workers and group meetings with Tusla social workers, the Investigation Team found that despite the focus placed on supervision as an assurance mechanism within Tusla, there was considerable variation in practice.

There were examples of timely and well-recorded supervision meetings where decision-making in relation to children at risk had been clearly articulated and acted upon. There was also evidence to verify supervision as an effective way of holding staff to account for individual practice in the cases they were assigned. Actions related to casework had been identified and monitored by the supervisor in each session. There was evidence of staff development through learning and experience, and of opportunities to develop further being discussed. Of the 132 staff files reviewed against designated time frames and whether a supervision contract was in place, the Investigation Team found that 32 (or 24%) out of the 132 supervision records were of good quality as they were carried out in line with the designated time frames and had a supervision contract in place in line with Tusla's supervision policy.

However, the Investigation Team also found that in other cases, the supervision policy had not been consistently adhered to. For example, supervision contracts were not always in place for staff, supervision records were sometimes illegible and unsigned, and supervision was not always provided within the required time frames. Managers reported providing and receiving supervision at frequencies of between four and 12 weeks (compared to the policy which states that staff should be formally supervised at a minimum of four- to six-week intervals). There was evidence that staff learning and development had not been consistently progressed with staff, and in some instances there was little evidence of the overall performance of the staff member being discussed. The Investigation Team was informed by the CEO that the peer-to-peer supervision within Tusla's new approach to practice, Signs of Safety, should enhance learning and development across the service in relation to practice.

While the supervision policy refers to the management of under-performance, the Investigation Team was surprised to learn from Tusla managers that Tusla has no formally agreed performance management system.* The Investigation Team is mindful that performance management is a key governance activity and is a set of processes that aim to maintain and improve employee performance in line with an organisation's objectives. It is strategic as well as operational, as its aim is to ensure that employees contribute positively to business objectives.

Furthermore, performance management is about creating a culture that encourages the continual improvement of business processes and an individual's skills, behaviours and contribution to an organisation. Therefore, in the opinion of the Investigation Team, not having a formally agreed performance management system is a major governance shortfall in supporting staff and the wider organisation to deliver a safe, quality service to vulnerable children. HIQA recommends that Tusla's executive addresses this major governance failing as a matter of priority.

Tusla area managers reported at interview that team meetings were held at regional and local level and that these meetings provided an additional layer of assurance and accountability across the service. The Investigation Team reviewed the terms of reference for five local management teams provided during on-site fieldwork and found that there was an inconsistency in how these principles were being applied in practice. There was evidence that some terms of reference clearly articulated the membership, purpose, functions, objectives and decision-making process for their respective management teams, while other local management teams lacked structure and any formal business processes.

Similar to the findings in relation to local meetings, there was evidence of effective and less than effective regional meetings. The Investigation Team expected to find that key service challenges such as waiting list management and performance reports would be a standing agenda item; however, this was not always the case. In some cases following the meetings' deliberations, actions within defined timelines had been clearly assigned. However, in others, there was no recorded evidence to support that this occurs.

There is now an opportunity for Tusla both at a national and regional level to maximise and enhance its local assurance and staff communication processes through improved monitoring of staff performance and by addressing any non-adherences to its supervision policy. The Agency should also improve how it supports managers in effectively and consistently getting the best out of its meeting and supervision arrangements.

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* The Investigation Team was informed by Tusla in May 2018 that it intended to introduce the second phase of its leadership and management training programme with a specific focus on establishing a performance management system throughout its line management structure. Furthermore, commencing mid 2018, it intends to develop a performance and accountability framework which it stated would set out Tusla's approach to performance management.

3.5 Risk management processes in Tusla

At the time of this investigation, Tusla had a national organisational risk management policy and procedure in place, which had been approved in July 2016.[28] The Investigation Team reviewed the policy and found it to be very detailed and comprehensive. It clearly identifies all staff roles and responsibilities in relation to risk management, and explains how to identify, analyse, evaluate and assign a risk rating. It details completing the risk register and outlines the risk escalation pathway that staff must use.

The Investigation Team welcomes the obvious importance that the executive of Tusla places on effective risk management, and it is apparent that at executive level this is well understood. The policy clearly states that risk management is not optional and is a continual process that must be adaptable to change. In addition, the 2016 policy identifies that adhering to and implementing the policy would be formally audited on an annual basis.

Additional components of the risk management process are (a) Tusla's incident management process, a statutory requirement — under the National Treasury Management Agency (Amendment) Act 2000 — to report incidents on the National Incident Management System (NIMS),* and (b) 'need to know' reporting. Need to know reporting is for incidents which may attract potential media coverage, have Tusla-wide implications, expose Tusla to significant corporate risk or litigation, and involve a number of other Government departments or State agencies.

Therefore, the Investigation Team subsequently explored the level of understanding and adherence by Tusla personnel to the risk management policy and processes at regional and local level and found a discrepancy between the official policy and processes and the actual practice on the ground. The Investigation Team found deficiencies in both the application of the risk management policy and the process.

The Investigation Team was concerned to hear from some operational managers that they had neither read nor received any training in relation to the policy. While there were local risk registers in place in all 17 service areas, there was a considerable difference in the standard of risk reporting in different service areas, and in the degree to which risk registers were completed and re-evaluated. In some cases, a risk had not been risk-rated and had not been assigned an owner to mitigate the risk. There was evidence of some risks remaining on a risk register for over three years.

* NIMS is a web-based system used to manage incidents throughout an incident lifecycle, while also fulfilling legal requirements to report to the State Claims Agency (SCA).

For example, child protection cases awaiting allocation to a named social worker remained on one service area risk register from 2015 and it also recorded allegations of retrospective child sexual abuse from 2014 which had not been assessed. Another service area's risk register noted risks as a result of inadequate therapeutic services from 2014.

There was evidence indicating examples of poor understanding of the risk register system. For instance, in one service area, unallocated retrospective cases had been identified as posing a potential risk to children, but this had not resulted in a set of actions to address this risk. The Investigation Team reviewed the regional risk register for the Tusla region within which this service area is located and found that there were unallocated child sexual abuse cases in three of its service areas, in some cases for over three years and these had not been recorded as a regional risk. In another service area, 322 cases had been awaiting an initial assessment since 2016; however, no mitigating actions had been identified on the local risk register.

Another service area had identified governance of its child protection team as being a risk because the principal social worker involved had oversight of over 800 cases, which in the opinion of the Investigation Team was an excessive amount of cases for one individual to sustainably manage. However, the potential risk this posed to the safety of children had not been described and there were no resulting actions recorded in order to manage these risks.

The Investigation Team identified that risks escalated by a designated regional team, the Sexual Abuse Regional Team (SART),* had not been identified by one local service area. The same local service area receives referrals of child sexual abuse, including retrospective child sexual abuse referrals. However, in some cases, the service area did not adhere to Tusla's policy on managing allegations of child sexual abuse by completing all necessary actions to ensure the safety of a child, as required, prior to transferring these cases to Sexual Abuse Regional Team. This risk was subsequently identified by the designated regional team and it escalated this risk to the service director. Records of completed risk escalation forms showed that lack of identification of risk at a local level caused a delay in their escalation to the service director and potentially to the senior management team.

Furthermore, the Investigation Team found examples of two cases where risk escalations had been required but in fact had not been made. Members of the Investigation Team brought these to the attention of the area manager at the time of on-site fieldwork and assurances were provided to the Investigation Team that this would be immediately reviewed.

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* Sexual Abuse Regional Team is a designated team in the Tusla Dublin North East Region that deals with retrospective cases and current child sexual abuse allegations against adults.

The Investigation Team observed that inadequate staffing levels to meet service needs was a persistent risk identified in the majority of service-area risk registers reviewed across the country. A recorded consequence of this risk was that there is a significant number of cases nationally of adults alleging they were abused as children by adults of concern which have not yet been allocated to a social worker to review and assess these allegations.*(24)

The Investigation Team also found examples of good risk reporting in other service areas. There was evidence to show that area and regional managers had appropriately identified risk, weighted the impact of this risk on the welfare of children and, as a consequence, had been adequately resourced to mitigate the identified risk.

The Investigation Team explored these findings with Tusla staff and management. Many staff interviewed agreed that there was a divergence between risk policy and practice in the service areas. However, there was evidence to show that in recent times, regional quality risk and service improvement managers had increasingly supported, advised and assisted area managers with compiling their risk registers. The annual audit of the risk management policy was due to have been completed by Tusla by December 2017. However, this report was not available to the Investigation Team at the time of reporting.

The Investigation Team recognises the challenges in implementing effective and consistent risk management processes and acknowledges that there is evidence of Tusla having increased its investment in supporting staff. However, many practitioners interviewed — while acknowledging the importance of risk management — perceived these current processes as overly burdensome and as taking them away from their core work in child protection and welfare.

The evident disparity between Tusla policy and practice on the ground, in addition to almost universal reports in risk registers across the country about inadequate staffing levels, represents a serious ongoing challenge to providing safe and sustainable management of child sexual abuse allegations. Tusla should now consider these findings and plan how it will increase support for staff at operational level, provide adequate training to address the lack of risk management prowess, put systems in place to address inconsistencies in practice and risk management planning, and fundamentally streamline the implementation of these processes.

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* In May 2017, 590 such cases and 483 in January 2018. These figures include retrospective child sexual abuse and retrospective physical, emotional abuse and neglect.

3.6 Quality improvement

Tusla has a Quality Assurance Directorate which is responsible for putting systems in place aimed at assuring the quality and safety of its services.

To assist in this goal, Tusla has defined three quality principles that underpin what it terms as its quality improvement framework, which are that services are:

1. Child centred

- The rights and views of children and families are respected and taken into consideration when planning, delivering and improving services.

2. Well led

- There are governance, leadership and management systems in place that support staff to deliver consistent, appropriate and accountable services for children and families.

3. Safe

- Services are designed and developed to achieve the best and safest outcomes for children and families in a timely and proportionate manner.

Each quality principle has a suite of supporting criteria. Senior management team members stated at interview that the Tusla quality improvement framework is a three-year strategy which includes a self-assessment phase. Self-assessments are completed by Tusla managers and or staff, as appropriate to the nature and scope of the service being delivered. Verification of completed self-assessments is carried out by the Quality Assurance Directorate through audit and sampling methods, and this directorate is responsible for providing learning seminars for Tusla staff following self-assessments. At the time of the investigation, the first self-assessment, looking at the principle of a well-led service, was underway within Tusla.

Thereafter, the quality improvement framework establishes that the senior management team and the Quality Assurance and Risk Committee of the Tusla board will review compliance with the self-assessment process. In addition, rapid improvement plans will be considered where difficulties are identified with implementing and complying with the self-assessment process.

The process and necessary support for this will be agreed by the Chief Operations Officer in consultation with the director of quality assurance and the senior management team.

In addition, in 2016, Tusla developed a guide for staff on conducting quality assurance audits. This guide was reviewed by the Investigation Team, and it was found to clearly outline the audit process and approach. The guide also provides an appropriate escalation process and standard form for reporting risks identified during the audit process.

3.7 Audit

Audit is the review of current practice for the purpose of quality improvement. At a national level, senior staff told the Investigation Team that audit activity is managed by the Quality Assurance Directorate. Four key audits relevant to child protection and welfare services were conducted by Tusla between 2015 and 2017. These were the:

- 2015 audit of child protection and welfare and children-in-care cases, which had not been allocated a social worker to undertake an assessment or provide ongoing support and intervention
- 2015 national audit of the application of Tusla's standard business processes relating to the child protection and welfare intake and initial assessment processes
- 2016 national audit of a select number of cases across Tusla to establish if children at ongoing risk of significant harm had been placed on Tusla's Child Protection Notification System (CPNS) in a timely way and had been appropriately managed
- 2017 national audit of retrospective cases allocated and awaiting allocation to a named social worker to determine if they had been being managed and responded to in a safe and effective manner.

The 2015 audit of unallocated cases had found that cases had been awaiting allocation to a named social worker for lengthy periods of time and as a result, current risk to children had not been assessed. It identified that priority levels assigned to individual cases did not always reflect the level of risk to the children involved. Furthermore, the audit uncovered cases unnecessarily open to Tusla.

The 2015 audit of the application of Tusla's standard business processes found that there had been:

- different levels of compliance across the service
- variation in how Tusla's national threshold for a social work service was being applied and
- an absence of a reliable method of recording the outcome of initial assessments.

It identified inadequate staffing as a contributing factor to the lack of adherence to its standard business processes.

The 2016 audit of child protection and welfare cases and the Child Protection Notification System found that there were children who had remained active on this system unnecessarily. This meant that they were inappropriately listed as being at ongoing risk of significant harm. It identified the inappropriate application of Tusla's national threshold of need for a social work service.*

Tusla's unpublished 2017 audit of retrospective cases, which related to allegations of retrospective child sexual abuse only, found that there were risks in the service which required either further improvement or urgent attention. This related to potential risks to children which had not been assessed in 88% of unallocated retrospective cases and a lack of safety planning in 57 cases where persons subject of allegations of abuse had ongoing contact with children. However, the audit highlights that there may be a reason in some instances why safety planning had not occurred and these reasons varied from legal issues to cases requiring allocation to a named social worker before an assessment of the allegation could start.

Recommendations from these audits included the review of Tusla's policies and procedures, the revision of how Tusla defines different aspects of its practice, improved data collection and staff training in areas such as professional judgments. There was also a recommendation to adopt a national standardised approach to social work practice.

In addition to national audits, senior, regional and area managers reported to the Investigation Team that audits of practice are carried out locally. Tusla has a guidance document to support staff in conducting and acting on the findings of these local audits. The Investigation Team reviewed reports on local audits provided for the purpose of this investigation and found that each service area had audited different practice areas related, for example, to the management of retrospective disclosures of abuse, unallocated cases, staff supervision and adherence to Tusla's business processes.

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* Tusla reported to the Investigation Team in May 2018 that the majority of this cohort of children (10 out of 14) had been received into care and their names were not removed from the Child Protection Notification System at the time of the audit.

The Investigation Team found that the resulting audit reports were not standardised in terms of format and as a result varied in the level and nature of information provided. These reports were not always aligned to Tusla's guidance documents and did not always identify reciprocal actions to promote practice improvement. There was limited evidence to show how learning from these local audits was systematically communicated to Tusla staff.

The Investigation Team found that, in its opinion, some managers did not make the best possible use of audit to monitor the level of identified risks or performance issues, or to check whether actions taken to reduce risk had been effective. The Investigation Team believes this is at odds with the value placed on audit at a national level as a driver of improvement. Furthermore, several managers interviewed by the Investigation Team reported low levels of auditing activity due to other demands on their time.

The Investigation Team reviewed a sample of case records which had been subject to a local audit in the service areas visited and found that audits did not always result in improved practice. By way of example, while it was evident from case records that the recommendations of local audits had been implemented in some cases, others had been audited on more than one occasion but actions continued to remain unaddressed. For example, a child was referred to Tusla in May 2015. An audit of the case carried out in February 2017 had noted that no action had been taken in the case following an initial assessment. This case was audited for a second time in April 2017 but by September 2017, a further assessment which had started had not yet been completed in this case.

Another example was a case referred to Tusla in October 2016 and which was audited in July 2017. While work had started on this case, at the time of the investigation fieldwork in September 2017, an initial assessment had yet to begin and a notification of suspected abuse had yet to be made to An Garda Síochána.

Unlike child protection and welfare services in other jurisdictions, Ireland does not have third-party independent assessment underpinned by legislation. In the opinion of the Investigation Team, registration of child protection and welfare services would provide an independent assurance to the State of statutory child protection and welfare services.

3.8 Performance indicators

Tusla staff told the Investigation Team at interview that they believed performance data and information have a number of benefits as a management tool and, when used effectively, have the potential to encourage performance and form the basis for continual improvement.

At the time of this investigation, based on its standard business processes,[29] Tusla had identified a suite of key performance indicators relevant to this investigation.

These include:

- activity related to referrals to the service
- activity related to the Child Protection Notification System (CPNS)
- the number of cases:
  - open to the service
  - allocated and or awaiting allocation
  - awaiting allocation by priority level
  - awaiting allocation by length of time
- staff data.

The Investigation Team explored the benefits of Tusla collecting these performance indicators. Senior managers at national and regional level said reviewing the data on the number of unallocated cases had resulted in an increased focus on the allocation of high-priority cases. In addition, Tusla staff said that this information allowed them to monitor trends in unallocated cases, for instance, the number of unallocated retrospective referrals.

Senior managers at national and regional level stated at interview that they are optimistic that the full implementation of Tusla's national integrated information system (the National Child Care Information System) will support the systematic collection and analysis of performance data across the service. However, staff reported the integrated information system will not include retrospective allegations of child sexual abuse and therefore will not improve data collection in this regard. This will be further explored in Chapter 6 of this report.

3.9 Organisational culture

The establishment of Tusla in 2014 brought together a workforce of approximately 4,000 staff who had previously been employed with the Children and Family Services of the Health Service Executive (HSE), the Family Support Agency and the Educational Welfare Board. Senior managers at national and regional level told the Investigation Team that these were services with their own established cultures and that they considered that their merger called for a new culture.

It is in this context that senior staff reported, through a consultative process with staff and key stakeholders, that Tusla had developed a shared vision for the service which is that 'all children are safe and achieving their full potential'.[30] Tusla also produced a mission statement summing up its core purpose which is to design and deliver a child-centred, evidence-based service to ensure positive outcomes for children.[16]

Tusla has incorporated cultural change into its corporate and business plans since 2015 and it has described the cultural shifts it is endeavouring to achieve in terms of becoming a learning organisation which works collaboratively to deliver a quality service and one which is responsive to the needs of children and families.

Senior managers at regional and national level interviewed by the Investigation Team said Tusla is invested in bringing about cultural change. These managers had run a cultural survey among staff teams in 2016 which identified the need to move towards a collaborative, creative and innovative culture. Tusla's corporate plan 2018–2020,[(31)] launched in March 2018, sets an objective to develop and implement an 'Organisational Culture Change Strategy' and to assess cultural change through an annual survey.

Throughout this investigation, most Tusla staff and managers interviewed and met with described their practice as child centred and responsive. Due to the nature of the investigation, children were not interviewed by the Investigation Team. However, there was evidence that Tusla was making strides in terms of how it is structured to deliver a responsive service to children. There was evidence to suggest that Tusla had put arrangements in place to ensure that children at immediate risk were well responded to in the first instance. However, a significant number of medium- and low-priority cases remained unallocated to social workers across the service. Delayed responses may result in an unnecessary increase in risk to these children. Tusla staff at all levels referred to significant staff vacancies and the impact that this had on their capacity to provide a responsive child-centred service.

The Investigation Team found that while a culture of learning was evolving, it was not fully embedded in practice. Initiatives had been taken to encourage learning and development both at local and national level through forums such as complex-case meetings, mentoring and continuing professional development of staff. However, staff believed that there was a lack of shared learning across the service arising out of previous case reviews or adverse incidents related to specific cases. Staff highlighted that they would like to see an improvement in this area.

In addition, throughout this investigation there was no evidence of shared learning after cases had been escalated by HIQA in individual service areas. This was again reflected in the escalation by the Investigation Team of recurring practice issues across seven fieldwork sites. This was a missed opportunity and did not illustrate that Tusla transferred learning or indeed communicated across its services in a timely way. The Investigation Team was told at interview by some senior managers that they had not reviewed escalations made by the Investigation Team.

Nonetheless, Tusla was making progress in developing a culture of collaborative working with other organisations and agencies. Feedback from representatives of external agencies who attended group meetings (see Chapter 7 on bilateral engagement) with the Investigation Team was largely positive about their working relationship with Tusla (with some notable exceptions as outlined in Chapter 7). External professionals described structures being in place to facilitate planning and decision-making in relation to children.

3.10 Conclusion

The Investigation Team found that the board and executive of Tusla have achieved a considerable amount to embed the organisation during its four years in existence, particularly in the areas of corporate governance, and leadership and management structures. There is a clear strategic direction, and a long-term vision of what Tusla wants to achieve. The quality of its public and internal corporate and business documentation, national policy papers, and national corporate information and communications is of a very high standard. Its governance structures are underpinned by a quality improvement framework, risk management policies, business planning processes, and a large number of supporting policies and business processes.

However, all of these policies and defined processes need to be embedded at local level. The Investigation Team found evidence of a divergence between national Tusla policies and business processes and what is actually happening on the ground in the service areas visited. The Investigation Team believes this has the potential to leave children at risk in some situations.

Tusla, in moving towards providing a more responsive service to children and families, has a number of challenges to address. These challenges particularly relate to a lack of validated information to inform policy and direction, effective information communication technology (ICT) systems, and staff recruitment. While the implementation of Signs of Safety is at the core of Tusla's strategic direction for child protection and welfare services over the next five years, there are current systems risks which require immediate attention and which Signs of Safety will not address, as set out in Chapter 4.

The Investigation Team remained concerned about the lack of urgent measures from Tusla to address fundamental risks to the provision of a safe and sustainable service. While there is some evidence of practice being standardised across Tusla's child protection and welfare services, there are particular deficiencies related to:

- the early detection of poor practice
- improvements in staff development and support
- increased opportunities for sharing good practice
- and the provision of stronger consistent managerial oversight of practice at local level.

In order to achieve a safe and sustainable service, the above improvements should be supported by risk, quality and information management systems which are embedded in practice at all levels throughout the organisation.

The next chapter of this report examines the management of allegations of child sexual abuse referrals including retrospective allegations against adults of concern and the operational management arrangements in place to ensure they are effectively managed.

Chapter 4
Findings on management of child sexual abuse referrals, including retrospective allegations against adults of concern

4.1 Introduction

This section of the report presents the Investigation Team's findings in relation to the quality and safety of Tusla's management of child sexual abuse referrals, including retrospective allegations* against persons subject of an allegation of abuse.

Under the Child and Family Act 2013, the Child and Family Agency (Tusla) is charged with supporting and promoting the development, welfare and protection of children and the effective functioning of families.

In 2016, Tusla reported it had received 47,399 referrals to Tusla child protection and welfare services in Ireland. Four out of 10 referrals (40%, 19,087 referrals) were related to child abuse concerns, while 6 out of 10 referrals (60%, 28,312) were welfare concerns. Of these 19,087 child abuse concerns, child sexual abuse concerns accounted for 3,042 referrals (16%).

Tusla reported, that as of 1 May 2017, it had 1,240 open child sexual abuse referrals against adults across the 17 Tusla service areas. In addition, it reported that it had 1,439 retrospective allegations of child sexual abuse open to the service.

The Investigation Team conducted its on-site fieldwork between June 2017 and January 2018, visiting six Tusla service areas and one regional team.

Tusla's formal pathway for the effective and consistent management of referrals of child abuse and neglect, including child sexual abuse, is the same pathway for all child protection and welfare referrals[29] and is supported by a suite of standard business processes, policies and guidelines.[32,33,34]**

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* Retrospective allegations are those made by adults who allege they were abused when they were children.

** Framework for measuring, managing and reporting social work intake, assessment and allocation activity, HSE, 2012.

Threshold of need, guidance for practitioners in Tusla social work services, January 2014.

Child Protection Conferences and the Child Protection Notification System – National Guidelines for Child and Family Agency Area Managers, Conference Chairpersons, Conference Administrators, Social Work Managers & Practitioners — 2015.

At the time of the investigation, the management of all allegations of child abuse was informed by Tusla's *Policy and Procedures for responding to allegations of Child Abuse and Neglect* (2014).[35] In 2018, Tusla submitted draft *National Procedures for Determining an Outcome to Allegations of Retrospective and Extrafamilial Abuse Cases and Protecting Children at Potential Risk of Harm* to the Investigation Team.[34] This draft procedure, once finalised, will replace aspects of the above-mentioned 2014 policy in relation to extrafamilial abuse* and retrospective child sexual abuse referrals. The Investigation Team was informed by senior management in Tusla that a new policy dealing with managing allegations of child sexual abuse made against a family member or guardian was being developed.

The Investigation Team based its assessment of the management of referrals on the HSE document[29] related to business standardisation, which was still being used by Tusla in the management of child sexual abuse referrals. The Investigation Team reviewed relevant documentation and data, and conducted case-record reviews. It also interviewed Tusla staff with operational, regional and executive responsibilities for ensuring the effectiveness of this process. In addition, it conducted group meetings with relevant agencies and therapeutic services in the six service areas visited.

At the time of this investigation, Tusla had a business process in place to direct the management of child sexual abuse referrals. However, similar processes were not in place for the management of retrospective allegations of child sexual abuse setting out all of the required steps with aligned timelines to support the consistent management of referrals of retrospective allegations against persons subject of an allegation of abuse. This will be addressed in section 4.3 of this Chapter.

Tusla described its understanding of risk to the Investigation Team. Potential risk is understood by Tusla to refer to risk which has not been assessed by a social worker, whereas actual risk has been assessed by a social worker and is, therefore, the level of risk that has been determined. However, the HIQA Investigation Team has a broader understanding of actual risk which includes systemic risk. For example, a large number of referrals awaiting assessment presents an actual systemic risk because the service does not have the capacity to carry out assessments in a timely way. It is the existence of an actual systemic risk that places children at potential risk.

Figure 3 describes the process for managing all child protection and welfare referrals, including child sexual abuse referrals, as indicated by Tusla's standard business processes. While Tusla did not have a specifically defined process for managing retrospective allegations of abuse and persons subject to allegations of abuse (PSAA)** during this investigation, Figure 3 reflects the key steps being taken locally and informally in the service areas.***

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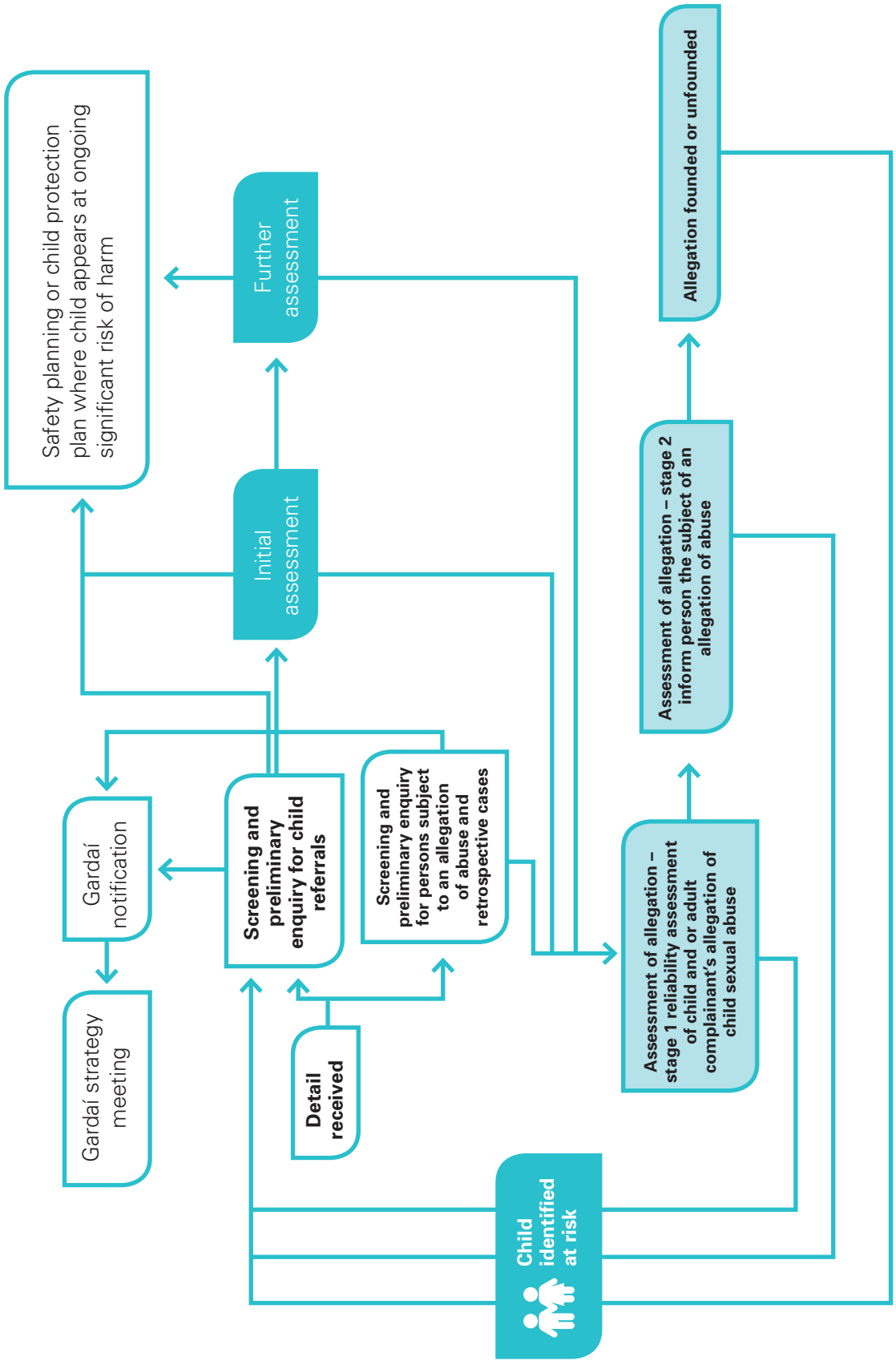
* Extrafamilial abuse refers to allegations of abuse occurring outside of the child's family or care giver.

** For the purposes of reporting in this investigation report, an adult of concern (in line with the Terms of Reference) is referred to as person subject of an allegation of abuse (PSAA).

*** The figures included in this chapter were developed by HIQA based on Tusla's standard business processes, policies and procedures.

Figure 3. Tusla's formal processes for managing **all child protection and welfare referrals**, including child sexual abuse referrals, as indicated by Tusla's standard business, including local informal steps for managing retrospective allegations



As part of its case-record review, the Investigation Team examined case records relating to 671* referrals, both open** (490) and closed*** (181) at six Tusla service area sites and one sexual abuse regional team.

4.2 Management of child sexual abuse referrals

The Investigation Team followed the HSE's standard business processes used by Tusla in reviewing the arrangements in place for the management of child sexual abuse. The process map in Figure 4 demonstrates the key steps that Tusla has in place to respond to child protection and welfare referrals, including child sexual abuse referrals.

Within this pathway, the Investigation Team identified five critical steps that Tusla staff must complete to ensure the safe and effective management of child sexual abuse referrals and indeed all child protection and welfare referrals. These steps**** are:

1. Screening and preliminary enquiry.
2. Safety planning.
3. Initial assessment.
4. Further assessment.
5. Engaging with the persons subject of an allegation of abuse.

In the six service areas and one regional dedicated team, the Investigation Team reviewed case records of 307 open referrals of child sexual abuse and 123 closed cases to assess the operational efficiency of Tusla's policies, procedures and staff guidance.

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* The Investigation Team reviewed 671 referrals in a total of 656 case records, as 15 case records had more than one referral.

** An 'open case' is where a referral is either waiting for a service or is being actively worked on by Tusla.

*** A 'closed case' is where Tusla has completed all necessary work and or circumstances have changed and the services of Tusla are no longer required. In such cases, the matter has either been brought to a satisfactory conclusion or, for example, a person has died and a social work service is no longer required. Before a case can be closed, the social work manager must review the case and agree that it can be closed.

**** During the initial assessment (step 3 above) and or further assessments (step 4 above), where relevant, Stage 1 of Tusla's allegation assessment process may start, which includes a reliability assessment of the child's allegation. A reliability assessment involves interviewing the child. Stage 2 of the allegation assessment follows whereby Tusla engages with the relevant persons subject of an allegation of abuse.

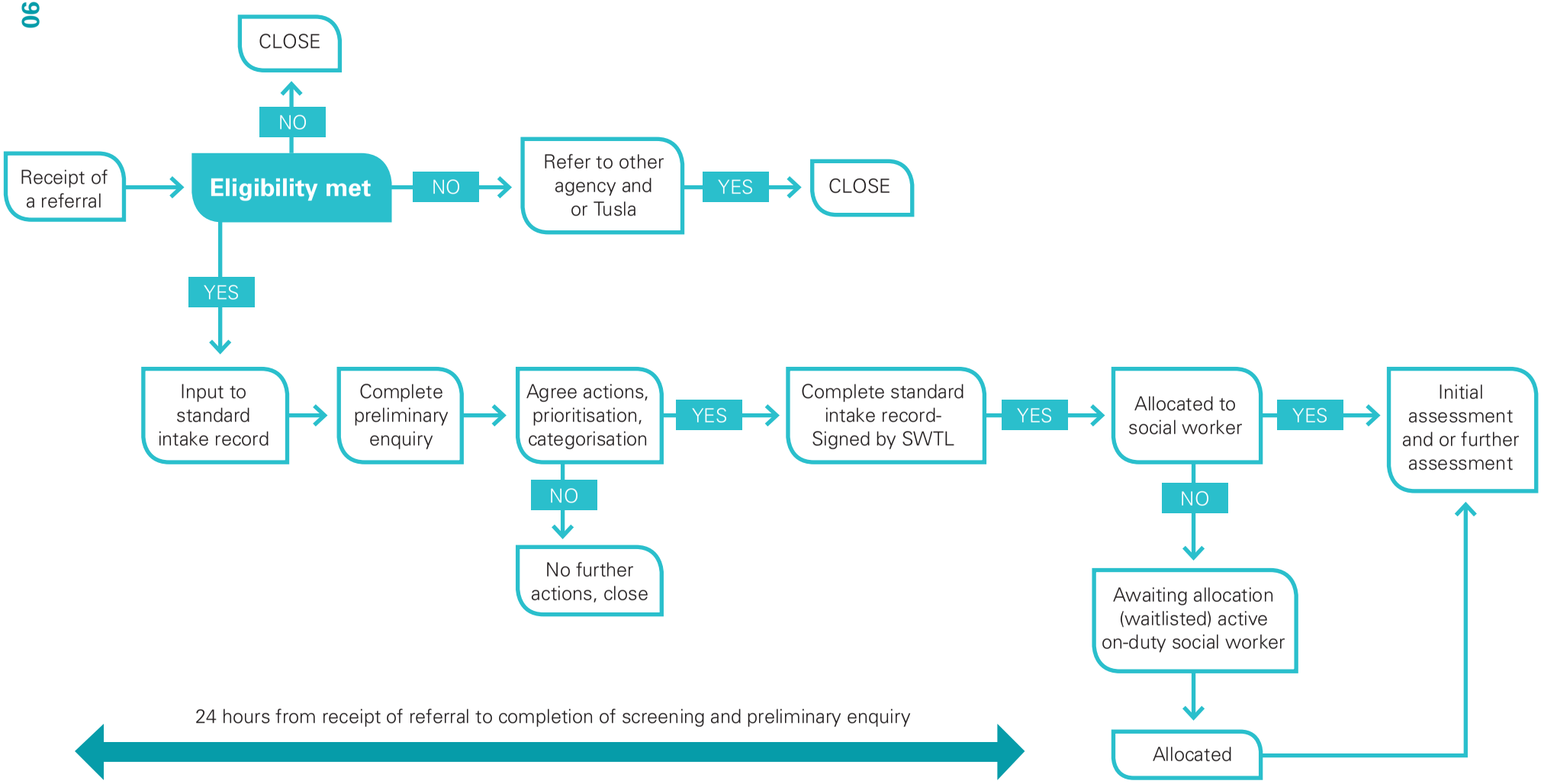
4.2.1 Screening and preliminary enquiry

Members of the public, professionals, community, voluntary services and An Garda Síochána can refer an allegation of child sexual abuse to Tusla. *Children First: National Guidance for the Protection and Welfare of Children* (2011)[36] has a standard referral form for this.* Tusla reported that it also receives child sexual abuse referrals verbally and in writing from, for example, parents and sometimes children.

Screening refers to the first step taken by a social worker in managing a referral of child abuse once it is received. Children First (2011) dictates that it is essential that all referrals of alleged child abuse, including child sexual abuse, should be promptly screened on receipt of the referral by Tusla. Figure 4 illustrates the screening and preliminary enquiry stage of the process.

* In May 2018, Tusla reported to the Investigation Team that referrals may also be received through an electronic reporting system.

Figure 4. Additional details on Tusla screening and preliminary enquiry process for child protection and welfare referrals, including alleged child sexual abuse



Note: SWTL = Social work team leader

At the point of receipt of a referral, the social worker assesses whether the referral meets the eligibility criteria of the service. If it does, Tusla will then proceed with the referral and the screening and preliminary enquiry stage. Tusla has an internal guidance document entitled *Threshold of need Guidance for Practitioners in Tusla Social Work Services – 2017* to guide staff in assessing referrals when they are received.

Tusla's threshold has four levels:

- A child at Level 1 requires no input from Tusla.
- A child at Level 2 may, for instance, require family support services.
- Level 3 relates to a child with multiple needs who may require a coordinated multiagency response.
- Level 4 refers to children with highly complex needs who may be at immediate risk of harm.

For the purpose of this investigation and in line with its Terms of Reference, the majority of referrals reviewed by the Investigation Team were screened by Tusla to be Level 3 cases. Once the eligibility is met, a preliminary enquiry is carried out by Tusla. This enquiry includes clarifying the details of the referral made and carrying out an internal check to establish if the child is already known to Tusla services, including whether the child is on the Child Protection Notification System (CPNS).* At the time of this investigation, Tusla's standard business processes stipulated that screening and preliminary enquiry should be completed within 24 hours of receiving the referral.

The information gathered at this stage should inform the decision of the social worker on the duty intake team** and his or her manager to accept and prioritise each case for allocation to a named social worker.

During its case-record review, the Investigation Team found evidence that Tusla had an internal document in place called 'A Framework for Measuring, Managing and Reporting Social Work Intake, Assessment and Allocation Activity — 2012'. This guided social workers in how to prioritise cases as high, medium or low priority. The document outlines that this guidance supports professional judgment.

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* The Child Protection Notification System is a notification system for children who are deemed to be at ongoing risk of significant harm and who have a protection plan. A protection plan is formulated at a child protection conference following the decision that the child is at ongoing risk of significant harm. The purpose of the child protection plan is to set out a series of actions that will promote the child's welfare and reduce the risk of harm.

** The duty intake team receives all new referrals and completes screening and preliminary enquiries on these.

The majority of cases reviewed by the Investigation Team were high- and medium-prioritised* cases. Most of those categorised as high priority had been allocated to a social worker.

Cases that were not allocated to a social worker were put on a waiting list. The effective management of waiting lists is necessary to ensure children at risk of sexual abuse are managed in a timely and effective manner. The Investigation Team reviewed the management of these particular waiting lists in five of the six service areas visited, as in the remaining service area, all child sexual abuse referrals had been allocated to a social worker. Of 53 high-priority child sexual abuse referrals identified and reviewed in the five service areas, 11 (21%) were unallocated at the time of the on-site fieldwork in two of the five service areas. Of these:

- three had been awaiting allocation for one month or less
- three were awaiting allocation for one to three months
- three were awaiting allocation for three to six months
- one was awaiting allocation almost 12 months
- one was awaiting allocation almost two years.

Referrals that had been categorised as medium- and or low-priority were awaiting allocation to a named social worker in five service areas.

The Investigation Team found inconsistencies in Tusla's approach to managing unallocated cases. For example, some areas used a referral team meeting to review new referrals, while, in another area, it remained the responsibility of the principal social worker and or team leader to make a weekly, fortnightly or monthly assessment of waiting lists. Other areas had devised a risk-rating system for all their referrals, including retrospective cases.**

Furthermore, there was no record of the rationale applied by Tusla as to why a decision had been made to retain a case on a waiting list or why a case was classified as 'active on duty'.***

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* A high-priority referral happens if, for example, an initial assessment or further assessment of a child protection concern is required. A medium-priority referral is where an initial assessment or further assessment is required for a child welfare concern. A low-priority referral is, for example, where a child may be on a family support plan following initial assessment.

** The Investigation Team was informed by Tusla in May 2018 that, as part of the Child Protection and Welfare Strategy, there is a dedicated work-stream for reform of its duty and intake system which is due to be fully implemented in 2018 and will include a revised prioritisation system for cases awaiting allocation and the management of caseloads.

*** Where a referral is held on a duty or intake team, work is being completed on it, including meeting the child and or parents, but the case has not been allocated to a social worker.

The Investigation Team recommends that Tusla reviews the current 'waitlist' system and as a priority, designs and implements a consistent approach nationally to the effective management of waiting lists across all 17 service areas.

During the screening and preliminary enquiry process, the social worker will also establish whether there are other children related to the referral that are at actual or potential risk and, if there are other children identified, that those children in turn go through the same screening and preliminary enquiry process.

Through a review of the system in place for screening and preliminary enquiries, the Investigation Team believed the quality of screening and preliminary enquiries was poor in all six service areas that it reviewed.

The Investigation Team reviewed records of 116 open children's referrals for the purpose of assessing the arrangements for screening and preliminary enquiry. Of those, an intake record was found on file in 108 (93%) referrals.

The Investigation Team found that referral information had not always been recorded on the Tusla standard intake form. In addition, there was no evidence that the screening and preliminary enquiry process had been completed with the appropriate action recorded on the form.

Standard intake forms were found to be unsigned and undated, and the Investigation Team was, therefore, not always able to determine whether screening took place within 24 hours. In 71 referrals where an intake record was on file, the Investigation Team recorded the dates that case records had been signed as completed. Of those, just over one in three (37% or 26 out of 71) were completed within 24 hours. Eighteen out of 71 (25%) remained incomplete for 10 working days or more.

In referrals where a standard intake form had been used, 64 out of 108 (59%) of referrals reviewed were of poor quality in the context of timeliness, lack of clarification of details of the allegation and an absence of or inadequate checks. For example, there was no evidence of internal checks having been carried out in line with standard business processes of whether children were already known to their service or already listed on the Child Protection Notification System (CPNS).

An effective quality screening and preliminary enquiry gives Tusla the appropriate information to decide what action is required to progress with the referral and to protect children at immediate risk. While the Investigation Team acknowledges that no service is without risk and there is always the potential for human error, a well-governed service will have effective processes in place to detect actual and or potential risk to children and put arrangements in place to mitigate these risks.

Senior Tusla managers interviewed by the Investigation Team acknowledged the need to increase the effectiveness of screening and preliminary enquiry stages — particularly in light of the introduction of mandatory reporting from December 2017 and the potential increase in referrals.

They outlined that a new standard approach for completing and recording screening and preliminary enquiries would be put in place with the introduction of 'Signs of Safety' — Tusla's new national approach to child protection practice. However, this approach was not in place at the time of the investigation fieldwork, with senior management team members reporting that it would take five years before its full implementation.

In addition, senior Tusla staff were confident that introducing Signs of Safety and extending the timescale for screening new referrals from 24 hours to five working days* would ultimately provide additional time for staff to gather further information concerning the child and the family circumstances. This, they believed, would improve decision-making at the point of referral. Notwithstanding these developments, at the time of the investigation, the arrangements in place to assess the completion of screening and preliminary enquiry in line with Tusla's own standard business process were inadequate and inconsistently applied. While Signs of Safety provides social workers with additional time to complete screening and preliminary enquiries, extended time frames alone cannot improve the quality of social work practice without a competent, well-trained staff group whose work is subject to effective supervision and oversight.

The Investigation Team was also concerned that the draft *National Procedures for Determining an Outcome to Allegations of Retrospective and Extrafamilial Abuse Cases and Protecting Children at Potential Risk of Harm* guided Tusla staff not to open a file on a child for whom a person subject to an allegation of abuse has direct care of until child sexual abuse has been established. This draft procedure does not clearly identify if a file will be opened on a child in the care of a person subject to an allegation of abuse if there was a belief that they may be at potential risk of abuse. If implemented, this, in the opinion of the Investigation Team, could delay some children at potential risk of harm from being identified and appropriate protection measures being taken by Tusla.

While the Investigation Team acknowledges Tusla's ongoing child protection and welfare strategy, in light of these findings, HIQA recommends that Tusla's executive immediately reviews and strengthens managerial oversight and accountability structures in all service and regional areas. This is needed to ensure the effective adherence to policy and processes and comprehensive record-keeping by its child protection teams throughout the screening and preliminary enquiry processes.

* Tusla, Interim Practice Guide Referral and Assessment Version 1 (January 2018), page 4.

4.2.2 Immediate action

Tusla's *Policy and Procedures for responding to allegations of Child Abuse and Neglect* (2014) outlines that immediate action must be taken to protect a child who is identified at serious and ongoing risk of significant harm. In order to keep a child safe, an immediate action can be taken at any time by Tusla. Actions taken include children being taken into the care of the State, social work teams visiting children in their home, joint home visits with members of An Garda Síochána, and safety planning to assess the parent's ability to keep the children safe.

The Investigation Team reviewed a sample of children's records relating to child sexual abuse referrals in the six service areas it visited and found that, in these cases, appropriate action had been taken by social workers when children were assessed as being at serious and ongoing risk of significant harm. The immediate action step was further explored at group meetings with members of An Garda Síochána and Tusla staff, with all participants expressing satisfaction with the current arrangements.

4.2.3 Safety planning

At the time of this investigation, Tusla did not have a consistently applied definition of safety planning. Therefore, for the purpose of this investigation, safety planning refers to the arrangements put in place by Tusla to ensure children stay safe when there is an actual or potential risk of sexual abuse. In line with best practice, safety planning involves working collaboratively with families to keep a child safe.[37,38,39]

Tusla had a formal process in place for implementing a child protection plan wherever a child had been identified as being at ongoing risk of significant harm as a result of abuse (including child sexual abuse) or neglect. This can happen at any stage in the referral process, but it usually happens after the initial assessment stage.

Children are listed on the Child Protection Notification System (CPNS)* following a multidisciplinary** meeting — in which the child and, where appropriate, their family, social workers, An Garda Síochána, other professionals and representatives of community and voluntary organisations attend. At the meeting, an agreed child protection plan (safety plan) is put in place to keep the children safe.

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* Child Protection Notification System — children who are deemed at ongoing risk of significant harm are listed and external agencies such as An Garda Síochána and hospitals can access this information 24 hours seven days a week in order to safeguard children.

** Child protection conference is a multidisciplinary meeting where children judged at ongoing risk are discussed and a child protection plan is formulated to keep them safe.

The Investigation Team regards safety planning in the protection of vulnerable children from sexual abuse as a critical child protection and welfare step. With the exception of children on the Child Protection Notification System who have a protection plan in place, Tusla did not have a clear definition of safety planning or a standard process in place for safety planning.

Safety planning aims to make sure proportionate measures are put in place to ensure the safety of all other children in contact with a person subject to an abuse allegation who have yet to be assessed but are potentially at risk. Staff told the Investigation Team, through group meetings and interviews, that safety planning measures included Tusla ensuring a child is supervised by an appropriate adult whenever the child is in contact with a person subject to an abuse allegation. These measures also included a person subject to an abuse allegation being asked not to live with children while an assessment of the alleged child sexual abuse is ongoing.

During its case-record review, the Investigation Team reviewed the records of 149 children's referrals across six Tusla service areas for the purpose of assessing the arrangements in place for safety planning. In the absence of a clear definition of safety planning or a standard process in place for safety planning, it was not surprising that the Investigation Team found variation in safety planning practices across the six service areas it visited. Some children, including those placed on the Child Protection Notification System, had appropriate safety plans in place, while others had none or inadequate safety plans in place. For example, of the 149 referrals reviewed for safety planning which included children on the Child Protection Notification System, 109 referrals (73%) required a safety plan, while 22 (20%) who required a safety plan did not have a safety plan in place.

All children on the Child Protection Notification System that were reviewed by the Investigation Team had a safety plan (protection plan). However, it was of particular concern to the Investigation Team that the monitoring systems in one service area had failed to identify that three children on the Notification System were not being appropriately monitored by Tusla and, therefore, were not being protected.

In addition, the Investigation Team also found that of the 87 referrals where there was a safety plan in place for children (80%), 24 referrals (28%) were not consistently monitored to ensure that the plans were effective. The Team found that a small number of parents or guardians (10 out of 87, or 11%) were not assessed as to their ability to keep a child safe, as social workers had in some instances not met with the parents or had not completed any assessment of the parents' capacity to protect the child. Therefore, it was not consistently evident how social workers were assured that an adult had the capacity to actively protect a child.

The Investigation Team found practice inconsistencies across the six service areas which suggest ineffective and inconsistent safeguarding arrangements for vulnerable children at risk of sexual abuse. Once again, the Investigation Team found in some cases evidence of poor managerial oversight and inadequate assurance arrangements to effectively detect and address these inconsistencies.

During this phase of the investigation, the Investigation Team escalated — to the relevant area manager and senior Tusla managers — any children's referrals where it could not find any evidence of safety planning and or where the safety planning records were inadequate. This was in the context of social workers monitoring safety arrangements for children and in ensuring that parents or guardians had the ability to implement the arrangements of a safety plan. In response to these escalations, Tusla provided satisfactory written assurance that plans were or had been put in place to keep a child safe

The Investigation Team explored these findings, in relation to safety planning, at interview with Tusla staff. Again, senior staff believed the implementation of the Signs of Safety programme would provide a consistent methodology and recording format for safety planning. It is acknowledged by the Investigation Team that the Signs of Safety model clearly outlines that social workers have to ensure the safety of the child, and where this is not possible by a safety plan, then protective action such as taking a child into care should be taken where appropriate.

Following this, Tusla provided the Investigation Team with the draft practice guidance on fair procedure dated February 2018.[33] The Investigation Team reviewed this draft practice guidance and noted that Tusla now clearly states that 'any form of sexual abuse or exploitation meets the threshold for significant harm' which requires that a social worker is to be assured that a child is safe. It also provides guidance to social workers on informing third parties such as family members about an allegation in order to ensure potential risks to children are planned for and managed. The Investigation Team welcomes this clarity and is of the view that if this aspect of the guidance is implemented, it will significantly improve safety planning arrangements for vulnerable children.

The draft *National Procedures for Determining an Outcome to Allegations of Retrospective and Extrafamilial Abuse Cases and Protecting Children at Potential Risk of Harm* and its accompanying guidance document did not clearly direct Tusla staff in their approach to safety planning for children. This policy also did not clearly identify if a file will be opened in relation to a child who meets Tusla's eligibility criteria and who is being cared for directly by a person subject of an allegation of abuse, or until a determination of the allegation is completed.

Therefore, safety planning for children in the direct care of a person subject of an allegation of abuse may not happen until a finding of a founded allegation of child sexual abuse is made against that person.

At the time of the investigation, this policy was in draft format and had not been implemented. Further clarity was required in order to provide clear guidance to Tusla staff and to ensure effective safety planning for all children at actual or potential risk.

While the Investigation Team welcomes Tusla's strategic approach to child protection and welfare, in reality, staff reported that Signs of Safety would take at least five years to fully roll out. Therefore, the Investigation Team recommends that as a priority Tusla review the current arrangements to ensure a shared understanding of and consistent approach to safety planning across all Tusla services. In tandem, Tusla must ensure there are effective quality assurance arrangements in place to check that these approaches are working.*

4.2.3 Initial assessment

If concerns related to the alleged sexual abuse of the child remain unresolved following screening and preliminary enquiry, an initial assessment is undertaken by Tusla.

The purpose of the initial assessment is to:

(a) identify whether a child is at risk and has unmet needs and

(b) to determine what actions are required to keep a child safe.

It is also at this stage that Tusla meets the child and, if required, completes an assessment of the reliability of their allegation of child sexual abuse. This is referred to as Stage 1 of Tusla's policy on responding to allegations of child abuse and neglect, including child sexual abuse. This may also be carried out at the further assessment stage.

Tusla reported that as of 1 May 2017, 165 (or 15%) of the 1,083 open child sexual abuse referrals against an adult that required an initial assessment were awaiting an initial assessment. Tusla's business processes state that, once started, all initial assessments are to be completed within 20 days.

In all six service areas visited, the Investigation Team reviewed a sample of case records of child sexual abuse referrals to check the arrangements in place for conducting initial assessments were in line with Tusla standard business processes. The Investigation Team found that an initial assessment was required in 125 referrals. Of those, 74 (59%) had commenced while the remainder were awaiting assessment.

With the exception of the high-priority cases, the cases reviewed by the Investigation Team demonstrated significant delays in either beginning or fully completing the initial assessment.

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* Signs of Safety provides a clear definition and approach to safety planning.

For example, of the 74 referrals where an initial assessment had started, there were dates available in the records for 60* (81%). Also, 24% of children's initial assessments (14 out of 58) had not started within the first three months of receipt of the referral, with two of those waiting between one and two years.

The Investigation Team found that Tusla had not consistently adhered to its 20-day completion business rule for initial assessments. Of the 74 referrals, 56 (75%) had been completed at the time of the on-site fieldwork. Both start and completion dates were available for 49 referrals.** The Investigation Team found that for these 49 completed initial assessments, 23 (47%) were completed within the 20-day time frame, with most of the remaining assessments (15 out of 49, or 31%) being completed within three months. Others were continuing for 6 to 12 months or more. In some instances, delays varied due to the personal circumstances of children and families who were unable or unwilling to engage with the social worker or where a social worker was awaiting further information from external services. The Investigation Team found that in some cases it was not recorded why the assessment was not completed within designated time frames.

In conducting the case-record review, the Investigation Team was mindful of *Children First: National Guidance for the Protection and Welfare of Children* and also Stage 1 of Tusla's policy to guide its staff on the management of child sexual abuse. Despite the delays seen with assessments, the Investigation Team found that children identified as being at ongoing risk of significant harm during the initial assessment process had been referred appropriately for case conference and protection planning.

There was also evidence that, when a further assessment had been recommended, that it had in fact happened, and that some referrals had been closed at this stage of the process as there had been no risk to the child.

The quality of these 56 completed initial assessment varied. These variations ranged from assessments being comprehensive and child-centred to those lacking detail and adequate analysis of information. Contrary to Children First (2011) and best practice, in two of the six service areas reviewed, five children had not been met by a social worker during the initial assessment process. In two out of five of these referrals, their cases were closed after the initial assessment, despite the children not being met by Tusla during the process.

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* Two of these referrals had recorded a start date for initial assessment that was prior to the referral date recorded.

** In May 2018, the Investigation Team was informed by Tusla that its new approach means a child may be met at the screening stage of managing a referral.

Stage 1: Meeting with the child and reliability assessment

Where the purpose of the initial assessment was to assess the reliability of the child's allegation, the Investigation Team found during a review of six such assessments that a clear rationale for social worker's professional judgments on the reliability of child sexual abuse allegations had not been consistently set out in line with Tusla's policy on responding to allegations.

These findings relating to initial assessments were further explored at interview with local, regional and senior Tusla managers. Tusla personnel highlighted that the implementation of the Signs of Safety programme would increase the time taken to complete the initial assessment from 20 to 40 days. However, the variation in quality of assessments and delays of up to three months and more in starting them in a large number of cases reinforces the need to improve managerial oversight, quality assurance arrangements, audit processes, accountability arrangements and staff training and support in order to ensure the safe and effective management of all child sexual abuse referrals.

4.2.4 Further assessment

A further assessment is an in-depth assessment of a child's circumstances. This assessment is carried out by Tusla either at the end of the screening and preliminary enquiry step or at the conclusion of the initial assessment step.

Tusla reported that, as of 1 May 2017, there were 63 child sexual abuse cases on a waiting list for further assessment by a social worker.

The Investigation Team reviewed further assessments in six service areas and explored with Tusla staff the processes in place. The Investigation Team found that further assessments, which evaluate child sexual abuse referrals, had resulted in appropriate responses to the assessed needs of the child and that a clear rational had been outlined in relation to the reliability of the allegation where appropriate. It was observed in case records that staff had also made recommendations for therapeutic supports for children where required. It is of note that in the planning of further assessments, consultation between Tusla and An Garda Síochána usually occurred prior to the commencement of a further assessment of alleged child sexual abuse in order to discuss the roles of both organisations.*

* In some instances, a child sexual abuse case may not be subject to a criminal investigation and therefore did not require this level of coordination between both agencies.

There was evidence of some delays in conducting the further assessment, Tusla personnel stated that these primarily related to:

- an ongoing criminal investigation
- awaiting specialist interview by a third-party
- the child's personal circumstances.

In addition, there was evidence of a variation in the approach to and the time frames for completing further assessments.

The Investigation Team recommends Tusla sets out clear guidelines and business rules to guide staff in this area. Furthermore, Tusla should as a priority assess the impact that any delay in further assessment has on children's safety, particularly in the cases of ongoing criminal investigations.

4.2.5 Stage 2 of Tusla's policy on responding to allegations of child abuse and neglect, including child sexual abuse — engaging with the person subject to an allegation of abuse (PSAA)

The Stage 1 assessment of the reliability of a child's allegation was usually carried out through the initial assessment or further assessment process. This could include, in line with Tusla's policy on responding to allegations of child abuse and neglect, a social work review of the evidence provided by An Garda Síochána.

Once the reliability of the child's allegation has been established, the next stage of the assessment process, Stage 2, involves Tusla meeting with the person subject of an allegation of abuse (where Stage 1 was completed). The main purpose of this meeting is to fully inform this person of the child sexual abuse allegations made against him or her and to provide the person with the right of reply. On completion of this meeting, the social worker makes a decision on whether or not the allegation against the person subject of an allegation of abuse is founded (that is to say, established) or unfounded.

The Stage 2 meeting is critical to bringing the assessment of an allegation to a conclusion. Delays at this stage may result in unnecessary protective measures being in place for children and also has the potential to negatively impact on adults against whom an allegation has been made.

The Investigation Team reviewed a selected number of case records in tandem with Tusla's supporting policies and found there were no defined timelines for the completion of the Stage 2 process. While there was evidence of good practices, there was also evidence of delays, particularly when there were ongoing criminal investigations and when the location of a person subject of an allegation of abuse was unknown or the case was awaiting the allocation of a named social worker. Some of the referrals reviewed did not clearly document the rationale behind the judgment made by Tusla.

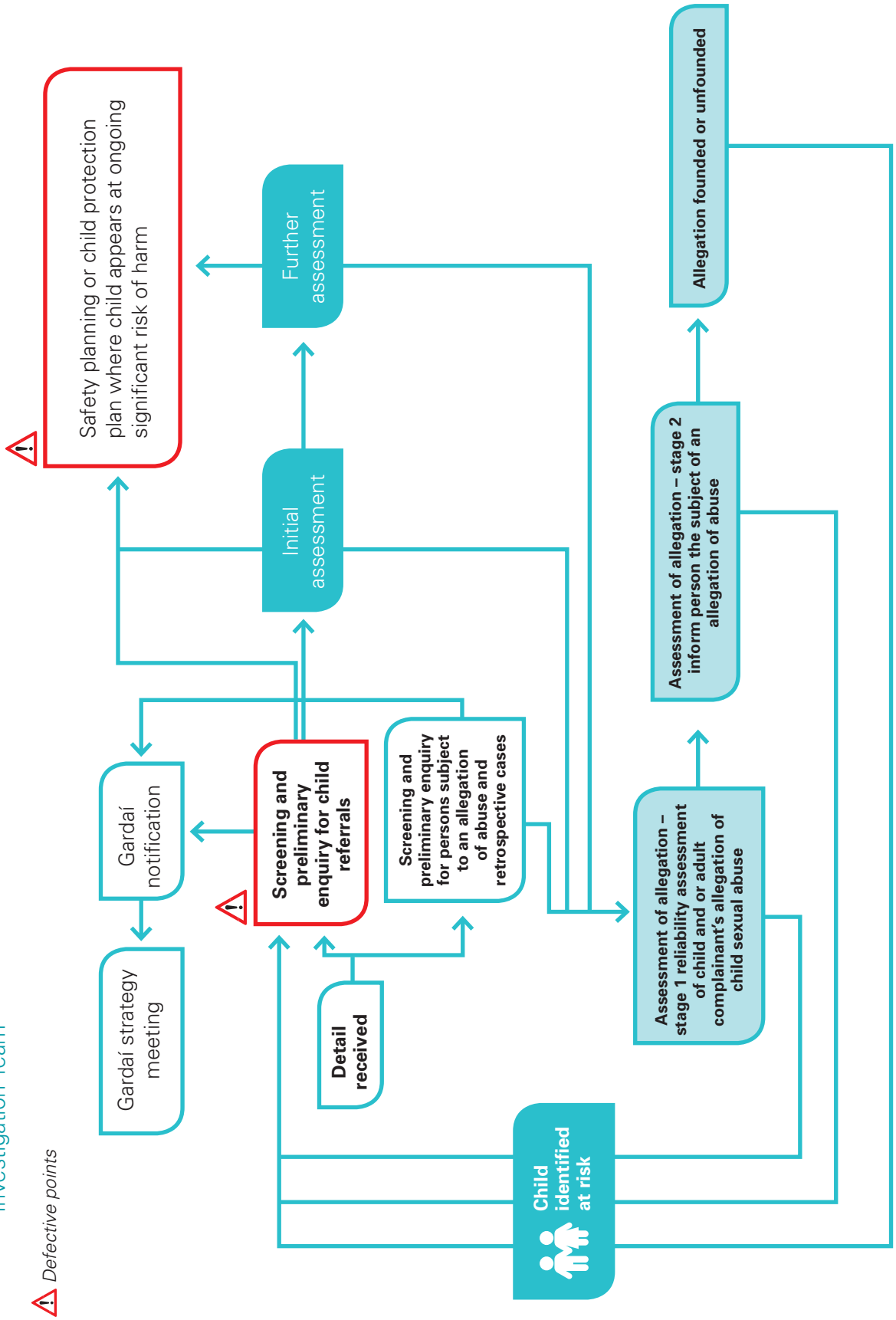
As with other aspects of child protection practice, the Investigation Team found variations in practice within and across the service areas visited. For example, while the person subject of an allegation of abuse should be informed in writing of the allegations made, the level of detail provided to people that were the subject of an allegation of abuse at this stage of the process differed and in some instances it was limited to a letter informing them only of 'an allegation'.

These findings were further explored with Tusla staff, who identified the introduction in December 2017 of a joint Children First liaison protocol between Tusla and An Garda Síochána as a significant and positive step towards improving interagency cooperation. The Investigation Team welcomes this development and recommends that Tusla further enhances its own internal arrangements by introducing a defined timeline and supporting guidance for staff to complete the Stage 2 meeting process and to ensure adequate managerial oversight of the process.

4.2.6 Summary of the management of child sexual abuse referrals

Given the findings described above, the Investigation Team was concerned about the arrangements that Tusla had in place for managing child sexual abuse referrals and in protecting vulnerable children. The shortcomings in the process are particularly evident at the screening and preliminary enquiry stage and the arrangements for ensuring the safety of children at potential risk. These two defective points in the process are highlighted in Figure 5.

Figure 5. Tusla's formal process for managing referrals of child sexual abuse with defective points of concern identified by the HIQA Investigation Team



Delays in screening and preliminary enquiry and incomplete information about the referral meant that children at potential risk were not being assessed and where necessary, protected, in a timely and effective manner. Furthermore, inconsistencies in safety planning meant that while some children were adequately safeguarded, other children were not as the measures that are necessary to ensure the child's protection and wellbeing were not set out in a safety plan. For children who had a plan, some were inadequately monitored by Tusla to ensure their safety.

The Investigation Team was concerned that its case-record review focused on the narrow lens of child sexual abuse referrals. As stated earlier, the pathway for the management of these referrals is the exact pathway for all child protection and welfare referrals. For example, in 2016, the referral and subsequent management of child sexual abuse cases equated to just over one in six of all child protection and welfare referrals (16% or 3,042 out of 19,087 referrals) it received.

Given the operational risks identified in this investigation and due to HIQA's findings across its monitoring programme for child protection and welfare services, the Investigation Team is concerned that there is possibly a much wider group of children at potential risk because of the shortcomings in this overall process. In short, the Investigation Team believes there is a significant risk that deficiencies it identified in this process may be replicated in other child protection and welfare referrals.

Therefore, the Investigation Team recommends, for the elimination of doubt in relation to real or potential risks to children, that Tusla, as a matter of urgency, implements a time-bound action plan to effectively address these findings, to include ongoing evaluation and assurance.

4.3 Management of retrospective allegations against persons subject of an allegation of abuse

Retrospective child sexual abuse referrals arise when an adult alleges that they were abused during their childhood.[36] Tusla reported that, as of 1 May 2017, it had 1,456 open referrals against persons subject of allegations of abuse allegations. Of those, 413 were retrospective cases awaiting a risk assessment.

Three out of the six service areas visited by the Investigation Team had developed retrospective abuse allegation teams, who were responsible for assessing retrospective allegations of child sexual abuse. A fourth service area was in the late stages of developing such a dedicated team. In the remaining two service areas, individual team members had specific responsibility for these cases.

At the time of this investigation, the service director in the Dublin North East Region had created and resourced a dedicated team* to manage some retrospective cases on a regional basis and to provide a standardised regional approach to the management of retrospective cases. The Investigation Team was informed that some cases were transferred from local service areas within that region to this dedicated team, while other cases were managed by the local service areas within that region. In addition, staff informed the Investigation Team that service improvement teams had been established in the other regions with the reported purpose of reducing the waiting list by reviewing low-priority retrospective cases.

Regular reviews of unallocated retrospective cases are essential in order to ensure that prioritisation levels reflect updated information and that cases are allocated to a named social worker in a timely manner. Similar to the review of child sexual abuse referrals on the waiting list, the systems examined by the Investigation Team and used by Tusla to review retrospective cases awaiting allocation varied greatly from place to place around the country.

At the time of this investigation, Tusla did not have a uniform system in place to monitor retrospective abuse referral waiting lists. Therefore, the systems and frequency of review of retrospective cases on these waiting lists varied. By way of example, some of these referrals were reviewed weekly while others were not consistently reviewed in a systematic way.

In line with the Terms of Reference of the investigation, the Investigation Team reviewed a sample of 241 case records (183 open and 58 closed) — in six service areas and in the regional dedicated team in the Dublin North East Region — to identify the arrangements in place for managing retrospective allegations of abuse and to consider the effectiveness of how retrospective cases were being managed by Tusla in relation to:

- screening and preliminary enquiry
- Stage 1 – Meeting the adult complainant and assessment of reliability
- Stage 2 – Engaging with the person subject of an allegation of abuse.

The Investigation Team also reviewed the supporting operational policies and procedures that Tusla had in place at the time of the investigation and interviewed relevant Tusla personnel.

* The Investigation Team was informed by Tusla in May 2018 that one of the strategic priorities for the Chief Operations Officer is the establishment of four regional teams to manage retrospective allegations.

The Investigation Team found waiting lists in all six service areas for retrospective cases awaiting allocation to a named social worker. In three of these service areas, 15 high-priority retrospective referrals were waiting to be allocated to a social worker at the time of the on-site investigation fieldwork visit. Of these, 13 were held in one service area, and 8 out of the 15 were open to the service for more than 12 months. All six areas had medium- and or low-priority cases which were awaiting allocation to a named social worker.

The Investigation Team recommends that Tusla puts in place uniform waiting list management systems to review and monitor retrospective child sexual abuse allegations and cases involving persons subject of an allegation of abuse which are awaiting allocation to a named social worker.

4.3.1 Screening and preliminary enquiry in the six service areas on receipt of a referral of an allegation of retrospective child sexual abuse

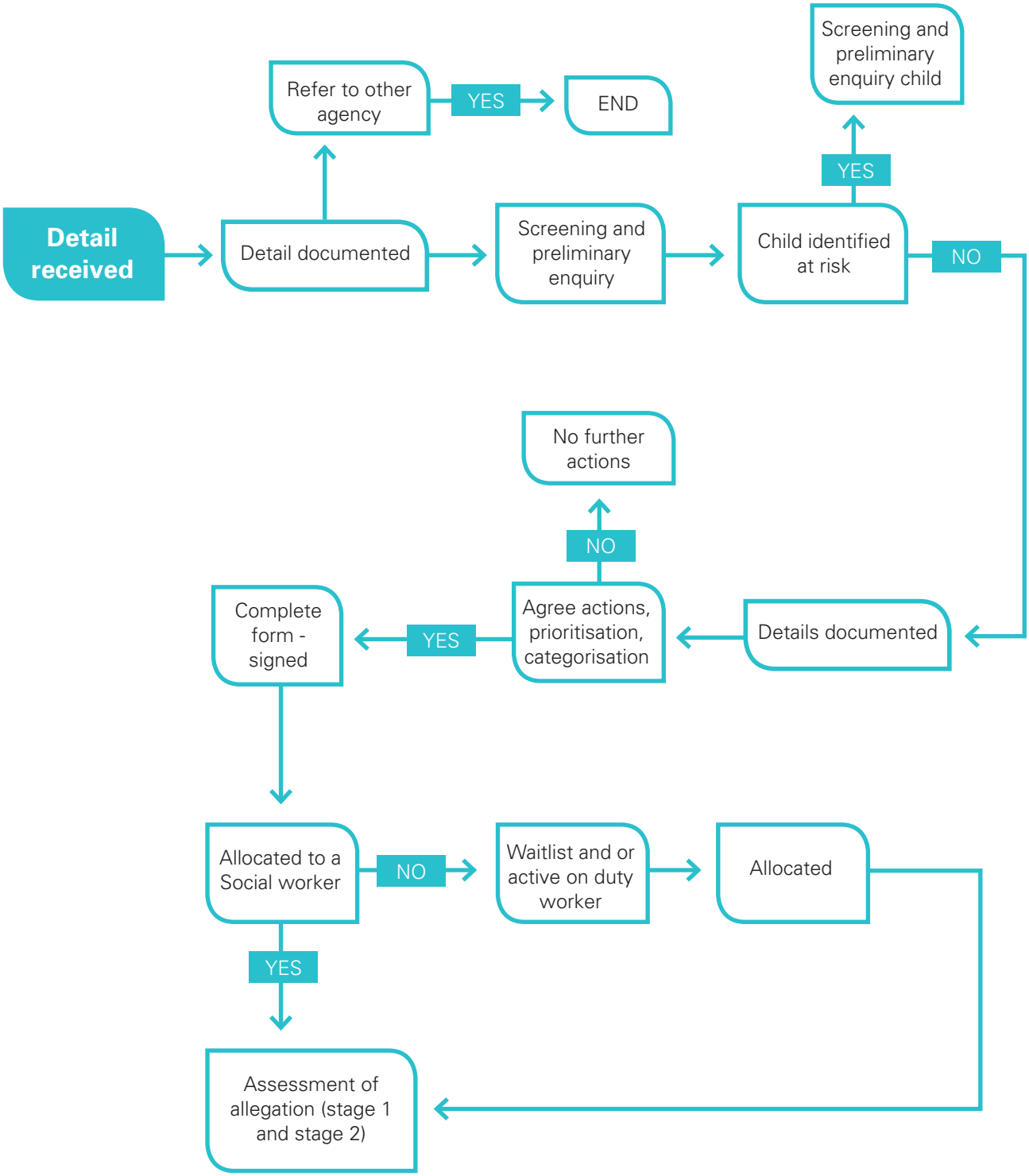
Similar to the screening and preliminary enquiry process for all child protection and welfare cases, on receipt of a referral of an allegation of retrospective child sexual abuse, Tusla establishes whether the referral is appropriate for its service to manage.

Once Tusla establishes that the referral is appropriate, a preliminary enquiry should be carried out. This enquiry includes clarifying the details of the referral made and establishing whether the adult complainant or the person subject of an allegation of abuse is already known to the service and also if the person subject of an allegation of abuse has current contact with a child.

The information gathered at this stage informs the social worker and his or her manager's decision to accept and prioritise each case for allocation to a named social worker. During this process, the social worker may establish that there are other children at potential risk arising out of the retrospective allegation, and those children in turn should go through the screening and preliminary enquiry process (as previously described in section 2.1 of this report).

At the time of this investigation, while Tusla have a policy and procedure to respond to allegations of child abuse and neglect, including retrospective allegations of abuse, Tusla does not have a standard business process in place to lead staff through all of the required steps to manage retrospective child sexual abuse allegations. As a result, the Investigation Team found that the six service areas had developed their own different processes, including recording systems in relation to screening and preliminary enquiry stages. The Investigation Team has included in Figure 6 the key steps being taken locally and informally in the service areas.

Figure 6. Key steps being taken **locally and informally** in the service areas reviewed for managing retrospective allegations of child abuse



The Investigation Team found that the majority of retrospective referrals of child sexual abuse allegations were received through the duty intake service as illustrated above. Despite this, the arrangements for screening and preliminary enquiry differed. For example, in one service area, the referrals were transferred to the local service area's retrospective team where the social work manager completed the screening and preliminary enquiry process. In another service area, a principal social worker completed this task, while in a third service area the process changed in the weeks prior to fieldwork whereby the duty intake team completed the screening and preliminary enquiry for all retrospective cases. The duty social workers in the remaining three areas completed the screening and preliminary enquiry process.

Significantly, the Investigation Team found that screening and preliminary enquiry was not always completed. The referral date was available for 173 out of 183 open retrospective cases reviewed, and 35 referrals (or 20%) were observed to have been open for over three years at the time of the on-site fieldwork. Some had not been adequately screened when they had been originally received despite managerial review of these referrals.

The Investigation Team found that Tusla did not consistently confirm whether or not a person subject of an allegation of abuse had current contact with children as part of the screening and preliminary enquiries process. This aspect is essential in establishing whether the referral is appropriate for Tusla due to the potential risk to children. During the course of the investigation fieldwork, one service area accepted this finding and addressed the deficiency by amending its screening methodology to incorporate this key issue. Nonetheless, the Investigation Team did not see any subsequent evidence that this finding and associated learning had been shared across all services areas.

In the week following the conclusion of the investigation fieldwork, the Investigation Team escalated to Tusla area managers, in writing, individual retrospective referrals at local service level which — through a lack of supporting evidence relating to the quality of screening and preliminary enquiries — presented a potential and or actual risk to children. Written assurances were again provided by area managers on further actions taken or which were being planned to be taken in relation to the individual cases escalated.

Tusla personnel reported that there was no guidance for applying a consistent prioritisation system for social worker allocation and assessment of allegations of retrospective abuse in local service areas. The Investigation Team believes this compromises their ability to adequately prioritise cases as there is no established set of criteria for this.

The Investigation Team reviewed these findings with senior Tusla personnel who said they were already well aware of the operational inconsistencies in the screening and preliminary enquiries for retrospective referrals.* Tusla had reviewed retrospective cases nationally in 2015 and repeated this review in 2016. In response to the findings of these two reviews, it had introduced a screening tool for staff to use. However, this occurred in February 2018 — 11 months after the report on the 2016 review had been completed in March 2017.

Some senior management team members told the Investigation Team in November 2017 that a new procedure was at that stage awaited to support staff with managing retrospective referrals, including screening and preliminary enquiries. The draft procedure[34] was submitted to the Investigation Team in February 2018, and it included clear guidance with regard to screening and preliminary enquiry of retrospective cases. Having reviewed this draft policy, the Investigation Team believes that if it is implemented, along with the new retrospective screening tool, it should help address the majority of deficiencies identified by the Investigation Team.

However, the Investigation Team remains concerned at the slow pace of introducing the necessary measures and supports to counter the problems and risks identified and escalated during the investigation fieldwork since it commenced in June 2017. Therefore, the Investigation Team recommends that as a matter of urgency, Tusla develops standard business processes for managing retrospective referrals of allegations of abuse to reflect the draft policy as outlined. This should include prioritisation levels and timelines for assessments and should be widely shared across all service and regional areas.

4.3.2 Stage 1 — Interview with adult complainant and reliability assessment in retrospective allegations of child sexual abuse

In order to determine whether a retrospective allegation of child sexual abuse by an adult is reliable (Stage 1), the allegation needs to be assessed. This process includes a meeting with the adult complainant and an analysis of all available information provided to Tusla. This may be the first step in determining whether a child is currently at risk. Delays in completing an assessment slows down Tusla's ability to respond in a timely manner to potential immediate risks to children.

At the time of this investigation, the Investigation Team was concerned to learn that Tusla had not set any timescales to inform its personnel of how quickly an assessment should be completed into whether an allegation of retrospective child sexual abuse is reliable or not.

* Tusla (March 2017): Report of the National Assurance Review of Retrospective Abuse Cases Awaiting Allocation.

The Investigation Team reviewed a random sample of retrospective child sexual abuse referrals within the six service areas that:

- were awaiting a Stage 1 assessment
- were undergoing Stage 1 of the assessment or
- had Stage 1 of the assessment completed.

The Investigation Team found a considerable period of time passed between the referral and the start of these assessments in all service areas, including in the case of 19 high-priority referrals in three service areas. Waiting times from the referral to the start of assessments ranged from one month to over three years.*

While there was evidence, in the opinion of the Investigation Team, of a lack of urgency in conducting and completing reliability assessments in the six service areas reviewed, Tusla personnel and case records outlined that these protracted assessments were primarily caused by:

- an ongoing criminal investigation
- the adult complainant's personal circumstances
- delays in the sharing of information between agencies and other professionals
- being on a waiting list for allocation to a named social worker.

It is important to note that adult complainants can exercise their right not to progress their allegation any further, and this was evident in records reviewed by the Investigation Team in all six service areas. However, there was a lack of a uniform response seen in such situations. Where there was a lack of engagement by the adult complainant, Tusla child protection services varied in its response to children currently at potential risk. Notwithstanding these challenges, the Investigation Team found that, in some cases reviewed, a lack of engagement with Tusla by the adult complainant did not interfere with Tusla continuing to assess the risk to current children. It was of concern to the Investigation Team that in other cases reviewed, no further action was taken in the absence of a reliability assessment being completed due to a lack of engagement of the adult complainant and the referral was closed to the system without establishing if children were at risk.

The Investigation Team was concerned that the considerable period of time taken to review and process such allegations could potentially inhibit or deter adult complainants with a well-founded concern from continuing with the process, thereby creating a risk of an opportunity to protect other children from abuse being lost.

* As part of the methodology of the investigation, the commencement of Stage 1 was recorded as when Tusla first contacted the adult complainant about the assessment process.

The Investigation Team also found that there was a lack of guidance for staff in how to effectively conduct the assessments of the reliability of the allegation. This may have contributed to a variation in practice in relation to the rationale used and the recording of the judgments of reliability.

The Investigation Team found in instances where Tusla judged that the adult complainant's account of the allegation was not reliable or where there were no risks evident to children, the adult complainant was informed of this and the referral closed to Tusla.

Senior Tusla management acknowledged that there was a historical backlog of retrospective allegations where there were delays in assessment. They outlined that they had put measures in place to reduce waiting lists for assessments, which had been reflected in the reduction of the number of unallocated retrospective cases (including retrospective child sexual abuse referrals) from 871 to 436 between January and November 2017.[40] However, a substantial waiting list of retrospective cases (436) remained, despite month-on-month reductions in the number of retrospective cases awaiting allocation to a named social worker.[40,41]

Tusla's draft *National Procedures for Determining an Outcome to Allegations of Retrospective and Extrafamilial Abuse Cases and Protection Children at Potential Risk of Harm* provides a list of factors that should be considered when making a judgment of reliability. The Investigation Team recommends that Tusla implement this guidance nationally in relation to judgments of reliability to:

a. adequately address the variations in practice identified during this investigation

b. support social work teams in their assessments

c. ultimately reduce any potential risk to children.

4.3.3 Stage 2 — Engaging with the person subject of an allegation of abuse in allegations of retrospective child sexual abuse

Where the allegations of retrospective child sexual abuse are deemed reliable by Tusla, the assessment of the retrospective child sexual abuse referral proceeds to the second stage of the process for managing allegations, which involves meeting with the person subject of an allegation of abuse.

The purpose of this stage of the process is to advise the person subject of an allegation of abuse of the allegations in full and to provide that person with the right to reply. At the end of this stage, the social worker involved in the process, in consultation with their manager, has to decide whether the allegation is founded (that is to say, established) or unfounded.

Again, the Investigation Team found that there were no defined timelines to guide Tusla personnel on how quickly the stage 2 process should be completed. Nonetheless, the Investigation Team found examples of some well-managed cases which had been brought to a conclusion in a timely way.

However, delays were frequent in starting and completing this stage of the assessment. The Investigation Team found cases of eight referrals where the Stage 2 assessments had not been completed at the time of the investigation and the referrals had been open longer than six months. Four of these referrals were open for more than three years. Tusla staff reported that the factors which contributed to delays in progressing the meeting with persons subject of an allegation of abuse included:

- ongoing criminal investigations
- An Garda Síochána requests to Tusla not to meet nor inform the person subject to an abuse allegation at that time
- the person subject to an abuse allegation exercising their right to seek legal advice
- the personal circumstances of the persons subject of an allegation of abuse
- where the location of the persons subject of an allegation of abuse is unknown.

Prior to social workers meeting with the person subject of an allegation of abuse, formal letters should be issued to notify the person that an allegation had been made against them and inviting the person concerned to meet with social workers and to respond to the allegation. The Investigation Team reviewed a sample of these letters in all six service areas. Although there was a standard template in use, the level of detailed information on the allegation provided to the person subject of an allegation of abuse varied and this frequently led to them requesting further information in order to be able to respond to the allegation.

Tusla cannot compel the person subject of an allegation of abuse to engage in the process. In line with policy, where the person subject of an allegation of abuse chooses not to engage in the process, the Investigation Team found that provisional conclusions to the assessment of the allegation were reached. However, the Investigation Team found inconsistencies in the application of the policy and cases that remained open in the absence of a provisional judgment being made. These factors all contributed to retrospective child sexual abuse referrals remaining open to the service but very little social work activity happening for protracted periods of time. Effective management of these cases would ensure that the policy is followed and provisional and final findings made in order to either close the case to Tusla or complete a risk assessment if required.

Where a retrospective allegation of child sexual abuse against a person subject of an allegation of abuse was 'founded' (that is to say, established) by Tusla, where required, the person subject of an allegation of abuse was informed in writing of the provisional and the final outcome and they had a right to appeal the judgment to Tusla. There were three cases where provisional/founded findings had not been provided to persons subject of allegation of abuse at the time of fieldwork. One of these cases was escalated due to the delay in informing the person subject of an allegation of abuse of the outcome.

The Investigation Team also found a variation in what was included in the Stage 2 assessment. In some individual cases, the assessment process included commentary on whether the person subject of an allegation of abuse posed a risk to children. In other areas, persons who received a finding of a founded child sexual abuse are referred for specific risk assessments.

The Investigation Team found that third parties were appropriately informed when a finding of founded child sexual abuse had been made. However, it was of concern to the Investigation Team that managerial oversight had not ensured that all relevant third parties be informed in a timely way in one case related to multiple children, when an established finding of child sexual abuse had been made against a person subject of an allegation of abuse.

Wherever the case-record reviews carried out by the Investigation Team raised concerns in relation to what it believed to be deficiencies in Stage 2 (relating to retrospective allegations of child sexual abuse), the Investigation Team escalated individual retrospective cases to Tusla at local level. Assurances were again provided by area managers that corrective steps had been taken in the individual cases escalated. However, Tusla should assure itself that all such risks are being actively and routinely monitored.

Senior managers at national and regional level and staff told the Investigation Team that there were challenges in managing these cases as many of these cases were complex. They believed that legislative change — such as changes to the Child Care Act, 1991 — in relation to the role and functions of Tusla was necessary. In addition, they pointed to the need to strengthen partnership work with the Gardaí and referenced joint social work and An Garda Síochána child protection teams* as a way of doing this.

Tusla provided the Investigation Team with draft national procedures for managing retrospective and extrafamilial abuse[34] cases accompanied by a draft practice guidance document dated February 2018,[33] which provides advice on each step of the process.

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* Teams comprising members of An Garda Síochána and Tusla social workers to enhance collaborative working between these agencies for the protection of children, as provided for in Children First 2017. Further information on joint social work and An Garda Síochána child protection teams can be obtained from: https://www.oireachtas.ie/ga/debates/debate/joint_committee_on_children_and_youth_affairs/2017-06-21/3/

The draft practice guidance, when fully implemented, should provide clear guidance for staff on the steps to be taken in relation to the effective assessment of retrospective and extrafamilial abuse cases. It outlines clearly that the child's safety is paramount and that corrective measures will always be taken to protect the child.

The Investigation Team recommends that this draft guidance document is now adopted and formalised by Tusla as a matter of urgency and implemented across all service areas. Tusla should put strong and effective assurance arrangements in place to ensure that staff are educated and trained in its use and that routine quality assurance controls are in place to measure its effectiveness.

4.3.4 Management of retrospective child sexual abuse cases — Sexual Abuse Regional Team (SART)

A stand-alone dedicated team was established in the Dublin North East Tusla Region in 2016 to reduce waiting lists for assessing allegations of retrospective abuse cases and also to standardise practice in the region. The Sexual Abuse Regional Team (SART) primarily held retrospective cases, but also had a number of referrals concerning current child sexual abuse allegations against an adult. In addition, other service areas had created dedicated teams within their own existing structures.

Overall, the Investigation Team found that this trained dedicated team worked well and provided a good service. Additional resources were provided to this team to support it in its development and delivery of the service. Specific training and external supervision in relation to completing a risk assessment was in place. The team had a uniform approach to its management of retrospective child sexual abuse cases.

Despite this, and similar to the six service areas visited by the Investigation Team, there was evidence of inconsistencies and delays in the management of retrospective cases across Tusla. However, the Investigation Team was satisfied that the local dedicated teams were still evolving and there was evidence to show how they were streamlining and improving processes.

4.3.5 Summary of management of retrospective allegations against persons subject of an allegation of abuse

As described above, while there is a current policy and procedure for the management of all allegations of child abuse including retrospective abuse, in the absence of a standard business process for the management of retrospective referrals, the Investigation Team identified a variance in practice in the management of retrospective referrals across the service areas visited.

This variance, together with the lack of a timely commencement and completion of Stage 1 and Stage 2 assessments, indicated a systems risk which posed a potential risk to children that remained unidentified and or unmanaged.

4.4 Risk determination in child sexual abuse referrals and retrospective cases

Risk assessments are required to be carried out once Tusla has arrived at a founded finding of child sexual abuse, including retrospective child sexual abuse, and may also be required where an individual has a conviction of child sexual abuse and has contact with children. Typically, risk assessments are carried out to establish if adults of concern pose a risk to children they live with or have contact with.

In October 2017, Tusla informed HIQA that in order to enhance staff skills, it had taken pro-active steps in 2017 to arrange for training in the completion of adult risk assessment for selected staff, in all of the fieldwork sites visited by the Investigation Team, who were primarily working on dedicated retrospective teams. Tusla also outlined that further training was being planned on a national scale. In addition, Tusla commissioned external agencies and professionals to complete these assessments.

The Investigation Team reviewed 11 completed risk assessments and six that were in the process of completion by Tusla. It found that there were frequent delays in carrying out these risk assessments, and a small number of records showed that Tusla had not determined if a risk assessment was required. Of those completed, the assessment had been comprehensive, while in others where the risk assessment was in progress at the time, it was found to be of good quality.

The Investigation Team recommends that Tusla ensure effective assurance arrangements are in place in the Sexual Abuse Regional Team (SART) and other dedicated teams to ensure that all risk assessments are effectively completed in a timely way and, where appropriate, the required protective measures are taken to ensure children's safety.

4.5 Closed cases of child sexual abuse and retrospective cases

A closed case refers to a case that has either been brought to a satisfactory conclusion or where circumstances have changed, for example, a person subject to an abuse allegation against children has died and a Tusla social work service is no longer required. Before a case can be closed, the social work manager must review the case and agree that it can be closed.

The Investigation Team reviewed 164 cases reported as closed in the six service areas and found evidence of poor record-keeping. As a consequence, it could not establish if some of the cases reviewed were actually closed. Furthermore, the Investigation Team found cases which were inappropriately closed as there were outstanding child protection concerns. These cases were escalated to the relevant area managers and reopened. It is incumbent on Tusla to ensure that no case is closed where child protection risks remain unassessed.

Not to ensure the resilience of the process places vulnerable children at continuing risk of neglect and abuse. As a priority, the Investigation Team recommends that Tusla immediately review and ensure its current processes are safe and effective.

4.6 Notifications of child sexual abuse, including retrospective allegations, to An Garda Síochána

Children First: National Guidance for the Protection and Welfare (2011) clearly outlined that there is a mutual responsibility on Tusla and An Garda Síochána to notify each other of suspected child sexual abuse in a timely way.

A sample of case records in all fieldwork sites was reviewed by the Investigation Team.

As Tusla had not been adhering consistently to the requirements of Children First (2011), the Investigation Team escalated this risk to Tusla at local level in relation to some individual cases involving alleged child sexual abuse that had not been notified to An Garda Síochána. In addition, the lack of timely notifications by Tusla was escalated by HIQA to Tusla as a systems risk in one service area.

While satisfactory assurances were provided by area managers in relation to the escalated referrals, the absence of or the delay in informing An Garda Síochána of suspected child sexual abuse could have impacted on the ability of the Gardaí to carry out its statutory duty in conducting a criminal investigation.

The Investigation Team recommends that Tusla implements a well-structured and transparent monitoring system for the timely notification by Tusla to An Garda Síochána of suspected child abuse, including allegations of child sexual abuse and retrospective child sexual abuse allegations.

4.7 Risk escalations

Over the course of the investigation, the Investigation Team escalated individual cases to Tusla. These cases, with the exception of further assessment, related to all other stages in the management of child sexual abuse referrals. For each potential risk identified, the Investigation Team asked the appropriate Tusla area managers to provide written assurances to the Investigation Team that the cases referred to were being reviewed, with protective measures being put in place. Senior Tusla managers were also informed of these escalated cases.

In regard to all the escalated cases, the Investigation Team received written responses from the appropriate area managers or service director outlining the steps that had been taken or were planned to be taken to progress each individual escalated case. These actions included visits to children, the creation of safety plans for children and the progression of assessment of referrals of child sexual abuse, including retrospective child sexual abuse.

Furthermore, two area managers also provided written assurance that they would complete a wider review to ensure there were no further risks similar to what the Investigation Team had found. Additionally, in response, one area manager had reviewed the effectiveness of the local standard operating procedures and screening tool — the Investigation Team welcomed this open and receptive response. Tusla should now ensure such quality improvements are routinely and widely shared across service areas.

In addition, in various correspondence received from Tusla, the Investigation Team received an overview of different initiatives designed to improve service delivery. These included the benefits of its new national approach to practice (Signs of Safety), including the:

- introduction of peer-to-peer supervision
- development of new procedures in relation to retrospective referrals and
- improvements in information computer technology systems, data collection and information quality.

By October 2017, the Investigation Team had completed fieldwork investigations at five Tusla service-area sites and the SART team and three main risks were identified.

These are:

- ineffective screening and preliminary enquiry of child sexual abuse cases, including retrospective cases
- ineffective safety planning
- ineffective management of retrospective allegations of child sexual abuse.

The Investigation Team is mindful that the pathway followed by Tusla when managing child sexual abuse is the exact same pathway for all child protection and welfare referrals. The Board of HIQA considered the interim investigation findings and decided to write to the Minister for Children and Youth Affairs in October 2017, escalating its concerns on the basis that the findings, at that point of the investigation, concurred with the Minister's belief that there was a risk to the safety and welfare of children. The Investigation Team subsequently presented these interim findings to officials of the Department of Children and Youth Affairs and senior Tusla managers in November 2017.

In February 2018, the CEO of Tusla submitted details of its review and its conclusions in relation to the individual cases that had been escalated by HIQA. The Investigation Team reviewed the submission, and accepted that 3 of the 45 cases commented on by Tusla did not require review. However, the Investigation Team believes that it is important that any doubts about the safety of children in such cases should always be addressed and that systems should support and encourage vigilant practice across the child protection and welfare system.

In January 2018, the Investigation Team visited the seventh and final fieldwork site — a local service area — scheduled in this investigation (having already visited five local service areas and the dedicated regional team). Once again, individual cases, largely reflective of the risks already escalated to Tusla throughout 2017, were identified and again these were escalated by the Investigation Team for review by Tusla.

4.8 Fair procedure

4.8.1 General principles of fair procedure

The right to fair procedures derives from the Constitution of Ireland, and the European Convention on Human Rights, which is part of Irish law. The concept of fair procedures has been elaborated by the courts through case law (that is to say, law as set out by the results of former court cases). In assessing allegations of child sexual abuse, Tusla has a positive duty from the outset to act fairly, proportionately and in accordance with the principles of natural and constitutional justice.

At the centre of fair procedures and natural and constitutional justice are the principles that the decision-maker must be free from bias or the appearance of bias and that every person who may be adversely affected by a decision should have the best possible chance to present their case. These principles mean that:

- the decision-maker must be seen to act in a fair and impartial manner
- the person against whom the allegation has been made is notified of the allegation, given the details of the nature of the allegation and is afforded a reasonable opportunity to consider the information and respond to the allegation.

The reasons for any decision should also be communicated to the person subject of an allegation of abuse (PSAA) and a record of any such decision should be made. The principles of fair procedures are enshrined in *Children First: National Guidance for the Protection and Welfare of Children* (2011 and 2017) and Tusla's *Policy and Procedure for Responding to Allegations of Child Abuse and Neglect* (2014). The Children First guidance emphasises that the person subject of an allegation of abuse has the right to be informed of the allegations made against them by social workers and to be given a reasonable opportunity to respond.

Tusla's policy and procedure acknowledges that its procedures on assessing allegations of abuse require staff to balance the co-existing obligation to promote the welfare of the child with the obligation to protect the rights of the accused. These sentiments are echoed in the general principles underlying the introduction and scope of Tusla's 2014 policy and procedure.

The policy sets out the obligation to ensure that all persons who have allegations made against them are treated fairly, with due consideration given to their right to know who has made the allegations, the nature of the allegations and the right to reply to them.

Tusla's policy notes the consequences that might arise with regard to the reputation of a person subject to an abuse allegation if unsubstantiated or unassessed information is shared inappropriately. Sharing of such information inappropriately has potentially serious consequences for any person subject of an allegation of abuse and, in this context, the confidentiality of such information cannot be overstated and should be considered by Tusla at all stages of its policy.

4.8.2 Findings in relation to this investigation

The Investigation Team reviewed records relating to the management of current and retrospective allegations and reviewed the implementation of fair procedures during this process. The Investigation Team found that in the majority of cases, persons who were the subject of an allegation of abuse were informed of the outcome of the provisional and final outcome of the assessment on completion of Stage 2 in line with Tusla policy.

The Tusla policy sets out that persons who are the subject of an allegation of abuse should be written to at the earliest stage. The Investigation Team found delays in informing them that an allegation had been made against them and in the completion of the assessment of allegations. Where there are delays with assessing the risk that such a person may pose, Tusla's obligations to promote the welfare of the child as the first and paramount consideration and afford persons who are the subject of an allegation of abuse the right to fair procedures can present challenges for Tusla.

In some instances, particularly where Tusla was unable to assess the reliability of an allegation of retrospective child sexual abuse made against a person subject of an allegation of abuse, some of these individuals had not been advised that an allegation had been made against them. Tusla's policy provides that the social worker in consultation with their line manager can use their discretion in deciding whether to inform the person subject of an allegation of abuse that he or she has been named in regard to an allegation of child sexual abuse.

The Investigation Team identified two cases where a reliability assessment (Stage 1) was completed but was not judged to be reliable and where the person subject of an allegation of abuse remained unaware that Tusla held a case file in their name or case file in which their name was documented. However, at the time of this investigation, Tusla reported it was trying to establish current contact addresses for these individuals. These situations mainly occurred in cases of retrospective child sexual abuse where an adult complainant chose not to proceed with their allegation.

In some of these cases, the complainant had provided a name and contact details for a person subject of an allegation of abuse. The Investigation Team found in these circumstances that persons who were the subject of an allegation of abuse were not consistently informed of the allegation. Neither were they informed of Tusla's decision not to take further action.

Tusla's policy allows for discretion to be exercised by social workers and their line managers when deciding whether to inform the person subject of an allegation of abuse that he or she has been named in regard to an allegation of child sexual abuse. This ensures that that each case can be considered on its own merits. However, the Investigation Team found that the use of this discretion has led to inconsistency in how it is applied in five out of the six service areas and the dedicated team visited. While the number of these cases is low, this approach, in the Investigation Team's opinion, could present challenges for Tusla when persons who are the subject of an allegation of abuse seek to assert their rights to fair procedures.

Tusla's *Draft Practice Guidance: Meeting the Requirements of Fair Procedure 2018* advises that in certain circumstances Tusla can hold records of allegations against individuals under the name of the complainant without those individuals being made aware of the details of any report or allegation being made against them or of the actions of Tusla. This applies even when Tusla has decided that no action is warranted. Where new information that may change the position becomes available, staff are advised to seek legal advice. This suggests that where the allegation by the complainant is not going to be assessed, the person subject of an allegation of abuse is not 'necessarily' entitled to know that the allegation has been made against them.

The Investigation Team found that there was a variation in practice with regard to the level of information provided by Tusla to a person subject of an allegation of abuse when Tusla was informing them that an allegation of child sexual abuse (including retrospective allegations) had been made against them. For example, some individuals received a letter informing them that an allegation had been made against them, while others received a summary of the information. In other cases, persons subject of allegations of abuse received a full account of the allegations.

The Investigation Team found that persons who were the subject of an allegation of abuse frequently request further information prior to deciding if they will engage with Tusla. Tusla's *Policy and Procedure for Responding to Allegations of Child Abuse and Neglect* recommends that a letter should be written to the person at the earliest stage and this letter should provide him or her with 'the full detail of the allegations (including the identity of the complainant unless that person wishes to remain anonymous) together with detail of the procedural process which will be followed'.

The policy also recommends that a copy of written information, including any reports in respect of the allegations made against the person subject to an abuse allegation, should be enclosed in this letter.*

Fundamental to the right to fair procedures is that the person affected should be given notice of the complaint and the details of it and must be afforded appropriate facilities to make the best possible case in which to reply. Where a person subject of an allegation of abuse is given limited information on an allegation, in the opinion of the Investigation Team, Tusla is potentially exposed to the risk of challenge by such persons seeking to assert their right to adequately present their case and their right to be treated fairly and consistently as set out in Tusla's policy.

The Investigation Team reviewed four appeals of the outcome of findings of established child sexual abuse, including retrospective allegations. One case reviewed by the Investigation Team was not managed in line with the time frames provided in Tusla's policy.

4.9 Conclusion

This investigation found many examples of good practice by dedicated Tusla personnel in the management of allegations of child sexual abuse and retrospective cases. Tusla staff whom the Investigation Team met with and interviewed were professional and openly committed to child protection and welfare. Many staff freely shared their experience and ideas for an improved service with members of the Investigation Team.

Notwithstanding, the Investigation Team found that Tusla needs to immediately improve its governance arrangements and strengthen managerial oversight to ensure that child sexual abuse referrals, including retrospective allegations against adults of concern, are effectively and consistently managed and provide an enhanced service-user experience. Case records, including written correspondence and details of phone calls between adults and Tusla, reviewed by the Investigation Team, indicated that service users had a varied experience of using Tusla services. Where referrals were well managed, children and adults experienced a timely, sensitive and person-centred service. Delays in managing referrals of child sexual abuse, in particular retrospective referrals, were a source of frustration to adult complainants and at times led to them disengaging with Tusla.

The findings of this investigation show that there are currently three defective points in how Tusla does this, and these are illustrated in Figure 7.

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* The *Draft Practice Guidance: Meeting the Requirements of Fair Procedure* outlines that that the anonymity of the complainant cannot be guaranteed.

These three defective points in effectively managing such referrals are:

(a) ineffective **screening and preliminary enquiry**

(b) ineffective or an absence of **safety planning**

(c) ineffective management and or delays in the **management of retrospective cases.**

The contributing factors to these deficiencies include the:

- absence of, or failure to implement, Tusla's own policies and business processes
- failure to accurately document critically important decisions and actions
- failure to monitor the effectiveness of the current processes.

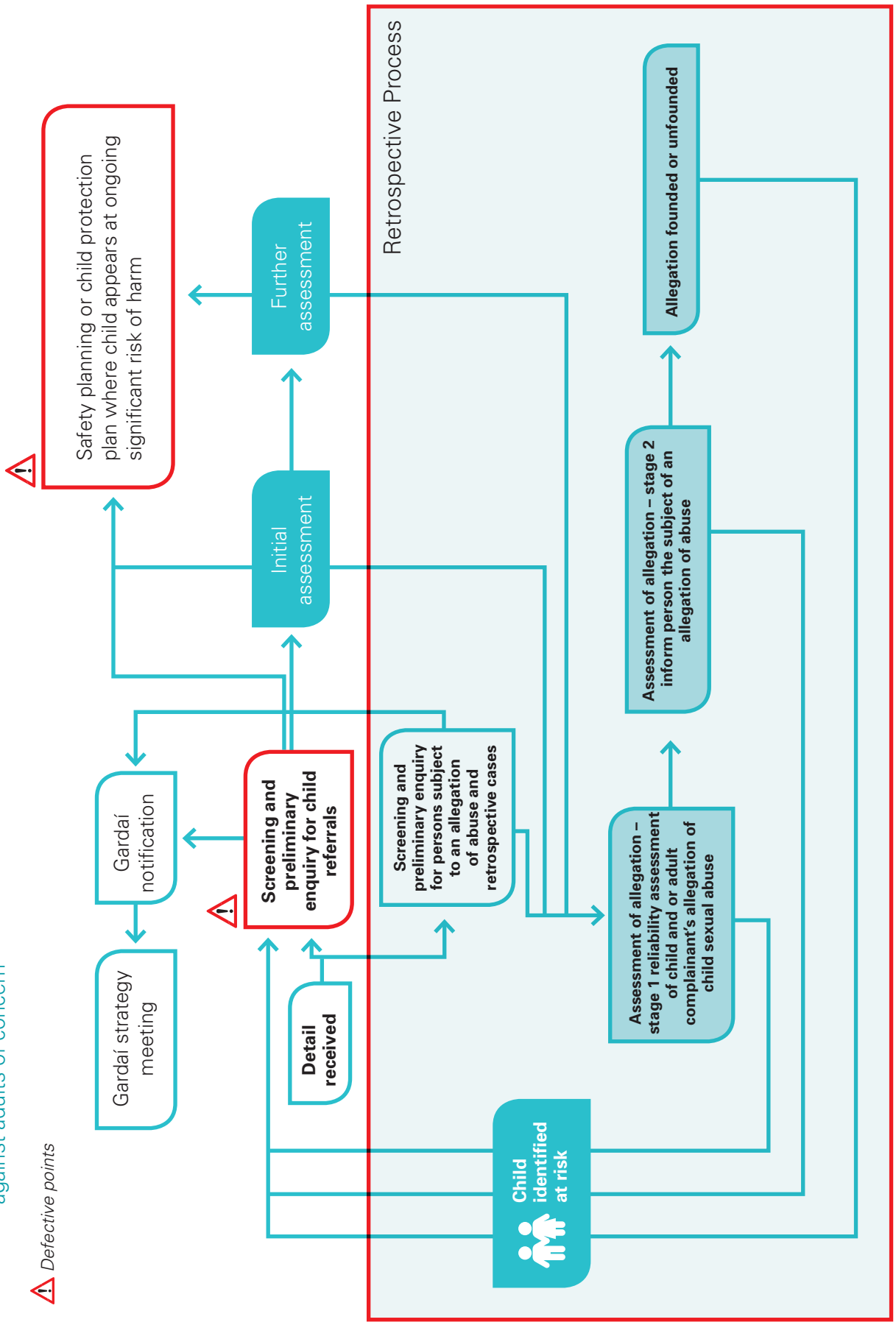
The absence of effective assurance processes means that:

- good practice may not always be shared across service areas, with mistakes not being detected or mitigated against
- poor staff practices not being effectively addressed
- senior executive and Tusla board members not being assured of the quality and safety of the service being provided.

Most importantly, these failings in the national systems and supports available to front-line staff in local service areas mean children may remain at risk — this is an unacceptable situation which must be addressed with the utmost urgency.

In addition, there was evidence to show that even when Tusla was aware of the need to address recognised operational problems, it failed to act swiftly to produce and finalise the supporting guidance and policy to support staff to address these issues. Developing area-based dedicated teams is a welcome development, and there was evidence to show that this approach is helping to increase the effectiveness of the assessment process.

Figure 7. Three defective points of concern in how Tusla manages referrals of child abuse allegations, including retrospective allegations against adults of concern



One of the recurring reasons cited by Tusla staff for delays in managing child sexual abuse referrals is due to ongoing criminal investigations by An Garda Síochána. The Investigation Team heard of alleged delays with information sharing between both agencies, which if substantiated would not be in the best interests of children.

However, this investigation focused exclusively on how Tusla managed allegations of child sexual abuse, and the role of An Garda Síochána was outside the Terms of Reference of this investigation.

Nonetheless, there was evidence of a commitment by Tusla and An Garda Síochána to the implementation of the Children First joint working protocol for liaison between both organisations, introduced in December 2017, and that this was contributing to the more effective and timely management of these referrals.

The Investigation Team welcomes the development by Tusla of the Child Protection and Welfare Strategy which includes the Signs of Safety programme. Tusla is confident that full implementation of this strategy will address the risks identified throughout this investigation. However, Tusla needs to focus initially on addressing current problems across service areas and assuring itself that it is currently providing safe and efficient services to children and families.

This investigation specifically looked at the management of child sexual abuse referrals, including retrospective allegations against adults of concern. However, those with responsibility at executive and board level in Tusla must recognise that this is the exact same pathway for all child protection and welfare referrals. Therefore, and in light of HIQA's monitoring findings across child protection and welfare services, the Investigation Team believes there is a significant risk that deficiencies it identified may be replicated across the wider service.

With regard to fair procedure, the Investigation Team found that in the majority of cases, persons who were the subject of an allegation of abuse were informed of whether the allegation was founded or not at the end of the process. However, there were delays in the overall conduct and completion of these assessments. The Investigation Team believed this posed a risk to the organisation and to the person subject of an allegation of abuse in the context of potentially infringing on their constitutional rights, as long as the assessment was ongoing and the person involved remained uninformed of the allegation. Similar risks may arise in the variation of the nature of information provided to persons who are the subject of an allegation of abuse.

The Investigation Team is mindful of the child protection and welfare strategy's five-year time frame and the resources that will be required for the full and successful implementation of the strategy in order to improve the quality and safety of services as a result. In the interim, the deficiencies in the current arrangements to safely manage referrals of allegations of child sexual abuse and retrospective allegations against adults of concern and all child protection and welfare referrals must be addressed.

Chapter 5
Findings on workforce

5.1 Introduction

The Health Information and Quality Authority (HIQA) has always emphasised that the sustainable delivery of safe, effective and reliable person- and child-centred care depends on service providers having the capacity and capability in the areas of leadership, governance and management; workforce planning; development and use of resources; and use of information.

The Minister for Children and Youth Affairs requested HIQA to include in this investigation an assessment of the number, skill-mix and sufficiency of staffing levels. However, the Board of HIQA was of the opinion that a comprehensive workforce assessment would be outside the scope and competencies of this investigation.

However, in line with the Terms of Reference of the investigation, an assessment was made as to the arrangements Tusla had in place to ensure a competent workforce to deliver its service objectives, in line with the *National Standards for the Protection and Welfare of Children.*

Consistent with the Terms of Reference, this chapter describes the investigation's findings in relation to Tusla's workforce. The findings in relation to the use of information are described in Chapter 6. The findings in relation to governance and management are described in Chapter 3.

5.2 Tusla workforce demographics

As of December 2016, Tusla reported that it had 3,597 whole-time equivalents. More than 70% of the total number of its personnel comprises social work (40.5%) and social care (31.1%) professionals.

Administration staff (14.38%) and management (3%) make up the bulk of the remaining number of staff. The number of staff in healthcare and allied health sectors represent small percentages. Tusla has a relatively young workforce with almost 70% of the workforce aged under 50 years of age.[42] Table 9 depicts Tusla's workforce by staff category at December 2016 and 2017.

Table 9. Tusla's workforce by staff category at December 2016 and December 2017

Category	WTE December 2016	% of workforce 2016	WTE December 2017	% of workforce 2017
Social work	1,457.67	40.52%	1,465.98	39.7%
Social care	1,119.37	31.12%	1,127.15	30.5%
Psychology and counselling	23.23	0.65%	20.52	0.6%
Other support staff including catering	62.72	1.74%	59.13	1.6%
Other health professionals	9.82	0.27%	17.18	0.5%
Nursing	50.60	1.41%	46.46	1.3%
Management VIII+	107.57	2.99%	137.28	3.7%
Family support	162.61	4.52%	155.45	4.2%
Educational and welfare officer	86.22	2.40%	89	2.4%
Admin Grade III-VII	517.46	14.38%	578.17	15.6%
Total	**3,597.27**	**100.00%**	**3, 696.32**	**100.0%**

Note: WTE = whole-time equivalents.

5.3 Workforce planning and capacity

It was reported at interview and in the documentation received and reviewed that social work and social care are the main focus of Tusla's workforce planning. Over the course of this investigation, many Tusla managers repeatedly stated that it had insufficient staffing levels to meet service needs, particularly in managing referrals at the point of intake and early assessment of the concerns reported.

All grades of staff interviewed believed insufficient staffing levels were the reason behind the number of cases in the service awaiting allocation to a named social worker for initial assessment by Tusla's duty intake and assessment teams. It was evident from interviews and documentation reviewed by the Investigation Team that challenges in staff recruitment were persistently reported as an organisational risk at board, executive and operational levels of Tusla.

To address service requirements, it was reported in Tusla's Corporate Plan 2018–2020 that its annual funding has increased by over €142 million (23%) since its establishment on 1 January 2014 to €759.7 million in 2018. To date, Tusla managers reported that they had made a number of improvements to support its workforce capacity. For instance, during 2016, Tusla established its own in-house recruitment function, Tusla Recruit, to manage recruitment campaigns, including the annual social work graduate campaign and its 2016 social care recruitment campaign.

In addition, to address service requirements, senior Tusla managers said they had developed a workforce plan, reporting that the Human Resources Directorate will aim to always have 4,167 whole-time equivalents working with Tusla. To meet this target, managers reported the introduction of a number of measures, which included a staff-resource allocation model, supply and demand analysis, staff retention and attendance management, reduced recruitment timelines and promoting Tusla as an employer of choice. At the time of reporting, overall staff absence rates had decreased from 5.3 % in October 2016 to 4.70% in October 2017. This compares to the overall public sector target of 3.5%.[43]

Senior managers at national and regional level also asserted at interview that there is an insufficient number of social work graduates in Ireland to meet Tusla's service needs. In response to this, senior Tusla management said bespoke recruitment campaigns were held to attract social work graduates from Ireland and other jurisdictions. Furthermore, some members of the senior management team reported that they were in active engagement with the relevant third-level institutions in Ireland in relation to Tusla's social work workforce requirements.

Tusla managers frequently expressed concern at interview about staff recruitment and retention. They reported that despite the improvements in recruitment processes and an increase in approved posts, the service experienced ongoing difficulties filling these posts. This was verified in Tusla's performance reports published in November 2017 which showed an increase of 12 whole-time equivalent social workers over the preceding year — from 1,461 in November 2016 to 1,473 in November 2017.

It is already known to HIQA, through HIQA's ongoing monitoring programme of Tusla's child protection and welfare services, that Tusla uses external agencies to complete assessments of cases where there are no child protection concerns but where families require an intervention to meet the welfare needs of their children. During on-site fieldwork, the Investigation Team noted the use of social work graduates who had yet to be registered with the Health & Social Care Professionals Council (CORU), their regulatory body, as 'project workers', in order to manage child protection referrals. Some operational managers reported that these social work graduates once registered would have to apply for full-time positions in Tusla.

5.4 Workforce allocation

It was reported at interview and in the documentation reviewed that Tusla undertook work in late 2015 on developing an appropriate needs-based Resource Allocation Profiler (RAP) for service delivery. This work was adapted from the existing model developed with the Health Service Executive (HSE) for use in primary and community care settings. At the time of this investigation, senior staff reported that the use of the Resource Allocation Profiler against predefined criteria informs decision-making about the equitable use of resources and assists in allocating specific resources to areas with, for example, identified operational risk.

Thereafter, local and regional managers reported, if they required an increase in staffing numbers, they could submit a business case to Tusla's executive for consideration. It was reported by some managers interviewed that when they had submitted a business case, additional resources had been subsequently allocated.

Following research and a pilot programme, in May 2014, the senior management team approved the local implementation of a Tusla caseload management system, called *Guidance For Caseload Management for Child and Family Agency Social Work (2014)*. In summary, managers explained that the caseload management system is completed at staff supervision meetings. The process involves the team leader using a suite of tools which provide a model for determining an acceptable number of cases on a caseload for social workers that is practical, standardised, evidence-based and can be applied consistently and routinely.

They highlighted to the Investigation Team that effective use of the system helps focus reflective discussions with the supervisor and supervisee and between team leaders and their line managers. The system is a paper-based system and involves completing a case management recording tool with all aligned actions recorded in the staff supervision file.

The Investigation Team reviewed documentation that reported that an internal audit of the caseload management system had taken place in 2016, resulting in some further improvement to the system and some changes in line with the planned introduction of the 'Signs of Safety' programme.

The Investigation Team acknowledges that the mechanism for caseload management has proven challenging in other jurisdictions and welcomes the introduction of such a system in Tusla. Managers interviewed collectively viewed its introduction in a positive light and said that they felt it did contribute to a more equitable and appropriate allocation of cases to social workers.

Nonetheless — as the Investigation Team identified in Chapter 3 of this report — in the service areas visited, supervision meetings, which are an integral part of the caseload management system, were not always consistently held and were of variable quality.

The Investigation Team found from a review of a selected number of staff records that there was variance across the service areas visited by the Investigation Team about how this caseload management system was implemented and recorded. Individual caseload management tools were completed and on file for many social workers but not all. Some individual social work files held team caseload summaries only. In other instances, caseloads were not discussed as part of the supervision process, nor was there a completed caseload management tool on file.

Tusla's guidance for caseload management (2014) identifies that in addition to facilitating discussion, caseload allocation and reflective practice, the information gathered also informs discussions on workload pressures, management and opportunities between the social worker team leader and principal social worker. The Investigation Team saw examples of the team leader sending caseload summary information to a principal social worker. However, the accuracy of this information depends on consistently adhering to and using Tusla's 2014 guidance for caseload management and associated tools. Furthermore, the caseload management system is not applicable to retrospective cases on social work caseloads and therefore these cases are not considered within the caseload management process.

As part of the documentation submitted by Tusla, the Investigation Team saw that staff training in the system was being planned for late 2017. The Investigation Team recommends in light of these findings that Tusla evaluates the efficacy of this training and monitors the effective implementation of the caseload management system on an ongoing basis.

It was evident throughout the investigation fieldwork that social work staff were being re-deployed whenever assistance was needed to address problems in a particular area, for example, backlogs in carrying out initial assessments. However, at the time of this investigation, senior staff reported that critical social work posts remained vacant to varying degrees across service areas and this, in the opinion of those interviewed, continued to negatively impact on the consistent delivery of high-quality and timely services. In three of the six service areas visited, the Investigation Team observed a small number of non-social work professionals supporting social workers to complete their assessments of allegations.

The provision of high-quality social work services relies upon a well-trained, supported and motivated workforce. However, a shortage of experienced child and family social workers is evident in Ireland, England, the US, Canada and Australia.[44] Direct social work with children and families is the core reason social workers enter the profession and is central to their job satisfaction.[45] Inefficient and overly bureaucratic systems reduce the amount of time practitioners are able to spend in direct social work.

Research commissioned by the previous CEO of Tusla[46] suggested that sources of social work stress are less connected to the nature of the work that they do and their relationships with service users and is more closely connected to the structures they work in. The authors of this research suggest that this indicates an essential conflict between the motivations of many social workers towards their work and the manner and context in which they carry out that work.

The Investigation Team met social workers and social work team leaders, and many said that the systems in place are overly administrative; there is too much paperwork; too many policies and procedures to read; and these are distracting them from their primary role.* By way of example, many practitioners interviewed, whilst acknowledging the importance of adhering to the risk management processes, perceived these current processes as overly burdensome.

Members of the senior management team told the Investigation Team that the implementation of the Signs of Safety approach will free up social work professionals to return to direct social work with children and families, or to 'basics'. While the Investigation Team acknowledges this as a potentially positive development, the team remains concerned that it will take an estimated five years to implement it fully and up to 10 years to embed it within the organisation.[47,48] In the interim, the Investigation Team recommends that Tusla's executive needs to challenge local practices by simplifying and integrating procedures wherever possible or investing in more administrative support to free up social work practitioners' time and expertise.

Other jurisdictions have made best use of non-social work staff to carry out activities currently undertaken by social workers in Ireland. For example, in the Queensland, Canberra and New South Wales areas of Australia, staff with a range of professional qualifications, including social work, are graded on a scale in relation to their level of experience — which informs the tasks that they can carry out.[49] In these Australian regions, a staff member with a social care background could be assigned to a duty intake team and complete initial assessments. Their role is further enhanced by trained administrative staff who carry out tasks such as notifying suspected abuse to the police and carrying out initial preliminary enquiries.

A similar model is in operation in the UK, whereby following screening of referrals and during the assessment process, social work assistants are used to provide practical support or gather information to help inform social workers in their assessment.

* The Investigation Team was informed by Tusla in May 2018 that Tusla has clerical administration panels in place to provide a talent pool for the appointment of administrative grades to support social work teams. In addition, a multi-annual workforce plan will be available by quarter two of 2018, which will identify the projected workforce requirements to enable multi-skilled team work.

These may be areas that could be explored by Tusla to improve its workforce planning and to respond to a deficiency in the supply of qualified social workers. This could include the identification of core tasks associated with the referral pathway that could be assigned to other grades of staff

Conducting a comprehensive workforce assessment was outside the scope and competencies of this investigation. However, staff at all levels repeatedly told the Investigation Team that there are insufficient numbers of staff. They believed this deficit was constantly causing delays in the system, including timely allocation of a named social worker to a child and in general to the timeliness of the management of child protection and welfare referrals.

Tusla's Corporate Plan 2018–2020 reports that it had 4,100 employees, which equates to approximately 3,700 whole-time equivalents (WTEs). The Human Resources Directorate, in documentation reviewed, reported that it aims to always have 4,167 WTEs — an increase of 467 WTEs compared to the corporate plan figure. Undoubtedly, Tusla believes it is currently under-resourced from a workforce perspective, in particular social workers. However, the Investigation Team did not find a comprehensive strategic approach to workforce planning that was informed by the reality of the current employment market. For example, there was little evidence that a review of current processes and requirements and or consideration of upskilling other social care disciplines has happened or is formally underway.

Without taking such a strategic approach, the Investigation Team believes that Tusla cannot rely on recurring staff shortages as a default reason for failing to deliver an efficient and safe service to children and their families, and for not providing a workforce environment where social workers and social care workers can enjoy doing the core job they have been trained and are qualified to do. Tusla has to manage the same workforce challenges faced by other jurisdictions and as a relatively young organisation must, in the opinion of the Investigation Team, avoid an organisational mind-set that sees such problems as insurmountable due to factors outside of its control.

5.5 Staff training and development

In line with the Terms of Reference for this investigation, the Investigation Team reviewed the staff training and development arrangements in place in Tusla to ensure the safe and effective management of child sexual abuse allegations, including retrospective allegations, against adults of concern. Workforce development has been on Tusla's corporate agenda since it was established in 2014, and this is reflected in its first corporate plan (2015–2017). This corporate plan focused on developing a valued workforce within a learning culture.[16]

The Human Resources (HR) Directorate in Tusla holds corporate responsibility for its workforce learning and development function. This function is managed by a national manager who reports directly to the Director of Human Resources. However, at the time of this investigation, the national manager post was filled on a temporary basis.

The National Manager reported at interview that there were four regional managers, a national training and development coordinator, a business support manager, a national training officer and four regional teams with a combined total of 33 training and development officers supporting the function. Four of the 33 officers have specific responsibility in supporting the training of staff in Signs of Safety and the broader child protection and welfare strategy.

Senior management stated at interview that the workforce learning and development function in the HR Directorate is responsible for all the learning and development activities in Tusla,[17] assisting the delivery of national training programmes and that it works collaboratively with local area managers to identify staff training and development needs. At a local level, service area managers had discretionary funding to facilitate the commissioning and provision of, for example, specific team-focused training.

Tusla has a National Continuing Professional Development Strategy (2016). Tusla managers explained that this strategy applies to the entire Tusla workforce and staff groups. The strategy has four distinct stages:

- the personal development plan stage
- the training needs analysis stage (TNA)
- participation in learning activities
- monitoring and evaluation.

Staff reported that the personal development plan is a planned process conducted by line managers with individual staff members who directly report to them. It is used to identify the learning and development needs of the individual for his or her professional role within the organisation. This process results in a learning and development plan being agreed and recorded by the manager and staff member in order that the personal development plan can be monitored and reviewed.

In addition, the strategy document details that the line manager and staff member should ensure that the learning and development needs of individual staff is agreed in the context of their role and the goals of Tusla, as set out in the annual business plan and the three-yearly corporate plan.

Thereafter, the staff member's personal development review form is used to reflect on progress over the previous six months, to plan for the next six months and to provide an opportunity to agree ongoing learning activities while evaluating and monitoring this process.

The next step in the implementation of the continuing professional development model, following the personal development planning process, is the training needs analysis (TNA). This is a method of identifying the development needs of the 'team' as opposed to individuals and the gaps between current and required levels of knowledge, skills, attitudes and values.

Managers at local, regional and national level reported that Tusla is committed to supporting its staff to attend formal training programmes and identified a wide range of additional training and development opportunities, which include mentoring, coaching, reflective practice, face-to-face training events, attending meetings, writing case reports and participating in research. In addition, there is protected professional development time available for social work staff grades. The Investigation Team learned of the positive initiative in the Tusla West Region where formal arrangements are in place for staff to access continuous professional development through the National University of Ireland Galway (NUIG). Mentoring programmes are not provided in a uniform way throughout Tusla unlike in other jurisdictions. In the UK, mentoring programmes for newly qualified social workers, linked to local universities are in place to support them in their first year of practice and are viewed as an important component in recruitment, retention and professional development.

All staff can access Tusla's electronic hub, which includes e-learning opportunities. Staff reported that the learning hub, email, staff meetings, one-to-one supervision and team communications are the main forum to hear what training is scheduled and what new policies, procedures and guidance have been launched.

5.6 What the Investigation Team found

At the time of this investigation, Tusla managers identified the personal development planning process as an essential prerequisite in effectively collating, planning and responding to staff members' learning and development needs. While they were aware that the personal development planning process* is aligned to Tusla's corporate and business objectives, the Investigation Team believes personal development planning, if effectively followed, should provide an assurance to the executive and the Tusla board that its staff learning and development programmes are appropriately aligned.

Managers explained that the personal development plan meeting is part of the staff supervision process and the completed six-monthly personal development plan is filed with the staff supervision record.

* National Strategy Continuing Professional Development (2016).

However, the Investigation Team found practice on the ground to significantly diverge from Tusla's national objectives in this critical area. Through interviews, group meetings and a review of staff files, 132 in total,* in the six service areas and the one regional team visited, the Investigation Team found the personal development planning process was not fully embedded in management practices.**

For example, the Investigation Team found personal development plans in place for some but not all staff, and of those completed, the plans were of variable quality. It was evident from the staff files reviewed that personal development planning was at the initial stage of the process and there were a limited number of plans which had been reviewed on a six-monthly basis. This is contrary to the guidance, and it needs to be addressed by Tusla nationally.

As stipulated in the strategy, each service area collates from the personal development planning process the training needs of its teams. It was reported at interview that staff from the learning and development function in HR assist the area manager with this.

The Investigation Team was provided with a copy of Tusla's 2016 and 2017 national workforce learning and development work plan and reviewed both plans. The plans are very comprehensive, detailing the learning and development in each specific Tusla function, the formal course schedule, course content and target group. It was reported that Tusla had run 712 training courses in 2016 and 626 training courses in 2017, and approximately 11,000 training places were provided each year. The Investigation Team acknowledges the breath of the extensive training programmes in place.

In the context of this investigation, child protection and welfare practice and management training included Children First, court-room skills, case-load management, leadership, direct work with children, assessment and analysis, reflective recording and report writing, signs of safety and information communication technology (ICT) training. In addition, the Investigation Team saw examples of stand-alone local training programmes which included policy briefings, managing allegations of abuse and child-specific interview training. Tusla managers reported that Children First and Signs of Safety are considered as mandatory training for staff.

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* A further five staff files reviewed were not required to be in line with policy, for example, the relevant staff member may have recently commenced and was not in the role long enough to make an assessment against frequency of supervision meetings.

** In May 2018, the Investigation Team was informed by Tusla that a national training needs analysis review had begun. Tusla has scheduled a review of current personal development plans. It further reported that all personal development plans would be started for staff by the end of 2018.

In an attempt to find out the degree of training and development that staff received in managing child sexual abuse referrals, the Investigation Team explored this topic with all grades of staff that it met and interviewed in the service areas visited, and through review of documentation and staff training records. The Investigation Team found that there was limited training across the service areas in relation to risk assessment, understanding the profile of those who sexually abuse children and the assessment of child sexual abuse allegations, including joint specialist interviewing with An Garda Síochána.

The Investigation Team was extremely concerned to hear staff report there was no standardised approach to ensure all staff had received training on Tusla's national policy and procedures for managing allegations of abuse.* While some staff had a certain level of training, and while one service area had specifically facilitated four staff members to receive a policy briefing, in general, staff believed training was insufficient to meet their requirements.

This concerning finding was further explored with a member of the senior management team in November 2017, who stated that the associated national policy and procedures for managing allegations of abuse had been issued in haste to staff in 2014. The manager recognised that this had been a mistake and said that Tusla had learned from this and that policy development now includes a process for implementation. Despite this assurance, at a minimum the Investigation Team would have expected Tusla to have taken corrective actions to address these implementation shortcomings. However, there was no evidence that this had occurred. Staff interviewed told the Investigation Team that the aforementioned national policy and procedures for managing allegations of abuse had been under review since around 2016 and no formal training had been provided to staff in the interim. Indeed the Investigation Team noted that one service area had escalated this risk to its regional service director.

The documented control for this flagged risk in September 2017 was that it was awaiting completion of the policy review, which — in the opinion of the Investigation Team — meant that no concrete action had been taken to mitigate the risk.

Staff met with and interviewed told the Investigation Team that there were insufficient numbers of staff trained in all aspects of managing allegations of child sexual abuse, including retrospective cases. The Investigation Team acknowledges Tusla's plan to increase the number of dedicated teams and or regional teams; however, this will not address its immediate training requirements.

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* Tusla informed the Investigation Team in May 2018 that it had reviewed the training required for the management of allegations of abuse and this training is due to start in tandem with the launch of its new policy.

In addition, documentation and data reviewed by the Investigation Team indicated that some line managers providing social work practice supervision did not themselves have the necessary training in managing child sexual abuse, including retrospective allegations.

5.7 Conclusion

The Investigation Team found that there were external and internal factors negatively impacting on Tusla's ability to ensure that it has a competent, motivated workforce that can deliver on its service objectives. In terms of the external factors, there is no question that the lack of availability of qualified social work staff is contributing to delays in the appropriate management of referrals and early assessment of concerns. Tusla itself has identified this as an organisational risk at board, executive and operational levels.

In order to address the challenges of recruitment, the senior management team has introduced a number of measures, including a dedicated in-house recruitment service; a staff-resource allocation model; improved staff retention and attendance management; and bespoke recruitment campaigns both in Ireland and abroad. Notwithstanding the measures outlined above, Tusla only managed an increase of 12 whole-time equivalent social workers between November 2016 and November 2017. The lack of available social work graduates is key to this poor return and Ireland is not alone in experiencing such a shortage.

The external challenges described above are exacerbated by internal factors such as workforce allocation and staff training and development. Having reviewed documentation and spoken with Tusla staff, it is evident that some staff feel they are spending too much time on administrative and on overly-bureaucratic tasks and processes, rather than building relationships with people using service. The Investigation Team also formed the view that Tusla had not given due consideration to this by way of introducing non-social work staff to assist in these duties. There is evidence from other jurisdictions as to how this may be achieved.

The Investigation Team noted the management systems in place to provide supervision for staff and manage their caseloads. While these systems were appropriate in theory, they were inconsistently applied in practice in the service areas visited by the Investigation Team. For example, caseload management tools were completed for some social workers but not all. In addition, personal development plans, a key element of staff supervision, were also found to be of variable quality and not in place for all staff.

In terms of staff training and development, there is a significant concern in relation to the failure to provide appropriate training in Tusla's national policy and procedures on managing allegations of abuse.

This is a serious shortcoming which is further compounded by the finding that some line managers providing social work practice supervision did not have the appropriate training in managing child sexual abuse, including retrospective allegations. In such cases, there is a pressing need to support managers to upskill or gain experiences in these crucial areas.

Tusla believes it is currently under-resourced in terms of workforce, in particular social workers. However, the Investigation Team did not find a comprehensive strategic approach to workforce planning that was informed by the reality of the jobs market, and little evidence of consideration of upskilling other social care disciplines. Without taking such a strategic approach, the Investigation Team believes that Tusla cannot rely on recurring staff shortages as a default reason for failing to deliver a more efficient and safer service to children and their families.

Tusla also needs to develop a workforce environment where social workers and social care workers can enjoy doing the core job they have been trained to do. Such an approach should contribute to greater retention of existing staff and allowing others to take on extra responsibilities. Tusla has made some progress in the area of staff retention, but it has to manage the same workforce challenges faced by other jurisdictions and avoid seeing staffing problems as insurmountable due to factors outside of its control.

Chapter 6
Findings on use of information

6.1 Introduction

In order to effectively manage and deliver child protection and welfare services, and be assured that they are providing high-quality, timely and safe care, it is fundamental that data is collated, analysed and action taken as necessary. Accurate data has the potential to be used for many important purposes, such as measuring the safety outcomes of people using services, informing decision-making and effective planning of services, improving the welfare of people, and for reporting purposes.

The primary purpose of collecting this data should be to improve and to manage the quality and safety of the services being provided. The delivery of a safe and effective service depends on access to high-quality data and use of information that is accurate, valid, reliable, timely, relevant, legible and complete.

This chapter describes HIQA's findings at a local, regional and national level in relation to the use of information for child protection and welfare — with a particular emphasis on how Tusla manages allegations of child sexual abuse referrals, including retrospective allegations against adults of concern by adults who allege they were abused when they were children.

6.2 Findings from interviews with Tusla personnel

At interview, Tusla reported that it had poor information communication technology (ICT) systems. In 2016, Tusla had introduced an integrated ICT system called the National Child Care Information System (NCCIS) on a pilot basis. Tusla staff reported that the National Child Care Information System was developed to create an integrated child welfare and protection ICT system for recording each stage of the referral process from first contact through to case closure.

When fully rolled out, staff will enter information on the National Child Care Information System about the child and or children that are the subject of a child sexual abuse referral. It is noteworthy and of concern to the Investigation Team that senior staff reported that staff will continue to maintain paper-based records for referrals of child sexual abuse made retrospectively by adults, which includes information about adult complainants and persons subject of an allegation of abuse.*

* Tusla informed the Investigation Team in May 2018 that a data protection impact assessment is being completed on the recording and file management of retrospective allegations of abuse.

At the time of writing, the National Child Care Information System was in place in less than half of Tusla's service areas (eight of Tusla's 17 services areas).* Senior Tusla personnel reported that they were on course to have the system in operation in all service areas by July 2018.

In addition, senior staff reported two additional ICT systems are in place in some service areas: a Social Work Information System (SWIS) or the RAISE system, which was available in 12 of the 17 services areas. It was reported to the Investigation Team that RAISE and SWIS are electronic databases on which social workers record information gathered at intake,** including details of the child being referred and their family compilation, case management records, social work case notes, the priority level assigned to the case and the allocation status of the case. There is also a facility to attach and hold relevant social work reports and reports provided by external agencies.

Notwithstanding there being some form of ICT in 12 of the 17 service areas, it was reported by Tusla staff that some service areas were also recording information on a spreadsheet software program and that all 17 service areas maintain paper-based records. These records were observed by the Investigation Team during on-site fieldwork in all six service areas visited.

In addition to the above, Tusla staff also reported that children who are identified by child protection and welfare services as being at risk of ongoing harm are recorded on a Child Protection Notification System (CPNS). This is an electronic database which is accessible to all service areas across Tusla and on a 24-hour, seven days a week basis to selected external agencies, such as hospitals and An Garda Síochána. The Child Protection Notification System is maintained at a national level and each service area has a named person called a 'super-user' who inputs local data and keeps the information updated. Service areas receive alerts when information held on the Child Protection Notification System is accessed by another agency or party. In addition, it was reported that the system will alert a nominated person with oversight of the system if a child does not have an allocated named social worker.

Up until 2017, Tusla's information and data systems had been stored within the Health Services Executive's (HSE's) infrastructure and had been administered by the HSE's ICT support service. It was reported at interview, and also seen through documentation reviewed by the Investigation Team, that Tusla's three-year ICT strategy (2017–2019) was to become as 'self-reliant as possible' and to continue to share or partner for some ICT services from the HSE in line with the public service ICT strategy to 'Build to Share'.[50]

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* The Investigation Team was informed by Tusla in May 2018 that the National Child Care Information System was fully implemented in 13 service areas.

** This is the point at which Tusla's duty intake team receives a referral.

At the time of this investigation, Tusla had appointed a director of ICT and support staff and its three-year ICT strategy (2017–2019) was in place. The Investigation Team reviewed the strategy, which clearly outlines the ICT requirements for Tusla to meet its business and strategic needs. It was reported at interview, in November 2017, that there has been a very significant resource allocation to support its implementation. However, at the time of the investigation, the ICT staff required to provide the necessary IT supports* in implementing this strategy were still being recruited.**

6.3 Key findings in relation to use of information in Tusla

Notwithstanding the limitations and or availability of ICT systems, the Investigation Team would expect Tusla to have effective arrangements and quality assurance controls in place to assure itself that the information currently gathered and used is meeting high levels of good and effective practice. At a minimum, the information must be accurate, valid, reliable, timely, relevant, legible and complete.

At the time of the investigation, Tusla had retained the HSE's 2009 standard business processes in place to guide practitioners on maintaining good-quality records.(29) As part of the investigation, the Investigation Team reviewed in excess of 656 case records across six service areas and one regional dedicated team. While there was some evidence of good record-keeping in the case records reviewed, overall, the Investigation Team found them to be of poor quality. There was extensive evidence of incomplete records, illegibility, unsigned records, records not updated and incorrectly filed records. In general, staff did not adhere to Tusla's guidance on maintaining good records.

A case chronology is a timeline representation of an agency's involvement with a child and or family, milestones reached and any known significant events that will impact on the child.(51) Keeping an updated and accurate chronology of events and decision-making is a prerequisite in maintaining transparency and consistency, and is evidence of good practice, for example, when a case is transferred to the management of another social worker. The Investigation Team found it difficult to follow the cases it reviewed and to navigate the case record. Case chronologies were not clear and or were not developed.

Local audits had — similar to the findings of the HIQA Investigation Team — previously identified unsigned and undated documents and reports, no case chronologies in place, essential information not on file and incomplete records.

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* The Investigation Team was informed by Tusla in May 2018 that over 1,000 social work staff had been provided with the equipment for remote access to its electronic system.

** The Investigation Team was told by Tusla in May 2018 that its ICT management team is now fully resourced and recruitment of ICT staff is on schedule for 2018.

However, there was no evidence in the service areas reviewed that these local audit findings had, at the time of this investigation, resulted in reciprocal service-wide improvement.

6.3.1 Opening and naming files

As already stated, service areas were operating overlapping ICT systems — using the National Child Care Information System; the Social Work Information System (SWIS) or RAISE system; and the Child Protection Notification System — supplemented with paper records. As a consequence of using electronic and paper-based systems, the Investigation Team found that both sets of records were not being consistently updated and were therefore, the Investigation Team believed, impossible to accurately validate.

In the interim of a uniform ICT system, the Investigation Team found through case-record reviews that Tusla had not developed a standardised approach for allocating identification numbers to case-record files, either paper or electronic, for managing referrals of child sexual abuse. As a consequence, the Investigation Team found that some paper files were created using an identification number only or in an individual's name or family name. These variations were further reflected in the Sexual Abuse Regional Team (SART). For instance, in this team, the Investigation Team found some files had been created in the name of the adult complainant who was the subject of the alleged abuse, while others had been created in the name of the adult about whom the allegation had been made. Where electronic systems were in place, files were created in an individual's name, accompanied by a reference number assigned by the electronic system.

These findings were explored with Tusla staff in the service areas and SART, who acknowledged the inconsistencies in practice. Local managers and staff informed the Investigation Team that there was a lack of adequate guidance on opening and naming files about adults against whom an allegation had been made.

Tusla subsequently provided the Investigation Team with draft national procedures for managing retrospective allegations of abuse. The Investigation Team reviewed this document and is of the opinion that it did not sufficiently guide social work staff on how to name files in a standardised way, or how to ensure sensitive information about adults is stored appropriately when their information is held on the complainant's file. This procedures document should be reviewed to ensure it includes sufficient guidance for staff on opening and naming files.

6.3.2 National Child Care Information System

The Investigation Team observed the National Child Care Information System in operation in two* of the six service areas visited as part of the investigation fieldwork.** This was a new system which was in the process of being rolled out across all Tusla services by July 2018. In one of the two service areas, the National Child Care Information System had been operational for less than a month and in the other, the system had been in use for seven months.

However, even in the service area where the National Child Care Information System had been in operation for the longest period, Tusla managers and staff reported to the Investigation Team that the system had not been completely aligned with Tusla's standard business processes for managing referrals. As a result, the Investigation Team was surprised to learn that it did not accurately record all aspects of the referral process and the aligned outcomes. This included not recording the actions required following the completion of screening and preliminary enquiries.

Significantly, in a sample of cases reviewed on the National Child Care Information System, the Investigation Team found that the social work case notes reviewed had not been updated and the gaps in information meant that there was a potential for delays in managing referrals and or the potential for incorrect action to be taken by Tusla staff. This therefore impacted on the effective and timely management of allegations of child sexual abuse and as a result Tusla's ability to protect children at risk.

In addition, managers and staff explained that all case referral meetings were recorded on paper and the decisions subsequently entered by administrative staff onto the National Child Care Information System.*** They further outlined that this approach was due to the fact that they did not have access to a computer during referral meetings, with laptops yet to be provided to all staff which would allow them to have mobile access to the National Child Care Information System. The Investigation Team found this situation to be unacceptable.

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* One additional Tusla service area began operating the system after the Investigation Team had visited.

** This system was not relevant to the work of the Sexual Abuse Regional Team (SART) and was therefore not intended to be implemented by this team.

*** The Investigation Team was informed by Tusla in May 2018 that over 1,000 social work staff had been provided with the equipment for remote access to its electronic system.

6.3.3 Data protection

In March 2017, the Special Investigations Unit of the Data Protection Commissioner started an investigation to examine Tusla's governance of personal data concerning child protection cases.[15] This special investigation had been started in response to information that came into the public domain in February 2017 regarding concerns relating to the handling at Tusla of personal data and sensitive personal data.

The main findings of the Data Protection Commissioner's investigation were published in the Data Protection Commissioner's Annual Report on 27 February 2018. One of the main conclusions of the investigation by the Data Protection Commissioner[15] was that the processing of personal and sensitive personal data — in the context of file management and record-keeping overall — had not been sufficiently planned for in the form of a strong and well-structured data governance strategy when Tusla was established in 2014.

The Data Protection Commissioner reported that it was critical that Tusla's casework management system should generate a full and complete record of all casework material concerning each case. The Data Protection Commissioner also reported that there were multiple and overlapping volumes of individual case files where no complete 'master file' could be identified, and with no audit trail in relation to the handling of the file. This HIQA investigation found similar deficiencies.

During this HIQA investigation, Tusla reported there had been data breaches reported to the Data Protection Commissioner in 3 out of its 17 service areas in 2016. The Investigation Team reviewed records of these data breaches in two service areas visited and found that the data breaches had been reported appropriately and that the individuals who were the subject of the data breach had been informed in a timely way. A record was maintained of all actions taken to address the matter.

Tusla had commissioned an external data protection assessment prior to the HIQA investigation. The resulting report, dated September 2016, made 72 recommendations for practice improvements. In response, Tusla completed a risk assessment table of the recommendations for implementation. However, Tusla's risk assessment did not identify the actions required to mitigate the risk, nor identify any timelines or identify the named person or persons responsible for addressing the identified risks. As a result, the Investigation Team believed it failed to provide a clear roadmap for implementing the recommendations.*

* The Investigation Team was told by Tusla in May 2018 that a formal tracking system has been put in place in relation to the recommendations of the external data protection assessment.

6.3.4 Performance and activity information

Tusla has a suite of key performance indicators and data on social work activity in place. Each service area has the support of an information officer to support it in collecting, reporting and analysing the data. Several area managers informed the Investigation Team that although the data collected is used, they were not confident that it was accurate. They attributed this lack of assurance to the limited access to appropriate ICT systems. At the time of the investigation, one of the six service areas visited did not have an ICT system in place — therefore the capacity of that particular service area to generate a wide range of reports based on manually collected data was reported to be limited.

Details of key performance indicators and related findings are included in the chapter on governance (Chapter 3), while the effectiveness of bilateral engagement between Tusla and An Garda Síochána and other external third parties — including findings on the sharing of information between these parties — is included in Chapter 7 of this report.

6.4 Conclusion

The Investigation Team found that Tusla has made progress in relation to addressing its information communication technology (ICT) deficits by securing additional ICT funding, by setting up an ICT directorate and by developing its ICT strategy. This should support Tusla to meet its business and strategic needs and will decrease its dependency on the HSE for the ICT supports that the HSE currently provides to Tusla.

The introduction of an integrated information system (National Child Care Information System) is a welcome finding as, when fully implemented by July 2018, it should enhance the systems of recording, storing and sharing of information about children at risk across its child protection and welfare services. The success of this system will, however, be improved through the urgent provision of essential equipment, such as computers and laptops, to social work departments.

Notwithstanding these achievements, Tusla continues to face significant challenges in relation to the quality of its records and the information it gathers. The Investigation Team found a number of alarming gaps in the management of information about child sexual abuse allegations, including those allegations made by adults about alleged abuse when they were children, including that:

- overall, staff did not adhere to Tusla's guidance on maintaining good records
- there was no standardised system in place to ensure the allocation of a uniform case-record identification reference number
- there was no evidence that service-area audit findings had led to service-wide improvement

- the new National Child Care Information System not been completely aligned with Tusla's standard business processes for managing referrals
- Tusla's external data protection assessment has made 72 recommendations for practice improvements but there is no clear roadmap for implementing these recommendations.

This investigation found that the checks that Tusla has in place to assure the effective recording of the management of child sexual abuse referrals, and in the wider context, child protection and welfare referrals, are currently ineffective. The National Child Care Information System did not accurately record all aspects of the referral process and the aligned outcomes. This, and other factors such as the failure to update social work case notes on this system, impacted on the effective and timely management of allegations of child sexual abuse and, as a result, Tusla's ability to protect children at risk.

Although Tusla's new integrated information communications system should contribute to the standardisation of recording systems, methods of recording and data collection, it cannot assure the quality of the records themselves nor allow Tusla's executive and board to be certain of effective child protection and welfare practices. To ensure effective and transparent decision-making about children's safety, child protection and welfare practices must be accurately recorded and maintained.

Furthermore, as Tusla will continue to operate a paper-based system for retrospective and adult cases on a national scale, the particular deficiencies related to paper-based records and manually gathered data and information must be addressed.

As an immediate interim measure, Tusla's draft national procedures for managing retrospective allegations of abuse should be reviewed and rolled out to ensure they clearly guide staff on the appropriate storage of sensitive information about adults of concern when their information is held on the complainant's file.

Chapter 7
Findings on bilateral engagement between Tusla and An Garda Síochána and other external agencies

7.1 Introduction

One of the key functions of Tusla, as set out in the Child and Family Agency Act 2013, is to strengthen interagency cooperation to ensure seamless services that respond to the identified needs of children. The Terms of Reference of the investigation included an assessment of the effectiveness of bilateral interactions between Tusla, An Garda Síochána and relevant third parties.

At the time of the investigation, Tusla submitted information in relation to the provision of services in each service area for the assessment and validation of child sexual abuse, and the key external agencies and professionals who make referrals to the service, as well as those that provide support services to children, young people and adults who have experienced child sexual abuse.

While the Minister specifically directed that HIQA's investigation should avoid the potential for overlap with the Tribunal of Inquiry established to inquire into certain protected disclosures, this investigation was to include an assessment of the effectiveness of bilateral interactions between Tusla, An Garda Síochána and all relevant third parties. This chapter will describe Tusla's engagement with those parties in each of the six service areas visited and in the Sexual Abuse Regional Team (SART), under separate headings:

- An Garda Síochána
- other external agencies.

A schedule of these engagements is set out in Appendix 9.

7.2 Investigation approach

The Investigation Team conducted on-site fieldwork at six out of a total of 17 Tusla service area sites and at the single Sexual Abuse Regional Team (SART) in the Dublin North East Region.

In examining the interagency workings between Tusla and An Garda Síochána and other relevant agencies and services, the Investigation Team reviewed documentation and case records, and conducted interviews with Tusla staff at six Tusla service area sites and at the Sexual Abuse Regional Team (SART).

To gain an insight into interagency cooperation and coordination of services between individual agencies and Tusla, the Investigation Team carried out seven group meetings with members of An Garda Síochána and, separately, seven group meetings with representatives of other relevant agencies.

In so far as it was practicable, attendance at these meetings was representative of the services provided in the six Tusla service areas visited with regard to the management of allegations of child sexual abuse against adults of concern, including retrospective allegations. In addition, the Investigation Team met with senior representatives of the Garda National Protective Services Bureau (GNPSB).

Group meetings with external agency services in the Tusla Louth Meath and Cavan Monaghan Service Areas reflected the services of the Sexual Abuse Regional Team, which is based in Tusla's Dublin North East Region.

7.3 The roles of Tusla and An Garda Síochána

Tusla and An Garda Síochána are the statutory bodies with primary responsibility in Ireland for the protection and welfare of children. Each organisation has distinct functions, powers and methods of working.

7.3.1 Tusla – Child and Family Agency

Since its establishment in January 2014, Tusla has responsibility for child welfare and protection services, family support, educational welfare and a range of other services, including those relating to domestic, sexual and gender-based violence. Under the Child Care Act, 1991, Tusla has a specific role to promote the development, welfare and protection of children who are not receiving adequate care and protection.

If it is found that a child is in this position, Tusla has a duty to take appropriate action to promote the child's protection and welfare, which includes supporting families who need help to provide care and protection to their children. Additionally, one of the key functions of Tusla, as set out in the Child and Family Agency Act 2013, is to strengthen interagency cooperation with other relevant agencies to ensure seamless services that respond to the identified needs of children.

7.3.2 An Garda Síochána

As outlined in the Children First 2017 guidance, 'the involvement of An Garda Síochána in cases of alleged child abuse and neglect stems from its primary responsibility to protect the community and bring offenders to justice.' An Garda Síochána is primarily responsible for preventing and investigating crime.

Where it is suspected that a crime has been committed, An Garda Síochána has overall responsibility for the direction of a criminal investigation. Part of the process of evidence gathering includes interviewing* and taking statements from the victims, witnesses and the accused, as well as gathering evidence such as medical reports, forensic testing results and any other relevant information. Gardaí then prepare a file for the Office of the Director of Public Prosecutions, which decides whether there is enough evidence to prosecute a criminal case before the courts.

The Garda National Protective Services Bureau (GNPSB) was set up in 2015 and provides the Garda Síochána's response to child protection matters. It has responsibility for developing policies in this area and also provides advice, guidance and assistance to Gardaí investigating particular crimes — including online child exploitation, child protection, specialist interview and sexual offender management.

It was reported by senior representatives of the Garda National Protective Services Bureau that they liaise with the Sexual Abuse Regional Team (SART) within Tusla whenever a multiagency approach is necessary. In addition, it was reported by members of the SART team that the Garda National Protective Services Bureau was a good resource and was available to provide advice and guidance in relation to sexual crimes.

7.4 Engagement between Tusla and An Garda Síochána

Joint working between both agencies is crucial to ensure effective, timely and consistent responses to allegations of child sexual abuse. *Children First: National Guidance for the Protection and Welfare of Children* (2017)[25] states that joint-working between Tusla and An Garda Síochána forms an integral part of the child protection and welfare service.

This section of this chapter describes the formal working arrangements for engagement and information sharing between Tusla and An Garda Síochána in the management of child sexual abuse referrals by Tusla. This section also presents the Investigation Team's findings in relation to these arrangements.

7.4.1 Information sharing between Tusla and An Garda Síochána

The Investigation Team identified through review of case records, at interviews with Tusla staff and through group meetings that at the time of the investigation there was no nationally agreed arrangements in place to ensure an effective and consistent communication process between both agencies.

* In order for An Garda Síochána to start a criminal investigation, a statement of complaint must be made, and in the case of a child, a parent and or guardian must consent to the interview.

Those who met with the Investigation Team reported that there were some formal structures in place; however, for the most part, informal arrangements predominate and participants reported that the success of some arrangements depended on relationships between individual members of both agencies.

At the time of this investigation, and up to December 2017, the Investigation Team found that there was no standardised practice in relation to sharing information between Tusla and An Garda Síochána. There was no national guidance for social workers in relation to seeking information from An Garda Síochána or indeed in responding to requests for written information from An Garda Síochána. As the process for sharing information was not nationally established, decision-making processes varied locally between service areas.

The Investigation Team reviewed case records in all six service areas visited and in SART in regard to information sharing between Tusla and An Garda Síochána. Requests for information sharing were made between the two agencies in writing, often to clarify information relevant to a criminal investigation or An Garda Síochána requesting information on the involvement of Tusla. There were, in some instances, lengthy delays in both agencies responding to such requests and this impacted on each other's work.

In the absence of a formal agreement between Tusla and An Garda Síochána for information sharing, the Investigation Team found that in some cases, this resulted in difficulties in identifying risks to children in a timely manner. For example, where child protection and welfare notifications were received by Tusla from An Garda Síochána, but did not contain the necessary details required to complete a social work assessment of a child sexual abuse allegation, this often required formal written requests for additional information from Tusla to An Garda Síochána.

Through a review of case files and correspondence in the six service areas visited, the Investigation Team found that there were lengthy delays in responding to requests by Tusla for additional information from An Garda Síochána, consequently resulting in delays in creating informed safety plans. Similarly, Gardaí told the Investigation Team that requests for written reports from Tusla are often delayed and, when provided, lacked the details previously relayed verbally and required to support criminal proceedings.

In light of the above findings, the Investigation Team welcomes the introduction in December 2017 of the Tusla and An Garda Síochána Children First joint protocol for liaison between both agencies.[52] It clearly details how both agencies should work together to deal with child protection and welfare concerns. In addition, the protocol clearly sets out the requirements in relation to formal communication, notification and recording of joint-working and decision-making.

The protocol details liaison arrangements between Tusla and An Garda Síochána from local to national level and outlines the primary functions of each forum and how they interact to promote safe, effective management of child protection referrals.

If fully implemented, this joint protocol would address a number of the deficiencies identified by the Investigation Team through its review of bilateral interactions between Tusla and An Garda Síochána. The protocol states that it will be reviewed annually by both organisations and that a report on the review will issue to the National Child Safeguarding Strategic Liaison Committee.*

During the investigation, the Investigation Team was informed by a representative of the Garda National Protective Services Bureau that a distinct protocol on the sharing of information between both agencies, within the confines of Children First and the Data Protection Act, was in development.

In tandem with these developments, in April 2017 the Garda National Protective Services Bureau established a designated Child Protection Unit to include the co-location of Tusla social work and An Garda Síochána staff. The purpose of the unit, will be to provide assurance that the requirements of Children First are being met; to ensure consistent implementation of the joint protocol; and to promote best joint-working practice between An Garda Síochána and Tusla.

7.4.2 Interagency child protection and welfare notifications

The Children First 2017 guidance requires that Tusla must formally notify the Gardaí without delay if Tusla suspects that a crime has been committed and a child has been sexually abused.

Similarly, in accordance with section 14(1) of the Children First Act 2015, where a member of An Garda Síochána has reasonable grounds for concern that a child has been harmed or is at risk of being harmed, he or she must report this knowledge or suspicion to Tusla. An Garda Síochána should also notify Tusla of cases that give rise to a potential risk to other children when a suspected abuser has ongoing contact with children. The investigation found that there were formal arrangements in place in both agencies to notify each other of cases of suspected or confirmed child sexual abuse. Standard notification forms used for this purpose are completed by both agencies.

* The purpose of this committee is to 'enhance joint working at a strategic level' and to ensure 'a coordinated effective response between agencies to resolve challenges within the child protection and welfare system'. It is co-chaired by the CEO of Tusla and An Garda Síochána Assistant Commissioner, Special Crimes Operations, and comprises other appropriate representatives within both organisations and the HSE.

In the course of the investigation fieldwork, the Investigation Team examined a sample of cases to establish whether notifications of suspected or confirmed child sexual abuse had been made by Tusla to An Garda Síochána and found that for the majority of cases, these notifications had been made. However, as referred to in Chapter 4, there were delays in notifications to An Garda Síochána.

How effective both agencies are in notifying each other of allegations or concerns about child sexual abuse impacts on their ability to efficiently carry out their respective statutory duties. Conscious of the need for timely notifications, representatives of the Garda National Protective Services Bureau told the Investigation Team that under the December 2017 joint protocol, there is a proposal that garda* superintendents will no longer be required to approve garda notifications before they are sent to Tusla. Within this proposal, this responsibility may be assigned to garda sergeants. This was viewed by An Garda Síochána as a means to ensure earlier notifications to Tusla.

At the time of writing, there was no electronic data transfer interface between the information communication technology (ICT) systems in Tusla and the Gardaí. This meant notifications have to be sent by fax or by post, which is an inefficient practice, particularly given that these notifications relate to allegations or suspicions of child abuse. The Investigation Team learned that there are plans for electronic transfer of notifications to be introduced in 2019.

7.4.3 Children at immediate risk

Children First: National Guidance for the Protection and Welfare of Children (2011) sets out a number of formal decision-making and information-sharing forums along the child protection pathway to facilitate joint-working between the Gardaí and Tusla. Such forums include strategy meetings, liaison meetings and child protection case conferences, which are discussed below in section 7.4.4.

However, there are times when both agencies, in the first instance, work together to take immediate action where it is deemed that a child is at immediate and serious risk. For example, where a garda has reasonable grounds to believe that a child is at immediate risk, the Gardaí can remove a child to a place of safety under section 12 of the Child Care Act, 1991, as amended, without first notifying Tusla. This takes place in circumstances where the Gardaí believe that the child's safety could not be ensured by awaiting notification to Tusla and an application by Tusla for an emergency care order under section 13 of this act. The Gardaí notify Tusla as soon as possible of the action it has taken, which may take place verbally, followed by the formal notification.

* Garda — the term for a police officer in Ireland.

Similarly, where a social worker believes that a child is at immediate and serious risk he or she can conduct joint home visits with the Gardaí, and where it is not safe to await an application for an emergency care order by Tusla, the Gardaí can invoke its powers under section 12 of the Child Care Act, 1991, as amended, if it believes that a child is at immediate and serious risk. Following removal of the child, the Gardaí can deliver the child into the care of Tusla.

Interagency working in regard to immediate actions taken to secure the safety of children was explored at group meetings with members of An Garda Síochána and Tusla staff, with all participants expressing satisfaction with the current arrangements.

Since 2016, where there is an immediate and serious risk to a child which requires an immediate response by An Garda Síochána, Tusla provides an emergency 24-hour social work service which provides consultation and advice to the Gardaí. During the group meeting with members of the Gardaí, it was reported that this 24-hour social work service is a valuable resource and a welcome improvement on the previous arrangements.

In the context of the existing service provision, members of the Gardaí reported at the group meeting that in their view, the response to immediate risks by Tusla was appropriate and effective and that arrangements in place to manage immediate risks to children were well established. Social workers and social work team leaders in the separate Tusla group meeting also agreed that whenever children were at immediate risk, the engagement with An Garda Síochána was effective.

Members of the Gardaí also told the Investigation Team that they had seen systematic improvements in interagency working with Tusla throughout 2017. By way of example, they reported an improvement in the acknowledgement of receipt of referrals into Tusla by the Gardaí. They also believed the system for allocating a named social worker with responsibility for managing a referral had resulted in improvements in the effective coordination of services between both agencies.

7.4.4 Strategy meetings

At any point during the child protection process, including where necessary during the initial assessment stage, a strategy meeting may be called to consider the protective measures necessary to ensure the safety of a child. The purpose of a strategy meeting is to facilitate the sharing of information between professionals and to prepare a plan of action for the protection of a child, including the completion of an interview of the child to meet their respective responsibilities.

It is the responsibility of the Tusla social work service to convene a strategy meeting. In the majority of cases, the strategy meetings are formally arranged; however, if deemed urgent, the meeting may be quickly arranged by Tusla.

It is important that the Gardaí attend these meetings, especially if a formal notification has been made by Tusla to the Gardaí, in order to:

- consider whether interviews are required in accordance with the Criminal Evidence Act, 1992
- to identify the evidence available to support a criminal investigation and
- primarily to ensure that actions are planned and prioritised to allow both agencies to carry out their statutory duties in the best interest of the child.

In separate focus group meetings, both Tusla and members of An Garda Síochána reported that in relation to specific child sexual abuse referrals, the most prevalent and effective forums to promote interagency working between both organisations were regular formal strategy meetings. These, they reported, are attended by social workers and designated members of An Garda Síochána assigned to the particular child sexual abuse case. Both groups reported that the strategy meeting format, with the correct personnel in attendance, promoted the timely sharing of information to ensure the protection of the child.

7.4.5 Garda liaison meetings

Following a notification of suspected child sexual abuse by either Tusla or An Garda Síochána, the social worker and the investigating Gardaí should maintain regular contact and inform each other of developments in an alleged child sexual abuse case as they occur, in line with the requirements of Children First 2011.[36]

At interview with Tusla staff and at group meetings with Tusla staff and members of An Garda Síochána, the Investigation Team was informed of formal communications channels. They reported that social work team leaders and designated garda inspectors and or sergeants from the corresponding Garda districts, who are members of a liaison management team,* meet every four to six weeks to review individual and ongoing cases, to ensure that interagency liaison is maintained and that each case is appropriately progressed.

Similarly, principal social workers and superintendents from the corresponding Garda districts form Senior Local Management Liaison Forums, which meet once every three months. They reported that this forum was important as it ensured effective interagency working and information sharing about the management of child protection referrals and the review of complex cases as required.

* The liaison management team is made up of the social work team leader and garda inspectors and or sergeants who are responsible for ensuring that interagency liaison occurs.

Although the Investigation Team saw examples of this engagement and information sharing in the case records reviewed, it found that formal minute taking and completion of joint-action sheets, arising out of strategy and liaison meetings, were not consistently seen in case files. In addition, where records of decisions were found, they did not routinely provide the rationale that informed the decision.

7.4.6 Child protection conferences

A child protection case conference is an interagency and inter-professional meeting, convened by Tusla whenever there are grounds to believe that a child is at ongoing risk of significant harm. The purpose of the conference is to facilitate the sharing and evaluation of information in order to identify both risk and protective factors and to develop a child protection plan if deemed necessary by the conference. The child protection plan outlines the actions that professionals, agencies and parents and or guardians need to take to ensure the child's ongoing protection and wellbeing.[36]

It was reported at separate group meetings with Tusla staff and members of An Garda Síochána that child protection conferences were an effective way to share information to create child protection plans to protect those children identified as being at ongoing risk of significant harm. Members of both organisations agreed that attendance by An Garda Síochána at child protection conferences was both necessary and beneficial to the protection of children at such risk.

Members of An Garda Síochána informed the Investigation Team that they were routinely invited by Tusla to attend child protection conferences and they always tried to prioritise their attendance. However, as these meetings were by necessity often called at short notice, some Gardaí reported that they were not always available to attend.

7.4.7 Sex offender risk assessment and management (SORAM)

The sex offender risk assessment and management (SORAM) model is the model for combined management of sex offenders between An Garda Síochána and The Probation Service with the involvement of Tusla wherever there is a child protection concern. SORAM was established to support enhanced levels of cooperation and coordination between agencies in order to adopt a multiagency approach to managing convicted sex offenders in the community.

Tusla staff and members of An Garda Síochána who met with the Investigation Team were very clear on the purpose of SORAM, as well as its associated procedures. This interagency approach to managing convicted sex offenders in the community was cited by many group members as an example of effective interagency collaboration and information sharing.

At the separate group meetings, members of the Gardaí and Tusla staff believed SORAM worked very well and provided for an effective joint-working process between the Gardaí, Probation Service, the Irish Prison Service and Tusla in relation to planning and sharing information on convicted sexual offenders. This, they reported, increases the quality of child protection assessments as well as the quality of risk-assessment management plans relating to convicted sex offenders, where there are identified child protection concerns.

7.4.8 Interagency cooperation in the management of allegations

Both Tusla staff and members of An Garda Síochána were very clear that the welfare of the child was paramount and that a child's safety should be at the core of all decision-making. As reported in Chapter 4 and at group meetings, the Investigation Team found evidence that appropriate action is taken by social workers whenever children were assessed at being of immediate and serious risk.

However, one of the reasons given by Tusla for delays in progressing the assessment of allegations of child sexual abuse, including retrospective allegations, related to ongoing Garda criminal investigations, including the carrying out of Garda specialist interviews. While both agencies have different functions, Tusla needs to be assured that it discharges its statutory responsibilities for child protection in a timely way.

Senior members of both agencies stated their commitment to better working arrangements and reported that the recently introduced joint protocol should improve the safe, timely and effective management of child protection referrals. The Investigation Team explored reported delays in Tusla's management of some child abuse referrals when a criminal investigation was also in train. A representative of the Garda National Protective Services Bureau told the Investigation Team that a Garda investigation should never require a delay in social workers taking protective action.

A representative of the Garda National Protective Services Bureau believed effective interagency communication and joint Garda-Tusla strategy and liaison meetings should mitigate any such risk. A representative of the Garda National Protective Services Bureau further outlined that a key aspect of joint-agency working which enhances timely interventions is joint specialist interviewing of children.

7.4.9 Joint specialist interviewing of children

Joint working between social work and policing services involved in the investigation of child abuse is recognised internationally as providing children with a less traumatic experience of the investigative process and better outcomes for children whenever criminal and social care enquiries run in parallel.*

* Source: Joint Protocol for An Garda Síochána/Tusla Child and Family Agency Liaison, December 2017.

Children First 2017 outlines that 'joint specialist interviews' are conducted in cases where it is deemed necessary by both the Gardaí and Tusla. Children First also sets out that they have joint responsibility to ensure that specialist interviewer training is provided to both Tusla staff and members of An Garda Síochána involved in the investigation of child welfare and protection cases and subsequent intervention.

It was reported by members of the Gardaí and also Tusla personnel that the aim of this joint training is to develop specialist expertise in interviewing children who may have been abused. The training enables members of each service to fully understand each other's roles and responsibilities and to learn how to work collaboratively.

Review of case files showed that practices varied nationally in relation to the interviewing of children about whom child sexual abuse referrals have been made. While both Tusla and An Garda Síochána agree that interviews with child victims of alleged sexual abuse should be kept to a minimum, the investigation found that in the six service areas visited, this was not always the case, and that some children were subject to separate interviews by both An Garda Síochána and Tusla.

Gardaí who met with the Investigation Team highlighted their concern about the risk associated with parallel social worker and garda interviews, as discrepancies in accounts can have a potentially negative effect on evidence for a criminal prosecution. Equally, Tusla staff highlighted their concern about the negative impact on the wellbeing of a child where the child is interviewed on more than one occasion by separate agencies. The potential for children to be interviewed separately in such fashion by An Garda Síochána and Tusla, is, in the opinion of the Investigation Team, unacceptable.

Joint training initiatives between Tusla and An Garda Síochána had reportedly occurred intermittently in the past and it was identified during group meetings with Gardaí as an area that needed to be improved in future. Gardaí reported that the combined training was a valuable method of establishing professional relationships and better understanding the distinct role of each agency.

At the time of the investigation, An Garda Síochána was responsible for training of specialist interviewers. However, access to this training by Tusla staff was inadequate for the timely implementation of a consistent approach to joint specialist interviews as defined in Children First 2017. Data provided by Tusla at the time of the investigation showed that six (35%) of the 17 service areas had staff who had completed joint Tusla/An Garda Síochána specialist interview training. Of the six service area sites visited, three areas had a total of 13 staff who had completed joint Tusla/An Garda Síochána specialist interview training.

Acknowledging the need for a more frequent programme of specialist interview training, the Investigation Team was informed by a representative of the Garda National Protective Services Bureau that the development of a model of interagency training is well advanced, with a focus on the integration of the functions of both agencies in the best interests of children. The Investigation Team was informed that the intention, wherever possible, is to run training programmes that facilitate the attendance of Gardaí and Tusla staff from the same Garda district/Tusla service area.

The Investigation Team was further informed that a programme of training for 2018 will include 10 courses, and facilitate a 50:50 ratio of trainees from each agency within groups of 12. However, it was clear to the Investigation Team that joint interviewing will not become standard practice without a significant increase in the numbers of existing social workers trained to conduct joint-specialist interviewing.

Senior Tusla managers reported to the Investigation Team that the practice of child-centred joint interviewing, which would reduce the need to re-interview a child, is one of the key elements to ensuring a consistent approach to assessments of child sexual abuse referrals across the country. In order to provide a nationwide joint-specialist interviewing service so that this practice becomes the norm, the Investigation Team recommends that Tusla ensures that a sufficient number of social workers receive joint training in specialist interviewing in order to comply with Children First 2017.

7.5 Engagement between Tusla and other external services and agencies

Tusla identified external agencies to attend group meetings conducted by the Investigation Team. These are services and agencies that make child sexual abuse referrals to Tusla; that are involved in the assessment and validation of child sexual abuse cases; and provide support services to children and adults who have experienced child sexual abuse. Representatives from these services and agencies were invited to attend the group meetings in the six Tusla service areas visited.

It emerged during these particular focus group meetings that the effectiveness of interagency collaboration between Tusla and the HSE varied across service areas. The investigation found that the arrangements for providing allied support services, such as therapeutic and medical services, to support the management of allegations of child sexual abuse were not equitable and largely depended on the available resources within a particular county or service area.

Tusla staff members reported that HSE services were readily available in some service areas. However, long waiting lists to access such services were reported to exist in other service areas.

Through review of case files, the Investigation Team observed the use to varying degrees of voluntary, community and charitable therapeutic and support services, as well as private providers, to supplement the provision of interventions for children throughout Tusla service areas.

Some external service providers reported a positive two-way communications process, prompt acknowledgement and action by Tusla once referrals were received and good links with the duty social work service for consultation and support. However, in one particular service area, external professionals asserted that it was necessary for them to follow up several times on referrals of allegations of child sexual abuse made to Tusla's duty social work team prior to any action being taken. This was reported to be the case in relation to retrospective referrals in particular, with some external professionals describing periods of years before an adult complainant attending their service received a response from Tusla. The Investigation Team found that these reported delayed responses were reflected in some case records reviewed.

External service providers and referrers spoke of common challenges such as the protracted period of time taken to manage child sexual abuse referrals, including retrospective referrals, across the service areas visited. They attributed this to the high turnover of Tusla social work staff, the inexperience of some social workers when completing assessments and a lack of confidence among some social workers in managing retrospective allegations of child sexual abuse. These sentiments were echoed in some group meetings with Tusla social work staff.

The experience of interagency working with Tusla — as reported by professionals supporting the management of child sexual abuse allegations — varied throughout the six service areas reviewed during this investigation. It was reported during focus group meetings in some areas that the arrangements in place for providing services to children at the request of Tusla were very clear. For example, in one area, the Investigation Team was provided with examples of local service-level agreements between Tusla and an external service to provide counselling services to victims of alleged or confirmed child sexual abuse.

However, the Investigation Team found variation in practice with regard to formal service-level arrangements at local, national and or regional level with external agencies or professionals to support the effective management of child sexual abuse allegations. These services by external providers and agencies were often provided on an informal basis, and attendees at focus group meetings reported varying levels of confidence in Tusla's processes for responding to or making referrals to their services.

The Investigation Team recommends that standardised service-level agreements written in plain and accessible language are put in place between Tusla and external services supporting Tusla in the management of child sexual abuse allegations.

7.6 Conclusion

Tusla has statutory responsibility for child protection and welfare services. In order to carry out this responsibility effectively, Tusla and An Garda Síochána need to work closely together in the best interests of those children who are the subject of child sexual abuse allegations and those adults who have presented themselves to Tusla with allegations that they were abused when they were children.

While there was a system in place for the notification of suspected child sexual abuse between An Garda Síochána and Tusla, there was no electronic data transfer interface between the information communication technology (ICT) systems in both agencies. Sending such notifications by fax or post is not efficient, particularly as these notifications relate to allegations or suspicions of child abuse.

Although there are a number of established forums for interagency working between both agencies, such as strategy meetings and liaison meetings, the Investigation Team found that many aspects of this set up needs to improve. Record-keeping to clearly reflect the discussions of these interagency forums was inconsistent across the six Tusla service areas visited. In addition, there was no agreed information-sharing protocol to facilitate the effective sharing of information and which both agencies have confidence in.

At the time of the investigation, while joint-specialist interviewing of children was acknowledged at interview and group meetings as a key element in the assessment of child sexual abuse, not enough social workers were trained in specialist interviewing to ensure that this was a standard practice nationally. In the opinion of the Investigation Team, it will not become standard practice without a significant increase in the numbers of existing social workers trained to conduct joint-specialist interviewing.

Participants at the focus meetings reported that there are good informal working arrangements between Gardaí and Tusla staff in the six services areas visited. In addition, it is anticipated that the new Tusla and An Garda Síochána Children First joint-protocol for liaison between both agencies will further improve these processes. The Investigation Team welcomes this initiative. This joint-protocol — along with a new information-sharing protocol and a better training scheme for joint-specialist interviewing — should, if fully implemented, address the deficiencies identified by this investigation of bilateral interactions between Tusla and An Garda Síochána.

In examining the interagency arrangements between Tusla and other third parties, the Investigation Team found that access to allied support services, such as specialist therapeutic and medical services to support the management of allegations of child sexual abuse, was not equitable, and largely depended on the available resources within a particular county or service area.

The Investigation Team believes that child protection and welfare services would benefit from an analysis of the availability and capacity of these resources. This would also highlight the likely impact of resource deficits wherever they may exist.

While the Investigation Team heard examples of effective interagency working at local level, it also heard concern about delayed responses by Tusla to referrals of child abuse to it. In addition, the variation in practice with regard to formal service-level arrangements at local, national and or regional level with external agencies represents a missed opportunity for enhanced interagency working in the best interests of children.

Chapter 8
Conclusions and recommendations

8.1 Introduction

This report has presented the findings of the investigation by HIQA into the local, regional and corporate arrangements provided by the Child and Family Agency (Tusla) to ensure the effective and safe management of child sexual abuse referrals involving adults of concern. This includes allegations made by adults about alleged abuse when they were children — these are termed retrospective allegations of abuse.

The report makes 4 overarching recommendations and a number of recommendations throughout the report to improve the quality, safety and standards of services provided by Tusla in relation child protection and welfare services. It is now imperative that Tusla responds in a clear and measurable way to the findings of this investigation. This is necessary to ensure that these findings do not constitute a lost opportunity for service improvement across the child protection and welfare services.

The following sections outline the key conclusions of this investigation.

8.2 National Standards for the Protection and Welfare of Children

In line with the Terms of Reference of this investigation, the Investigation Team identified a number of non-compliances by Tusla with the *National Standards for the Protection and Welfare of Children*, which are demonstrated in Table 10 below. These Standards had been approved by the Minister for Health and the Minister for Children and Youth Affairs in July 2012. A pattern of non-compliances in key areas had been previously detected by HIQA in its inspections of Tusla services, and brought to Tusla's attention during these inspections.

Between 2014 and 2016, HIQA had conducted 12 such inspections, against the National Standards, of Tusla child protection and welfare services, which include child sexual abuse referrals. While there was evidence of good practice, particularly around responding to children who were at immediate risk of significant harm, HIQA inspectors also found areas of significant concern across several service areas. There were inconsistencies in the arrangements provided by Tusla to ensure a safe and effective service.

Examples of poor practice found on those previous inspections, and in the earlier 2015–2017 review of governance in Tusla, included high levels of cases where a named social worker has not been assigned to a case, unmanaged retrospective referrals, poor quality record-keeping, inconsistent risk management and difficulties with staff retention and recruitment. There were also inadequate quality assurance arrangements to effectively detect, manage and learn from deficiencies in practice identified during HIQA's monitoring and inspection programme.

So it was a matter of significant concern, given that Tusla is a learning organisation, that during the fieldwork for this investigation, the same issues were emerging yet again. The investigation paid particular attention to four key areas of the National Standards. HIQA used these National Standards to inform the lines of enquiry (questions to be addressed) of the investigation. This approach aimed to identify opportunities to improve the arrangements that Tusla had locally, regionally and nationally to ensure the effective management of all child sexual abuse referrals involving adults of concern.

Table 10. Non-compliances by the Child and Family Agency (Tusla) with the *National Standards for the Protection and Welfare of Children* found during this HIQA investigation

National Standard Number	National Standard and findings
Standard 2.1	**Children are protected and their welfare is promoted through the consistent implementation of Children First.**
	Findings of non-compliance ■ Children First (2011) was not consistently implemented throughout Tusla to ensure that children's protection and welfare were effectively promoted. ■ Child sexual abuse referrals including retrospective allegations were not always managed in a timely or effective way from the point of referral to the point of closure. ■ Tusla did not identify, assess and manage risk to all children who are the subject of a child sexual abuse referral. ■ There was a variation in the level of adherence to Tusla's policy and procedure and standard business processes for the management of child sexual abuse referrals. ■ There was no standard business process to direct staff on the management of retrospective allegations. ■ There was no standard definition for safety planning to inform safeguarding practice, with the exception of children on the Child Protection Notification System (CPNS). ■ The interagency and inter-professional arrangements in place in Tusla did not adequately promote the protection of children who are the subject of a child sexual abuse referral. ■ Tusla did not have an effective system in place to ensure that all suspected cases of child sexual abuse, including retrospective allegations of child sexual abuse, were notified to An Garda Síochána and or were notified in a timely manner. ■ There was no nationally agreed arrangement in place to ensure effective and consistent information sharing between Tusla and An Garda Síochána. ■ There was no strategic approach to joint-specialist interviewing of children alleging abuse.

National Standard Number	National Standard and findings
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.**
	Findings of non-compliance ■ There was a lack of consistent adherence to Children First (2011) and National Standards to protect children and promote their welfare.
Standard 3.2	**Children receive a child protection and welfare service, which has effective leadership, governance, and management arrangements with clear lines of accountability.**
	Findings of non-compliance ■ The operational management arrangements in place did not provide consistent oversight and monitoring to ensure the effective management of child sexual abuse referrals including retrospective allegations.
Standard 4.1	**Resources are effectively planned, deployed and managed to protect children and promote their welfare.**
	Findings of non-compliance ■ There were gaps in resource planning and delivery which impacted on the effective management of child sexual abuse referrals including retrospective allegations. ■ Critical social work posts remained vacant to varying degrees across the service areas which impacted negatively on the consistent delivery of high-quality and timely services. ■ There was no formal performance management development system (PMDS) in place. ■ There was no standardised approach to staff training on the management of child sexual abuse allegations.

National Standard Number	National Standard and findings
Standard 6.2	**The service has a robust and secure information system to record and manage child protection and welfare concerns.**
	Findings of non-compliance ■ The National Child Care Information System (NCCIS) was not fully aligned with Tusla's standard business processes for managing referrals. ■ The National Child Care Information System did not capture information and data in relation to retrospective referrals.
Standard 6.3	**Secure record-keeping and file management systems are in place to manage child protection and welfare concerns.**
	Findings of non-compliance ■ Tusla's guidance on maintaining good records was not consistently adhered to. ■ There was inadequate guidance on opening and naming files about adults against whom an allegation had been made.

For public confidence and for the ongoing safety of services being provided to children and families, it is vitally important that Tusla reviews these findings of non-compliance against the National Standards in order to ensure continual improvements are made in the care and protection of children receiving Tusla's child protection and welfare services.

8.3 Management of referrals of child sexual abuse and referrals of retrospective child sexual abuse

In conducting this investigation, the Investigation Team was acutely mindful that the pathway for managing child sexual abuse referrals by Tusla is identical to Tusla's pathway for managing all child protection and welfare concerns. Therefore, these findings provide an insight into the governance and operational arrangements in place for all child protection and welfare referrals and retrospective cases.

This investigation found many examples of good practice by dedicated Tusla personnel in how they managed allegations of child sexual abuse and retrospective cases. Tusla staff with whom the Investigation Team met with and interviewed were professional and openly committed to their work.

Many staff shared their experience and ideas on how to improve the service. The Investigation Team found that Tusla appropriately responded to children who were judged to be at immediate and serious risk of harm. In these situations, there was good cooperation between Tusla and An Garda Síochána in taking protective steps to keep children safe.

Notwithstanding, the Investigation Team found that Tusla needs to immediately improve its governance and strengthen its managerial oversight of practice to ensure that all child sexual abuse referrals are effectively and consistently managed. Case records reviewed by the Investigation Team indicated that service users had a varied experience of using Tusla services. In those situations where referrals had been well managed, children and adults experienced a timely, sensitive and person-centred service. Delays in the management of referrals of child sexual abuse, in particular retrospective referrals, were a source of frustration and at times disengagement by the adult complainant.

In line with the Terms of Reference and in response to the Minister for Children and Youth Affairs' concern as to possible systemic risks to children arising from the creation and handling of information by Tusla in the garda whistle-blower case, the Investigation Team reviewed the systems in place in a number of service areas and in a regional team to see how Tusla effectively manages all child sexual abuse referrals, including retrospective referrals. The investigation identified three defective points in Tusla's management of these referrals, which Tusla should now address as a matter of urgency:

(a) **Screening and preliminary enquiry —** there were inconsistencies in practice around the screening of allegations and making preliminary enquiries, which meant that not all children at actual or potential risk were being assessed and where necessary, protected by Tusla, in a timely and effective manner.

(b) **Safety planning —** there were inconsistencies in safety-planning practice. While some children were adequately safeguarded, other children at risk were not. Even for children who had a safety plan, the ongoing suitability of the safety plan was not always re-evaluated to ensure the continued safety and wellbeing of the child.

(c) **Management of retrospective cases —** while there was a policy on managing allegations made by adults of abuse during their childhood, it did not include a standardised approach to direct and guide staff in case management, leading to variation in practice and delays. Some people were not told that an allegation of abuse had been made against them and others were given only limited information.

Failings in the national oversight systems in Tusla meant children may have remained at risk, a situation which HIQA views as unacceptable. Overall, there were shortcomings in implementing Tusla policies and procedures, poor record-keeping and inadequate monitoring of social work practice in the service areas visited. This meant that areas of good and poor practice were not shared across the organisation to promote and encourage improvement. In addition, Tusla's board and senior managers could not be assured of the quality and safety of the service at the front-line in the service areas.

Tusla was aware of these shortcomings prior to this investigation. Although it had developed three dedicated service-area-based teams in the areas visited and one regional team to manage retrospective allegations of child sexual abuse, it failed to act swiftly to produce and finalise the supporting guidance and policy to support staff to address these issues in a systematic way. This systemic risk is increased when staff who are operationally responsible for the service are unclear about the process they should follow or there is no standard business process to guide them in the first instance.

Some of the reasons cited by Tusla for the delays in managing child sexual abuse referrals included ongoing criminal investigations by An Garda Síochána and delays with information sharing between both agencies. While this investigation focused exclusively on how Tusla managed allegations of child sexual abuse, there was evidence of both Tusla and the Gardaí's commitment to implementing the Children First joint-working protocol, introduced in December 2017, and which, when fully implemented — in conjuction with an improved training scheme for joint-specialist interviewing — should improve the management of these referrals.

Tusla has a duty from the outset to act fairly, proportionately and in accordance with the principles of natural and constitutional justice. The Investigation Team found that in the majority of cases, persons who were the subject of an allegation of abuse were informed of whether the allegation was founded or not at the end of the process. However, there were inconsistencies in the level of detail about the allegation communicated to these persons, and there were delays to the start of the assessment, the assessment itself and the conclusion.

Tusla had developed a child protection and welfare strategy which includes a national approach to child protection and welfare practice, called Signs of Safety. This development is welcomed by the Investigation Team. Tusla is confident that full implementation of this strategy over a five-year period will address the risks identified throughout this investigation — including those deficiencies in relation to screening and preliminary enquiry of child sexual abuse referrals and safety planning.

However, the Investigation Team believes that Tusla must in the interim address the systemic deficiencies identified by the HIQA investigation team. In addition, Signs of Safety will not address the deficiencies identified by this investigation in relation to the management of retrospective referrals.

8.4 Recommendations for Tusla to address inconsistencies in practice

HIQA makes the following recommendations to adequately address the variations in practice identified during this investigation; to support social work teams in their practice; and to ultimately reduce any potential risk to children.

Tusla must as a matter of urgency:

a. put in place a uniform waiting-list management system to review and monitor all referrals awaiting allocation to a named social worker

b. review and adopt the draft *National Procedures for Determining an Outcome to Allegations of Retrospective and Extrafamilial abuse cases and Protecting Children at potential risk of harm*, and its accompanying draft practice guidance, and ensure its implementation across Tusla

c. develop standard approaches to support the implementation of the above policy and procedures for managing retrospective referrals of allegations of abuse, to include prioritisation levels and timelines for assessments

d. put in place strong and effective assurance arrangements to ensure that staff are educated and trained in applying this guidance and ensure that routine quality assurance controls are in place to measure its effectiveness

e. support the Sexual Abuse Regional Team (SART) in the Dublin North East Region and other dedicated service-area-based teams to quickly and effectively complete risk assessments and, where appropriate, put in place the required protective measures to ensure children's safety

f. review and ensure its current processes for case-record identification and closing cases are safe and effective

g. ensure all persons who are the subject of an allegation of abuse are informed in a timely manner that an allegation has been made against them.

These operational recommendations are in addition to the overarching recommendations made separately in this report (see pages 20–21 and pages 178–179).

8.5 Investigation findings on governance and management

The Investigation Team found that the board and executive of Tusla have achieved a considerable amount in embedding the organisation since its establishment in 2014, particularly in the areas of corporate governance and management structures. There is a clear strategic direction, and a long-term vision of what Tusla wants to achieve. Its governance structures are underpinned by a quality improvement framework, risk management policies, business planning processes, and a large number of supporting policies and business processes.

However, the Investigation Team found evidence of a divergence between national Tusla policies and business processes and the actual practice in the service areas visited, and which the Investigation Team believes is leaving children at potential risk in some situations.

Tusla, in moving towards providing a more responsive service to children and families, has a number of challenges which it must address. These challenges particularly relate to a lack of validated information to inform policy and direction, effective information communication technology (ICT) systems, and staff recruitment — all issues previously already identified in the 2015–2017 governance review. While the implementation of Signs of Safety is at the core of Tusla's strategic direction for child protection and welfare services over the next five years, there are current systems risks which require immediate attention and which Signs of Safety will not address.

The Investigation Team remained concerned about the lack of urgent measures from Tusla to address fundamental risks to the provision of a safe and sustainable service. There are particular deficiencies related to:

- the early detection of poor practice
- improvements in staff personal development and support and the absence of a formally agreed performance management development system (PMDS)
- increased opportunities for sharing good practice
- the provision of stronger and consistent managerial oversight of practice at local level.

In order to achieve a safe and sustainable service, the above improvements should be supported by risk, quality and information management systems which are embedded in practice at all levels throughout the organisation.

8.6 Workforce

External and internal factors were negatively impacting on Tusla's ability to ensure that it has a workforce that can deliver on its service objectives. In terms of the external factors, Tusla itself has identified as an organisational risk the lack of available and qualified social work staff. Ireland is not alone in experiencing such a shortage. Tusla has to manage the same workforce challenges faced by other jurisdictions and avoid an organisational mind-set that sees such challenges as insurmountable due to factors outside its control.

The Minister for Children and Youth Affairs had initially requested HIQA to include in this investigation an assessment of the number, skill-mix and sufficiency of staffing levels. However, a comprehensive workforce assessment was outside the scope and competencies of this investigation. Tusla believes it is currently under-resourced in terms of workforce, in particular social workers, with almost universal reports in risk registers across the country about inadequate staffing levels.

However, the Investigation Team did not find neither a comprehensive strategic approach to workforce planning that was informed by the reality of the employment market nor strong evidence of how to upskill other social care disciplines within its service. Without taking such a strategic approach, the Investigation Team believes that Tusla cannot rely on recurring staff shortages as a default reason for failing to deliver a better service to children and their families, and one where social workers can enjoy the core job that they have been trained and qualified to do. This approach should contribute to greater retention of staff and allow others to take on extra responsibilities.

The external challenges faced by Tusla are exacerbated by internal factors such as workforce allocation and staff training and development. The supervision and caseload management systems in place, while appropriate in theory, were inconsistently applied in practice in the service areas visited by the Investigation Team. In addition, the quality of personal development plans, a key element of staff supervision, were also found to vary across the service areas and were not in place for all staff.

In terms of staff training and development, HIQA is significantly concerned about the failure to provide appropriate training in Tusla's national policy and procedures on managing allegations of abuse. This is a serious shortcoming which is further compounded by the finding that some line managers providing social work practice supervision did not have the appropriate training in managing child sexual abuse, including retrospective allegations. In such cases, there is a pressing need to support managers to upskill or gain experiences in these crucial areas.

8.7 Use of information

Tusla has made much progress in relation to addressing its information communication technology (ICT) deficits by securing additional ICT funding, setting up an ICT directorate and developing an ICT strategy. This should support Tusla to meet its business and strategic needs and will decrease its dependency on the HSE for the ICT supports that the HSE currently provides to Tusla.

The introduction of an integrated information system (the National Child Care Information System) is a welcome finding as, when fully implemented (Tusla has identified July 2018 for full implementation), it should improve the systems of recording, storing and sharing of information about children at risk across its child protection and welfare services. However, the success of this system will be improved through the further provision of essential equipment, such as computers and laptops, and associated training and IT support to social work departments around the country.

Notwithstanding these achievements, Tusla continues to face significant challenges in relation to the quality of its records and the information it gathers. The Investigation Team found a number of significant gaps in the management of information about child sexual abuse allegations, including those allegations made by adults about alleged abuse when they were children, including that:

- overall, staff did not adhere to Tusla's guidance on maintaining good records
- there was no standardised system in place to ensure the allocation of a uniform case-record identification reference number
- there was little evidence that service-area audit findings had led to service-wide improvement
- the new National Child Care Information System was not fully aligned with Tusla's standard business processes for managing referrals nor was it currently developed to capture retrospective referrals
- Tusla's external data protection assessment has made 72 recommendations for practice improvements, but there was no clear roadmap for implementing these recommendations.

To ensure effective and transparent decision-making about children's safety, it is vitally important that child protection and welfare practices be accurately recorded and maintained. The checks that Tusla has in place to assure the effective recording of the management of child sexual abuse referrals, and in the wider context, child protection and welfare referrals, are currently ineffective. Although Tusla's new integrated information communications system should contribute to standardising recording systems, methods of recording and data collection, it cannot assure the quality of the records themselves nor allow Tusla's executive and board to be certain of effective child protection and welfare practices.

Furthermore, as Tusla will continue to operate a paper-based system for retrospective and adult cases on a national scale, the particular deficiencies related to paper-based records and manually gathered data and information needs to be addressed.

8.8 Bilateral engagement between Tusla and An Garda Síochána and external agencies

Tusla and An Garda Síochána need to work more closely together in the best interest of those children who are the subject of child sexual abuse allegations and those adults who have presented themselves to Tusla with allegations that they were abused when they were children.

There was an established system in place for the notification (by fax or post) of suspected child sexual abuse between An Garda Síochána and Tusla. However, there was no electronic data transfer interface between both agencies. This is neither efficient, appropriate nor wholly secure given that these notifications relate to allegations or suspicions of child abuse.

While there are a number of established forums for interagency working between both agencies, such as strategy meetings and liaison meetings, many aspects of these forums need to improve, such as record-keeping. In addition, during the investigation in 2017, there was no agreed information-sharing protocol to facilitate the effective sharing of information on cases and which has the confidence of both agencies.

At the time of the investigation, while joint-specialist interviewing of children was acknowledged at interview and group meetings as a key element in the assessment of child sexual abuse, not enough social workers were trained in this field to ensure that this was a standard practice nationally. In the opinion of the Investigation Team, it will not become standard practice without a significant increase in the numbers of existing social workers and gardai trained to conduct joint-specialist interviewing.

Participants at focus meetings with An Garda Síochána reported that there are good informal working arrangements between Gardaí and Tusla staff. It is anticipated that the new Tusla and An Garda Síochána Children First joint-protocol for liaison between both agencies should — if implemented fully and accompanied by an information-sharing protocol and an increase in the numbers of existing social workers and gardai trained to conduct joint-specialist interviewing — address the deficiencies identified by this investigation in regard to the bilateral interactions between Tusla and An Garda Síochána.

The Investigation Team found that the arrangements between Tusla and other third parties for providing allied support and medical services to support the management of allegations of child sexual abuse were not equitable. These largely depended on the available resources within a particular county or service area. Future provision and investment in child protection and welfare services would benefit from an analysis of the availability and capacity of resources available to service areas to support the management of child sexual abuse referrals. This, in addition, would also highlight the likely impact of resource deficits wherever they may exist.

While the Investigation Team was informed of examples of effective interagency working at local level, it was also informed by external agencies in one particular service area of delayed responses by Tusla to retrospective referrals of alleged child abuse. In addition, the variation in practice with regard to formal service-level arrangements at local, national and or regional level with external agencies working for Tusla represents a missed opportunity for better interagency working in the best interests of children.

8.9 Concluding remarks

Concerns about the handling of information by Tusla in relation to garda whistle-blower, Garda Sergeant Maurice McCabe, led the Minister for Children and Youth Affairs to direct HIQA in March 2017 to carry out a statutory investigation to assess whether there were systemic issues that constituted a serious risk to the health and welfare of children. The year-long HIQA investigation determined that these risks existed.

The creation of Tusla as a national agency in 2014 for the protection of children and families at risk is a positive development. It is evident that considerable strides have been made by Tusla to become established and to create a governance structure to assure the public that children at risk are being effectively assessed and protected by Tusla in a timely and proportionate manner.

Although there was evidence of positive strategic developments within Tusla and evidence of good front-line practice in the service areas visited, the serious shortcomings found in this investigation mirror that of HIQA's previous findings in its inspection and monitoring of child protection and welfare services, which includes child sexual abuse referrals, since Tusla was created in 2014.

Some children are being left at potential risk due to:

- failures at operational level to consistently implement Tusla's national policies and business processes
- to accurately record important decisions made and actions taken
- to monitor the effectiveness of the steps taken to protect children
- to support staff members' personal development, day-to-day practice and skill set.

These failings stem from a gap seen by the Investigation Team between national Tusla policies and business processes and what is actually happening on the ground in social work departments around the country.

Given that HIQA has repeatedly identified these risks in its previous inspections, and given that it raised similar concerns in its previous review of the governance of Tusla, it is of the utmost concern to HIQA that Tusla's corporate governance systems have failed to effectively share learning across Tusla's 17 service areas from adverse findings by HIQA, whose statutory role is to promote quality and safety in these services.

Tusla faces a number of workforce, use of validated information and information communications technology challenges, and while its implementation of the Signs of Safety initiative is at the core of its strategic direction for child protection and welfare services over a five-year period from 2017, these current challenges and systems risks require immediate attention by Tusla, as not all will be addressed by introducing Signs of Safety alone.

In the interim, shortfall in the current arrangements that have been identified in this investigation must be addressed to safely manage referrals of allegations of child sexual abuse and retrospective allegations against adults of concern. These referrals follow the same pathway as all child protection and welfare referrals, therefore raising the prospect that these deficiencies could be replicated elsewhere in the child protection and welfare system. Concurrently, there was little evidence found that Tusla is systematically seeking out and sharing good practice internally.

In order to be sustainable over the long term, it is vital that improvements made by Tusla are supported by risk, quality and information management systems which are embedded in practice at all levels throughout the organisation. Therefore, Tusla must review, design and implement a nationally consistent approach to effectively managing waiting lists across all its 17 service areas.

Safety planning must be approached consistently with a shared understanding of what it means, and there must be strengthened managerial oversight and accountability structures in place to ensure that Tusla staff adhere to good policy and processes.

This disparity between Tusla policy at national level and local practice on the ground, in addition to widespread concern about inadequate staffing levels, represents a serious ongoing challenge to providing safe and sustainable management of child sexual abuse allegations.

Despite a number of initiatives introduced by Tusla to recruit more social workers, it remains beset by insufficient numbers of social work staff. However, Tusla cannot rely on recurring staff shortages as a default reason for failing to deliver a more efficient and safer service to children and their families. In the absence of a strategic approach to workforce planning, as seen during this investigation, staff shortages will continue to directly impact on the timely management of child protection and welfare referrals.

Furthermore, the Investigation Team remains concerned that Tusla will continue to operate a paper-based system for retrospective and adult cases nationally in parallel to its new integrated information and communications system. This makes it crucial to provide clear guidance and support for staff on the appropriate storage of sensitive information about persons who are the subject of an allegation of abuse, in particular when such information is held on the complainant's file.

HIQA acknowledges efforts to improve working arrangements and information sharing between Tusla and An Garda Síochána, introduced in the latter part of 2017. However, the new Tusla and An Garda Síochána Children First joint-protocol for liaison between both agencies must be accompanied by an agreed information-sharing protocol to facilitate the effective sharing of information which has the confidence of both agencies.

Similarly, in order to ensure that joint-specialist interviewing of children by Tusla and the Gardaí becomes standard practice nationally, the numbers of existing social workers trained to conduct joint-specialist interviewing will need to significantly increase.

There must now be a recognition by those with responsibility at executive and board level in Tusla that the management of all child sexual abuse allegations follows the same pathway as child protection and welfare referrals. Therefore, there is a significant risk that the deficiencies identified during this investigation in the pathway for allegations of child sexual abuse in a sample of the services provided by Tusla may be replicated across the wider child protection and welfare services.

8.10 Moving forward

HIQA acknowledges the work that has been done to date by Tusla to amalgamate child protection, early intervention and family support services. However, Tusla must now address the risk and deficiencies identified within this report in order to improve how child sexual abuse referrals and retrospective cases are managed. It must also ensure that it addresses as a matter of urgency similar risks and deficiencies which may exist in the broader management of all child protection and welfare referrals.

Tusla's governance arrangements to support the implementation of the findings and recommendations contained in this investigation report must be clear, and include a named accountable person within Tusla who has the overall delegated responsibility for implementing these recommendations. Tusla's implementation plans should include clear timelines and identified individuals with responsibility for each recommendation and action.

HIQA acknowledges the appointment of a director of ICT and chief social worker within Tusla and the roll-out of the National Child Care Information System (NCCIS) and ICT Strategy. HIQA also welcomes the planned implementation of Tusla's Child Protection and Welfare Strategy; the project management approach being taken by Tusla to the NCCIS and these strategies; the establishment by Tusla of three additional dedicated regional teams to manage retrospective allegations of abuse; training initiatives with the specific purpose of improving governance and oversight activity at service director, area manager and principal social work grades; and Tusla plans to improve performance information and reporting; quality assurance and monitoring; and risk and incident management.

HIQA — in consultation with Tusla, the relevant professional organisations and children advocacy groups — will begin the design in 2018, through the lens of this investigation, a thematic inspection programme to promote improvement. In addition, it will begin to develop in 2019 revised National Standards for Children's Social Services. The standards should cover all support and protection services from point of referral to discharge of the child or client.

To inform the development of a regulatory framework for children's social services in Ireland, HIQA will assist the Department of Children and Youth Affairs in reviewing international best practice in the regulation of children's services. Given the significant system-wide recommendations outlined in this report, it will be vital that there is the necessary political commitment to their managed implementation in order to improve the quality and safety of all child protection and welfare referrals.

Therefore, HIQA recommends that the Minister for Children and Youth Affairs should establish, as a priority, an oversight committee in the Department of Children and Youth affairs to ensure the implementation of the recommendations contained in this HIQA investigation report. Implementing the report's recommendations provides an opportunity to build upon the essential work being carried out by Tusla staff and to learn from adverse events in a meaningful way for the betterment of services to protect Ireland's most vulnerable children.

Recommendations

1. The Child and Family Agency (Tusla) should:

A. review all of the findings of this investigation, including the identified non-compliances with the *National Standards for the Protection and Welfare of Children* as set out in this investigation report

B. review these findings as they relate to all other child protection and welfare referrals, which follow the same referral pathway as all child sexual abuse referrals

C. review all of the recommendations made by the Investigation Team throughout this report

D. publish an action plan on its website outlining in clear language and with clear timelines the measures it proposes to take to implement the actions identified in the recommendations A to C above. This action plan should include a named person or persons with responsibility and accountability in Tusla for implementing these recommendations and actions.

E. ensure it continually reviews and updates this action plan and that updates on progress being made against these recommendations and actions are included in its annual report.

2. As a matter of urgency, Tusla and the Department of Children and Youth Affairs should seek the assistance of the higher education and training establishments to create formal career-path mechanisms for students and graduates to support current and future workforce needs in Tusla, with the aim of providing a sustainable child protection and welfare service.

In the interim, Tusla and the Department of Children and Youth Affairs should review the current operational arrangements in Tusla to identify efficiencies and improvements in workflow. This should include a review of the existing social worker, social care worker and support staff skill-mix, and the development of a workforce strategy.

3. The Department of Children and Youth Affairs, with the assistance of the Health Information and Quality Authority (HIQA), should undertake an international review of best practice in the regulation of children's social services in order to inform the development of a regulatory framework for these services in Ireland. This is with the view to providing independent assurance to the public that the State's child protection and welfare services are safe and effective.

4. The Department of Children and Youth Affairs should establish an expert quality assurance and oversight group to support and advise Tusla and the Department on the implementation of the recommendations of this investigation report and Tusla's Child Protection and Welfare Strategy and Corporate Plan. The Department of Children and Youth Affairs should provide regular updates on its website to inform the public of the progress being made.

Chapter 9
References*

1. Health Act. Dublin: The Stationery Office; 2007.

2. *Prime Time.* McCabe files. Dublin: RTÉ Investigations Unit; 9 February 2017. Available online from: https://www.rte.ie/news/player/prime-time/2017/0209/

3. Health Information and Quality Authority. *National Standards for the Protection and Welfare of Children. For Health Service Executive Children and Family Services. July 2012.* Dublin: Health Information and Quality Authority. 2012. Available online from: https://www.hiqa.ie/sites/default/files/2017-01/Child-Protection-Welfare-Standards_2.pdf.

4. Health Information and Quality Authority. *Guidance on an 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 (the Minister).* Dublin: Health Information and Quality Authority. 2017. Available online from: https://www.hiqa.ie/sites/default/files/2017-04/Investigation-guidance-2017.pdf.

5. Child and Family Agency (Tusla). *Monthly Performance and Activity Dashboard October 2016.* Dublin: Child and Family Agency (Tusla). 2016. Available online from: http://www.tusla.ie/uploads/content/Monthly_Performance__Activity_Dashboard_Oct_2016_Final.pdf.

6. Health Information and Quality Authority. *Linking learning to National Standards.* Dublin: Health Information and Quality Authority. 2015. Available online from: https://www.hiqa.ie/sites/default/files/2017-01/Linking-learning-to-National-Standards.pdf.

7. Health Information and Quality Authority. *Investigation into the circumstances surrounding the provision of care to Rebecca O'Malley, in relation to her symptomatic breast disease, the Pathology Services at Cork University Hospital, Symptomatic Breast Disease Services at Mid Western Regional.* Dublin: Health Information and Quality Authority. 2008. Available online from: https://www.hiqa.ie/sites/default/files/2017-02/Rebecca_OMalley_Report%20(1).pdf.

* All online references were accessed at the time of preparing this investigation report. Please note that web addresses can change over time.

8. Health Information and Quality Authority. *Report of the investigation into the provision of services to Ms A by the Health Service Executive at University Hospital Galway in relation to her symptomatic breast disease, and the provision of Pathology and Symptomatic Breast Disease Services by the Executive of the Hospital.* Dublin: HIQA; 2008. Available online from: https://www.hiqa.ie/sites/default/files/2017-02/Investigation_Galway_Full_Report%20(1).pdf.

9. Health Information and Quality Authority. *Report of the investigation into the quality and safety of services and supporting arrangements provided by HSE at Mid-Western Regional Hospital Ennis.* Dublin: Health Information and Quality Authority. 2009. Available online from: https://www.hiqa.ie/sites/default/files/2017-01/investigation_report_mid-western_regional_ennis.pdf.

10. Health Information and Quality Authority. *Report of the investigation into the quality and safety of services and supporting arrangements provided by the Health Service Executive at Mallow General Hospital.* Dublin: Health Information and Quality Authority. 2011. Available online from: https://www.hiqa.ie/sites/default/files/2017-01/Investigation-Mallow-report.pdf.

11. Health Information and Quality Authority. *Report of the investigation into the quality, safety and governance of the care provided by the Adelaide and Meath Hospital, Dublin incorporating the National Children's Hospital (AMNCH) for patients who require acute admission.* Dublin: Health Information and Quality Authority. 2012. Available online from: https://www.hiqa.ie/sites/default/files/2017-01/Tallaght-Hospital-Investigation-Report.pdf.

12. Health Information and Quality Authority. *Investigation into the safety, quality and standards of services provided by the Health Service Executive to patients, including pregnant women, at risk of clinical deterioration, including those provided in University Hospital Galway, and as reflected in the care and treatment provided to Savita Halappanavar.* Dublin: Health Information and Quality Authority. 2013. Available online from: https://www.hiqa.ie/sites/default/files/2017-01/Patient-Safety-Investigation-UHG.pdf.

13. Health Information and Quality Authority. *Report of the investigation into the safety, quality and standards of services provided by the Health Service Executive to patients in the Midland Regional Hospital, Portlaoise.* Dublin: Health Information and Quality Authority. 2015. Available online from: https://www.hiqa.ie/sites/default/files/2017-01/Portlaoise-Investigation-Report.pdf.

14. Office of the Ombudsman. *Taking Stock: An investigation by the Ombudsman into complaint handling and issues identified in complaints made about the Child and Family Agency (Tusla).* Dublin: Office of the Ombudsman. 2017. Available online from: http://www.ombudsman.ie/en/Publications/Investigation-Reports/government-departments-other-public-bodies/Taking-Stock/Taking-Stock.pdf

15. Data Protection Commissioner. *Annual Report*. Dublin: Data Protection Commissioner. 2017. Available online from: https://www.dataprotection.ie/docimages/documents/DPC%20Annual%20Report%202017.pdf.

16. Child and Family Agency (Tusla). *Corporate Plan 2015-2017.* Dublin: 2015. Available online from: http://www.tusla.ie/uploads/news/Tusla_Corporate_Plan_2015_-_2017.pdf.

17. Child and Family Agency (Tusla). *Annual Report 2016.* Dublin: Child and Family Agency (Tusla). 2016. Available online from: http://www.tusla.ie/uploads/content/4153_Tusla_AnnualPlan_p08.pdf.

18. Child and Family Agency (Tusla). *Business Plan 2017*. Dublin: Child and Family Agency (Tusla). 2017. Available online from: http://www.tusla.ie/uploads/content/Tusla_-_Child_and_Family_Agency_Business_Plan_2017.pdf.

19. Central Statistics Office. *Census 2016.* 2016. Available online from: http://www.cso.ie/en/census/.

20. Child and Family Agency (Tusla). *Integrated Performance and Activity Report Quarter 4 2016*. Dublin: Child and Family Agency (Tusla). 2016. Available online from: http://www.tusla.ie/uploads/content/Q4_2016_Integrated_Performance_and_Activity_Report_Final_V2_Table_8_Amended_08Mar2017.pdf.

21. Child and Family Agency (Tusla). *Quarterly Service Performance and Activity Report Quarter 4 2017.* Dublin: Child and Family Agency (Tusla). 2017. Available online from: http://www.tusla.ie/uploads/content/Q4_2017_Service_Performance_and_Activity_Report_Final.pdf.

22. Child and Family Agency (Tusla). *Annual Report 2014.* Dublin: Child and Family Agency (Tusla). 2014. Available online from: http://www.tusla.ie/uploads/content/Tusla_Annual_Report_-_English.pdf.

23. Child and Family Agency (Tusla). *Annual Report 2015.* Dublin: Child and Family Agency (Tusla). 2015. Available online from: http://www.tusla.ie/uploads/content/Tusla_Annual_Report_2015_WEB.PDF.

24. Child and Family Agency (Tusla). *National Performance Activity Dashboard January 2018.* Dublin: Child and Family Agency (Tusla). 2018. Available online from: http://www.tusla.ie/uploads/content/National_Performance__Activity_Dashboard_Jan_2018_Final.pdf.

25. Department of Children and Youth Affairs. *Children First. National Guidance for the Protection and Welfare of Children.* Dublin: Department of Children and Youth Affairs. 2017. Available online from: https://www.dcya.gov.ie/documents/publications/20171002ChildrenFirst2017.pdf.

26. Child and Family Agency (Tusla). *Business Plan 2015*. Dublin: Child and Family Agency (Tusla). 2015. Available online from: http://www.tusla.ie/uploads/content/Busines_Plan_2015.pdf.

27. Child and Family Agency (Tusla). *Business Plan 2016*. Dublin: Child and Family Agency (Tusla). 2016. Available online from: http://www.tusla.ie/uploads/content/Tusla_Business_Plan_2016_-_Final.pdf.

28. Child and Family Agency (Tusla). *Organisational Risk Management Policy and Procedure*. Dublin: Child and Family Agency (Tusla). 2016. Available online from: http://www.tusla.ie/uploads/content/QA_Org_Risk_Management.pdf.

29. Health Service Executive. *NCCIS Business Process Standardisation Project*. Dublin: 2009. Available online from: https://www.hse.ie/eng/services/publications/children/nccis.html.

30. Child and Family Agency (Tusla). *Towards a Shared Purpose*. Dublin: Child and Family Agency (Tusla). 2014. Available online from: http://www.tusla.ie/uploads/news/News_tusla_purpose_06c.pdf.

31. Child and Family Agency (Tusla). *Corporate Plan 2018-2020*. Dublin: Child and Family Agency (Tusla). 2018. Available online from: https://www.tusla.ie/uploads/content/Tusla_Corporate_Plan_20-18_-_2020.PDF.

32. Child and Family Agency (Tusla). *Interim Practice Guide referral and Assessment Version 1 (January 2018)*. Dublin: Child and Family Agency (Tusla); draft and unpublished 2018.

33. Child and Family Agency (Tusla). *Practice Guidance: Meeting the Requirements of Fair Procedure* Dublin: Child and Family Agency (Tusla); draft and unpublished 2018.

34. Child and Family Agency (Tusla). *National Procedures for Determining an Outcome to Allegations of Retrospective and Extrafamilial Abuse Cases and Protection Children at Potential Risk of Harm (unpublished)*. Dublin: Child and Family Agency (Tusla); draft and unpublished 2018.

35. Child and Family Agency (Tusla). *Policy and Procedures for Responding to Allegations of Child Abuse and Neglect (provided to HIQA by Tusla)*. Dublin: Child and Family Agency (Tusla). 2014.

36. Department of Children and Youth Affairs. *Children First: National Guidance for the Protection and Welfare of Children 2011*. Dublin: Department of Children and Youth Affairs. 2011. Available online from: https://www.dcya.gov.ie/documents/Publications/ChildrenFirst.pdf.

37. Turnell A, Murphy T. Signs of Safety Comprehensive Briefing Paper 3rd Edition. East Perth: Resolutions Consultancy. 2014. Available online from: https://www.cornwall.gov.uk/media/12225430/Comprehensive-Briefing-Paper-3rd-edition.pdf.

38. Munro Turnell & Murphy and Partnering Local Authorities. *Transforming Children's Services with Signs of Safety Practice at the Centre*. UK: 2014. Available online from: http://www.wakefield.gov.uk/Documents/schools-children/safeguarding/signs-of-safety/transforming-childrens-services-with-signs-of-safety.pdf.

39. Struik A. *Safety Planning for long-term safety and wellbeing*. 2014. Available online from: https://www.partneringforsafety.com/safety-planning.html.

40. Child and Family Agency (Tusla). *National Performance and Activity Dashboard November 2017*. Dublin: Child and Family Agency (Tusla). 2017. Available online from: http://www.tusla.ie/uploads/content/National_Performance__Activity_Dashboard_Nov_2017_Final.pdf.

41. Child and Family Agency (Tusla). *Monthly Performance Activity Dashboard February 2017*. Dublin: Child and Family Agency (Tusla). 2017. Available online from: http://www.tusla.ie/uploads/content/Monthly_Performance__Activity_Dashboard_Feb_2017_Final.pdf.

42. Department of Health. *Working Together for Health*. Dublin: Department of Health. 2017. Available online from: http://health.gov.ie/wp-content/uploads/2017/11/13_11_2017_WFP_Framework_FINAL.pdf.

43. Child and Family Agency (Tusla). *Quarterly Service Performance and Activity Report Quarter 3 2017*. Dublin: Child and Family Agency (Tusla). 2017. Available online from: http://www.tusla.ie/uploads/content/Q3_2017_Service_Performance_and_Activity_Report_Final.pdf.

44. Bowyer S, Roe A. *Social work recruitment and retention*. Devon: Research in Practice. 2015. Available online from: https://www.rip.org.uk/resources/publications/strategic-briefings/social-work-recruitment-and-retention-strategic-briefing-open-access-download-2015/.

45. Eborall C, Garmeson K. *Desk Research on Recruitment and Retention in Social Care and Social Work Prepared for COI Communications for the Department of Health*. UK: Department of Health. 2001. Available online from: http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/assetRoot/04/07/43/20/04074320.pdf.

46. Redmond B, Guerin S, Nolan B. *The Retention of Social Workers in the Health Services: An Evidence-Based Assessment*. Dublin: University College Dublin. 2015. Available online from: http://www.ucd.ie/t4cms/UCD%20Retention%20of%20Social%20Workers.pdf.

47. Bunn A. *Signs of Safety® in England*. UK: NSPCC. 2013. Available online from: https://www.nspcc.org.uk/globalassets/documents/research-reports/signs-safety-england.pdf.

48. Government of Western Australia Department for Child Protection. *The Signs of Safety. Child Protection Practice Framework.* Perth: Government of Western Australia Department for Child Protection. 2011. Available online from: https://www.dcp.wa.gov.au/Resources/Documents/Policies%20and%20Frameworks/SignsOfSafetyFramework2011.pdf.

49. Queensland Government. *Child Protection Careers. 2018*. Available online from: https://www.communities.qld.gov.au/gateway/careers/career-choices/child-protection-careers.

50. Department of Public Expenditure and Reform. *Public Service ICT Strategy*. Dublin: Department of Public Expenditure and Reform. 2015. Available online from: http://ictstrategy.per.gov.ie/ictstrategy/files/Public%20Service%20ICT%20Strategy.pdf.

51. Health Service Executive. *Child Protection and Welfare Practice Handbook*. Dublin: Health Service Executive. 2011. Available online from: https://www.hse.ie/eng/services/publications/children/welfarepractice.pdf.

52. An Garda Síochána, Child and Family Agency (Tusla). *Joint Working Protocol for An Garda Síochána/Tusla – Child and Family Agency Liaison*. Dublin: An Garda Síochána, Child and Family Agency (Tusla). 2017. Available online from: http://www.tusla.ie/uploads/content/CF_Joint_Protocol.pdf.

Bibliography*

The following documents were provided to HIQA by Tusla

Child and Family Agency (Tusla) and Health Service Executive (HSE). *Joint Protocol for Interagency Collaboration between The Health Service Executive and Tusla – Child and Family Agency to Promote the Best Interests of Children and Families.* Dublin: Tusla and HSE; 2017. Available online from: http://www.tusla.ie/uploads/content/HSE_Tusla_Joint_Working_Protocol_v_1.0_March_2017_Signed.pdf.

Child and Family Agency (Tusla). *Code of Governance*. Dublin: Tusla; 2015.

Child and Family Agency (Tusla). *Commissioning Strategy*. Dublin: Tusla; draft and unpublished 2018.

Child and Family Agency (Tusla). CPNS Info for Older Child. Dublin: Child and Family Agency (Tusla); 2015.

Child and Family Agency (Tusla). CPNS Info for Teens. Dublin: Tusla; 2015.

Child and Family Agency (Tusla). CPNS Info for Young Child. Dublin: Tusla; 2015.

Child and Family Agency (Tusla). CPW and CPNS Proposal. Dublin: Tusla; 2015.

Child and Family Agency (Tusla). *Draft Creating A Culture of Quality. The Child and Family Agency's Quality Assessment and Improvement Framework.* Dublin: Tusla; 2015.

Child and Family Agency (Tusla). Draft Information Governance — Validation and Quality Assurance of Data Returns Procedure. Dublin: Tusla; 2015.

Child and Family Agency (Tusla). Family Support [Online]. Available from: http://www.tusla.ie/services/family-community-support/family-support/.

Child and Family Agency (Tusla). *Good Governance Framework*. Dublin: Tusla; undated. Available online from: http://www.tusla.ie/uploads/content/Good_Governance_Framework_1.pdf.

Child and Family Agency (Tusla). *Guidance for Caseload Management for Child and Family Agency Social Work*. Dublin: Tusla; 2015.

Child and Family Agency (Tusla). *HR Strategy Business Plan 2016*. Dublin: Tusla; 2016.

Child and Family Agency (Tusla). *Information Governance — Validation and Quality Assurance of Data Returns*. Dublin: Tusla; 2015.

* All online references were accessed at the time of preparing this investigation report. Please note that web addresses can change over time.

Child and Family Agency (Tusla). *Integrated Performance and Activity Report Quarter 3 2016*. Dublin: Tusla; 2016. Available online from: http://www.tusla.ie/uploads/content/Q3_2016_Integrated_Performance_and_Activity_Report_Final.pdf.

Child and Family Agency (Tusla). *Interim Guide for the Development of Child Protection and Welfare Policy Procedures and Practices*. Dublin: Tusla; 2015. Available online from: http://www.tusla.ie/uploads/content/Tusla_Interim_Guide_for_the_Development_of_Child_Protection_and_Welfare_Policy_16-04-15nt_(2).pdf.

Child and Family Agency (Tusla). Monthly Performance and Activity Dashboard December 2016. Dublin: Tusla. 2016. Available online from: https://www.tusla.ie/uploads/content/Monthly_Performance__Activity_Dashboard_Dec_2016_Final_V2.pdf.

Child and Family Agency (Tusla). *National Audit of the Standard Business Processes for Child Protection and Welfare Social Work Services: Intake and Initial Assessment*. Dublin: Tusla; 2015.

Child and Family Agency (Tusla). National Performance Activity Dashboard December 2017. Dublin: Tusla; 2017. Available online from: http://www.tusla.ie/uploads/content/National_Performance__Activity_Dashboard_Dec_2017_Final.pdf.

Child and Family Agency (Tusla). *National Strategy for Continuing Professional Development*. Dublin: Tusla; 2016. Available online from: http://www.tusla.ie/uploads/content/3529_Tulsa_NSCPD_lr.pdf.

Child and Family Agency (Tusla). Oct–Dec CPNS Report. Dublin: Tusla; 2015.

Child and Family Agency (Tusla). Overview of Performance From HIQA's 2014 Inspection Reports: Tusla — Child Protection And Welfare Services. Dublin: Tusla; 2014.

Child and Family Agency (Tusla). Policy and Procedure for the Escalations and Notification of Reportable Events (including Child Deaths, Serious Incidents and Need to Know Events). Dublin: Tusla; 2016.

Child and Family Agency (Tusla). Policy and Procedures for Responding to Allegations of Child Abuse and Neglect. Dublin: Tusla; 2014.

Child and Family Agency (Tusla). Progress Report on Service Improvement Plan (SIP) — South. Dublin: Tusla; 2018.

Child and Family Agency (Tusla). Protected Disclosures Policy and Procedure. Dublin: Tusla; 2016. Available online from: http://www.tusla.ie/uploads/content/Tusla_Protective_Disclosure_Policy.pdf.

Child and Family Agency (Tusla). Quality Assurance Directorate Midlands Review of Closed Cases Summary Report. Undated. Dublin: Tusla.

Child and Family Agency (Tusla). Quality, Risk and Service Improvement Team and Committee Structure. Dublin: Tusla; 2015.

Child and Family Agency (Tusla). *Report of the 2015 National Review of Cases Awaiting Allocation*. Dublin: Tusla; 2015.

Child and Family Agency (Tusla). *Report of the National Assurance Review of Retrospective Abuse Cases Awaiting Allocation*. Dublin: Tusla; 2017.

Child and Family Agency (Tusla). *Review of the Caseload Management Tool for Social Workers National Survey Area Managers and Principal Social Workers.* Dublin: Tusla; 2016.

Child and Family Agency (Tusla). Social Work Assessment of Child Protection and Welfare Concerns Information for Parents. Undated. Dublin: Tusla.

Child and Family Agency (Tusla). Standard Business Process Amendments to Intake Record and Initial Assessment.*

Child and Family Agency (Tusla). Standardised Operation Procedures Risk Systems Administration. Dublin: Tusla; 2016.

Child and Family Agency (Tusla). "Survival to Sustainability" Business Case for Investment in Children. Dublin: Tusla; 2015.

Child and Family Agency (Tusla). *Tusla Child Protection and Welfare Strategy 2017-2022*. Dublin: Tusla; 2017. Available online from: http://www.tusla.ie/uploads/content/Tusla_Child_Protection_and_Welfare_Strategy.pdf.

Child and Family Agency (Tusla). Tusla Corporate Risk Register February 2016. Dublin: Tusla; 2016.

Child and Family Agency (Tusla). Tusla Incident Management Policy – version 12. Dublin: Tusla; 2015.

Child and Family Agency (Tusla). Tusla Incident Management Policy and Procedure. Dublin: Tusla; 2016. Available online from: http://www.tusla.ie/uploads/content/QA_Incident_Management_Policy.pdf.

Child and Family Agency (Tusla). Tusla procedure for developing policies, procedures and guidelines. Dublin: Tusla; 2015.

Child and Family Agency (Tusla). Tusla Senior Management Team Structure. Dubin: Tusla; 2015.

* Received from Tusla at quarterly HIQA/Tusla review meeting in December 2017.

Child and Family Agency (Tusla). Tusla's Child Protection Processes and systems are responding to children at risk in a timely manner. Dublin: Tusla; 2015.

Child and Family Agency (Tusla). *Who are the children on the Child Protection Notification System? Developing a profile of children who are listed as active on the CPNS to better inform the delivery and development of child protection*. Dublin: Tusla. 2015.

Child and Family Agency (Tusla). Workforce Learning and Development Work Plan 2016. Dublin: Tusla; 2016.

Other resources

An Garda Síochána. *Garda Síochána Policy on the Investigation of Sexual Crime Crimes Against Children and Child Welfare 2nd Edition.* Dublin: An Garda Síochána; 2013. Available online from: https://www.garda.ie/en/About-Us/Publications/Policy-Documents/Policy-on-the-investigation-of-sexual-crime-crimes-against-children-and-child-welfare-.pdf.

Bacik I, Maunsell C and Gogan S. *The Legal Process and Victims of Rape*. Dublin: The Dublin Rape Crisis Centre and The School of Law, Trinity College Dublin; 1998. Available online from: http://www.drcc.ie/wp-content/uploads/2011/03/rapevic.pdf.

Beckett, Holmes, Walker. *Child sexual exploitation.* Definition and Guide for Professionals. Bedfordshire: Research in Practice; 2017.

Calder M, Hampson A, Skinner J. *Assessing risk in adult males who sexually abuse children. A practioner's guide*. Lyme Regis: Russell House Publishing; 1999.

Calder M. *Sexual Abuse Assessments: Using and Developing Frameworks for Practice.* Lyme Regis: Russell House Publishing; 2009.

Child and Family Agency Act 2013. Dublin: The Stationery Office; 2013. Available online from: http://www.irishstatutebook.ie/eli/2013/act/40/enacted/en/pdf.

Child Care Act, 1991. Dublin: The Stationery Office; 1991. Available online from: http://www.irishstatutebook.ie/eli/1991/act/17/enacted/en/html.

Childrens First Act 2015. Dublin: The Stationery Office; 2015. Available online from: http://www.irishstatutebook.ie/eli/2015/act/36/enacted/en/pdf.

Department of Children and Youth Affairs. *Better Outcomes Brighter Futures: The national policy framework for children & young people 2014-2020: Annual Report for the second year of implementation April 2015-2016*. Dublin: Department of Children and Youth Affairs; 2015. Available online from: https://www.dcya.gov.ie/documents/publications/20160804BOBFAnnRep2ndYearImpApr2015to2016.pdf.

Department of Health and Children. *The Ferns Report October 2005*. Dublin: The Stationery Office; 2005. Available online from: http://www.lenus.ie/hse/bitstream/10147/560434/2/thefernsreportoctober2005.pdf.

Department of Health. *Commission of investigation Terms of reference (relative to a disability service in the South East and related matters).* Dublin: Department of Health; 2017. Available online from: https://health.gov.ie/wp-content/uploads/2017/03/Commission-of-Investigation-Terms-of-Reference-FINAL.pdf.

Department of Justice and Equality. *Commission of Investigation (Certain Matters relative to the Cavan/Monaghan Division of the Garda Síochána)*. Final Report. Dublin: Department of Justice and Equality; 2016. Available online from: http://www.justice.ie/en/JELR/Commission_of_Investigation_Certain_Matters_relative_to_the_Cavan_Monaghan_Division_of_the_Garda_Síochána_Final_Report.pdf/Files/Commission_of_Investigation_Certain_Matters_relative_to_the_Cavan_Monaghan_Division_of_the_Garda_Síochána_Final_Report.pdf.

Department of Justice and Equality. First Interim Report 17052017 Disclosures Tribunal. Dublin: Department of Justice and Equality; 2017. Available online from: http://disclosuretribunal.ie/en/DIS/Pages/Interim_Report_2017.

Department of Justice and Equality. Tribunal of Inquiry into protected disclosures made under the Protected Disclosures Act 2014 and certain other matters. Dublin: Department of Justice and Equality; 2017. Available online from: http://www.disclosurestribunal.ie/.

Ferguson H. *How Children Become Invisible in Child Protection Work: Findings from Research into Day-to-Day Social Work Practice.* BASW. 2017; 47(4). Available online from: https://academic.oup.com/bjsw/search-results?page=1&qb={"Keywords1":%22Child%20protection%22}&SearchSourceType=1.

Government Agency for Child Protection. The Children's House in Iceland – "Barnahus". Reykjavík: Government Agency for Child Protection; 2015. Available online from: http://www.bvs.is/english/.

Health Information and Quality Authority. *Catalogue of national health and social care data collections.* Dublin: Health Information and Quality Authority; 2017. Available online from: https://www.hiqa.ie/sites/default/files/2017-10/Catalogue-national-health-social-care-data-collections.pdf.

Health Information and Quality Authority. National Incident Management System (NIMS). In: *Catalogue of national health and social care data collections.* Dublin: Health Information and Quality Authority; 2014. Available online from: https://www.hiqa.ie/areas-we-work/health-information/data-collections/national-incident-management-system-nims.

Health Service Executive. *Health Service Executive Standards and Recommended Practices for Healthcare Records Management*. Dublin: Health Service Executive; 2014. Available online from: https://www.hse.ie/eng/about/who/qid/quality-and-patient-safety-documents/v3.pdf.

Health Service Executive. *National Hospitals Office Code of Practice for Healthcare Records Management*. Dublin: Health Service Executive; 2007. Available online from: https://www.hse.ie/eng/about/who/qid/quality-and-patient-safety-documents/code.pdf.

Health Service Executive. Staff Guide to Data Protection and Freedom Of Information. Dublin: HSE; 2004. Available online from: https://www.hse.ie/eng/services/list/3/acutehospitals/hospitals/ulh/staff/careertrain/consumeraffairs/foidpaaguide.pdf.

Howe D. *Child Abuse and Neglect. Attachment, Development and Intervention.* Basingstoke: Palgrave MacMillan; 2005.

McGee H, Garavan R, de Barra J and Conroy R. *The SAVI Report — Sexual Abuse and Violence in Ireland. A national study of Irish experiences, beliefs and attitudes concerning sexual violence.* Dublin: Liffey Press; 2003. Available online from: http://www.drcc.ie/savi-report/.

Mooney J. Adult disclosures of childhood sexual abuse and section 3 of the child care act 1991: past offences current risk. *Child Care in Practice*; 25 July 2017. Available online from: http://www.tandfonline.com/doi/full/10.1080/13575279.2017.1347145.

Mooney J. Adult Disclosures of Childhood Sexual Abuse to Child Protection Services: Current Issues in Social Work Practice. *Irish Social Worker*. Spring Summer 2014. Available online from: http://www.lenus.ie/hse/bitstream/10147/550471/1/MooneyJ2014IASWArticleSpringSummerpp913.pdf.

Munro E. Effective Child Protection. London: Sage; 2002.

Munro E, Stone J. *The impact of more flexible assessment practices in response to the Munro Review of Child Protection. A rapid response follow-up.* London: Childhood Wellbeing Research Centre (CWRC). 2014. Available online from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/345476/DFE-RR376_-_The_effect_of_flexible_assessment_practices_follow_up.pdf.

National Treasury Management Agency (Amendment) Act, 2000. Dublin: The Stationery Office; 2000. Available online from: http://www.irishstatutebook.ie/eli/2000/act/39/enacted/en/pdf.

The Ombudsman for Children. *A statement of an investigation into the provision of supports and therapeutic services for a child following disclosures of alleged sexual abuse.* Dublin: Ombudsman for Children; 2013. Available online from: https://www.oco.ie/library/statement-investigation-provision-supports-therapeutic-services-child-following-disclosures-alleged-sexual-abuse/.

Office of the Ombudsman. *Putting It Right.* Dublin: Office of the Ombudsman; 2016. Available online from: http://www.ombudsman.ie/en/Publications/Annual-Reports/2016-Annual-Report/.

Ombudsman for Children. Advice of the Ombudsman for Children on the General Scheme of the Criminal Law (Sexual Offences) Bill 2014. Dublin: Ombudsman for Children; 2015. Available online from: https://www.oco.ie/library/advice-general-scheme-criminal-law-sexual-offences-bill-2014/.

Ombudsman for Children. *Annual Report 2016*. Dublin: Ombudsman for Children; 2016. Available online from: https://www.oco.ie/library/annual-report-2016/.

Ombudsman for Children. Ombudsman for Children Investigation Statement. Dublin: Ombudsman for Children; 2013. Available online from: https://www.oco.ie/app/uploads/2013/10/OCOInvestigationHSEprovisionofsupportsforchild.pdf.

Pearce J. *Moving on with Munro: Improving children's services.* (Pages 125–42). Bristol: Policy Press at the University of Bristol; 2014.

Pearce J, Beckett H. Understanding and Responding to Child Sexual Exploitation. London: Routledge Academic; 2018.

Shannon G. *9th Report of the Special Rapporteur on Child Protection.* Dublin: 2016. Available online from: https://www.dcya.gov.ie/documents/publications/201611189thReportoftheSpecialRapporteuronChildProtection.pdf.

Shannon G. *Audit of the exercise by An Garda Síochána of the provisions of Section 12 of Child Care Act 1991.* Dublin: An Garda Síochána; 2017. Available online from: http://www.lenus.ie/hse/bitstream/10147/621405/1/Audit+of+Section+12+Child+Care+Act+1991.pdf.

Shannon G. Joint Committee on Children and Youth Affairs Opening Statement, 21 June 2017. Available online from: https://webarchive.oireachtas.ie/parliament/media/committees/childrenandyouthaffairs/openingstatements/dr-geoffrey-shannon-opening-statement-28june.pdf.

Smith G. Parent, partner, protector: Conflicting role demands for mothers of sexually abuse children. In: Morrison T, Erooga M, Beckett RC (eds). *Sexual Offending against Children: assessment and treatment of male abusers.* London: Routledge; 1994.

Smith G. *The Protectors' Handbook: Reducing the Risk of Child Sexual Abuse and Helping Children Recover*. London: British Assosciation for Adoption and Fostering (BAAF); 2009.

Stalker CA, Mandell D, Frensch KM, Harvey C and Wright M. Child welfare workers who are exhausted yet satisfied with their jobs: how do they do it? Child & Family Social Work. Volume 12, Issue 2 May 2007. Pages 182–91. Available online from: https://onlinelibrary.wiley.com/doi/pdf/10.1111/j.1365-2206.2006.00472.x.

Steen JA. An Exploratory Study of the Relationship Between Child Protection System Stressors and Case Outputs. *Administration in Social Work.* 2010; 35(1): 46-59. Available online from: https://www.tandfonline.com/doi/abs/10.1080/03643107.2011.533620.

The National Board for Safeguarding Children in the Catholic Church in Ireland. *Safeguarding Children Policy and Standards for The Catholic Church in Ireland 2016.* Co Kildare: The National Board for Safeguarding Children in the Catholic Church in Ireland; 2016. Available online from: https://www.safeguarding.ie/images/Pdfs/Standards/Safeguarding%20Children%20Policy.pdf.

Tribunal of Inquiry into protected disclosures made under the Protected Disclosures Act 2014 and certain other matters following Resolutions passed by Dáil Éireann and Seanad Éireann on 16 February 2017. Established by Instrument made by the Minister for Justice and Equality under the Tribunals of Inquiry (Evidence) Act 1921, on 17 February 2017. Sole member: The Hon Mr Justice Peter Charleton, judge of the Supreme Court. Terms of Reference. Available online from: http://www.disclosuretribunal.ie/en/dis/pages/terms_of_reference.

Tribunal of Inquiry into protected disclosures made under the Protected Disclosures Act 2014 and certain other matters following Resolutions passed by Dáil Éireann and Seanad Éireann on 16 February 2017. Established by Instrument made by the Minister for Justice and Equality under the Tribunals of Inquiry (Evidence) Act 1921, on 17 February 2017. Sole member: The Hon Mr Justice Peter Charleton, judge of the Supreme Court. Interpretation of the Terms of Reference of the Tribunal. Available online from: http://www.disclosuretribunal.ie/en/DIS/Pages/Interpretation_of_the_Terms_of_Reference_of_the_Tribunal.

Turnell A, Murphy T. Signs of Safety Comprehensive Briefing Paper 3rd edition. East Perth: Resolutions Conultancy. 2014. Available online from: : https://www.cornwall.gov.uk/media/12225430/Comprehensive-Briefing-Paper-3rd-edition.pdf.

Turney D, Platt D, Selwyn J, Farmer E. Social work assessment of children in need: what do we know? Messages from research. Bristol: University of Bristol. 2011. Available online from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/182302/DFE-RBX-10-08.pdf.

Online resources

http://tusla.ie/

https://health.gov.ie/

https://books.google.com/

https://www.hiqa.ie/

https://www.oco.ie/

http://www.irishstatutebook.ie/

https://www.hse.ie/

Appendices

Appendix 1
Terms of Reference for the investigation as approved by the HIQA Board on 8 March 2017

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Terms of Reference

Section 9 Health Act 2007 (the "Act") Investigation

Investigation into the management of allegations of child sexual abuse (CSA) against adults of concern, by the Child and Family Agency "Tusla", upon the direction of the Minister for Children and Youth Affairs (the "Minister")

1. **Direction of Minister to undertake a Section 9 investigation**

   On 02 March 2017 the Authority was directed by the Minister (pursuant to the Minister's power to do so under Section 9(2) of the Act) to undertake an investigation (the "Investigation") under Section 9(1) of the Act. The Minister believes that the apparent poor handling by Tusla of information provided to it, arising from the Garda Sergeant Maurice McCabe case, indicates a possible "serious risk to the health and welfare" of children. The Investigation required by the Minister is to be "of Tusla's national practices in the handling of referrals of allegations of sexual abuse which involve adults of concern".

2. **Scope of Investigation specified by the Minister**

   In particular the Minister directed the Authority to provide in its investigation an assessment of the handling by Tusla of such referrals, at national and area level, having regard to the following areas:

   - Current risk to children
   - Fair procedure and due process for persons against whom allegations are made
   - Bilateral engagements with An Garda Síochána, including monitoring or co-ordination of efforts
   - An assessment of the number and mix of skilled and experience staff involved and if this is sufficient for the purpose
   - Allegations being managed in a timely manner and an indication of reasons where they were not
   - Management and control of information and data, both received and generated by Tusla.

3. **Exclusions from Scope of the Investigation as directed by the Minister**

   The Minister has specifically directed that the Authority, in its Investigation, should take all necessary steps to avoid the potential for overlap with the Tribunal of Inquiry established to inquire into certain protected disclosures, arising from the protected disclosures made by Garda Sergeant Maurice McCabe (the "Tribunal"). In particular the Minister has directed that any files "relating to allegations of child abuse that come within the terms of reference of the Tribunal and, in particular, files concerning allegations of abuse of children against members of An Garda Síochána, are formally excluded from the Authority's investigations".

The Minister has informed the Authority that the Ombudsman is also currently considering some complaints about retrospective cases involving adults of concern and their handling by Tusla. Tusla has informed the Authority that the Office of the Data Protection Commissioner is conducting an investigation on the overall governance of data protection throughout Tusla.

Utilising the National Standards for the Protection and Welfare of Children, the investigation team will examine the effective management of information and the availability of adequate resources. However, the investigation will not include a comprehensive assessment of the number and mix of skilled and experienced staff involved nor will it include assessment of Tusla's compliance to the Data Protection (Amendment) Act 2003.

4. **Specific Terms of Reference of the Investigation**

In conducting this Investigation, the Authority will investigate and assess against nationally mandated standards and evidence based practice how local, regional and national governance arrangements in Tusla, are supporting the effective management of child-sexual abuse ("CSA") referrals involving adults of concern (including allegations of CSA made by adults in relation to when they were children). This Investigation will be further to, and take account of, the existing information available to the Authority from its existing inquiries as part of its monitoring function under Section 8(1) (c) of the Act in relation to child protection services provided by Tusla.

The Investigation will be carried out on the basis of the following Terms of Reference:

(a) To carry out an Investigation into the safety, quality and standards of the services provided by Tusla in relation to referrals of allegations of child sexual abuse with particular regard to the areas identified by the Minister (and as set out in paragraph 2 above).

(b) In particular to investigate and assess how local, regional and national corporate governance arrangements provided by Tusla are supporting the effective management of CSA referrals involving adults of concern, including allegations of retrospective CSA.

(c) In particular to investigate and assess the efficacy of bilateral interactions between Tusla, An Garda Síochána and all relevant third parties.

(d) The Investigation will specifically include an assessment of the operational arrangements, including the oversight and monitoring processes in place, to ensure the timely screening, assessment, and management of:

A. CSA allegations involving adults of concern; and
B. Allegations of CSA which occurred in the past made by adults in relation to when they were children.

5. **Recommendations and Reporting**

If, in the course of the Investigation, it becomes apparent that there are reasonable grounds to believe that there are further or other serious risks to any children or persons receiving services, the Investigation Team may recommend to the Authority and/or the Minister that these terms be extended to include further investigation or that a new investigation should be undertaken, as appropriate.

The Authority shall, prepare a report of the findings of the Investigation and make national recommendations pertaining to Tusla's management of CSA allegations referred to it, to the extent

that the Authority considers appropriate. The report will be submitted to the Board of the Authority for approval. This report will be published in order to promote safety and quality in the provision of child protection services for the benefit and welfare of the public.

6. This Investigation will be carried out in accordance with Section 9 and all other relevant provisions set out in the Act. The Investigation will be conducted by an Investigation Team appointed and authorised by the Authority in accordance with Part 9 of the Act. The Team will carry out the Investigation and may exercise all of the powers available to it or its personnel under the Act, particularly those powers set out in Part 9 of the Act, including rights of entry, its rights to inspect premises, records and/or documents and its rights to conduct interviews and rights to require explanations in relation to documents, records or other information. In addition, the Authority (with appropriate Ministerial approval and in accordance with the Act, where required) may engage advisors as it considers necessary in the undertaking of this Investigation.

These Terms of Reference were approved by the Board of the Authority on 08 March 2017.

Appendix 2
Request to the Health Information and Quality Authority to carry out an investigation in accordance with Section 9(2) of the Health Act 2007

An Roinn Leanaí
agus Gnóthaí Óige
Department of
Children and Youth Affairs

Oifig an Aire
Office of the
Minister

Mr Brian McEnery,
Chair, Health Information and Quality Authority
Unit 1301, City Gate,
Mahon,
Cork,
T12 Y2XT.

02 March 2017

Dear Brian,

I am writing to you to request the Health Information and Quality Authority (HIQA) to undertake an investigation under section 9 of the Health Act 2007, as amended by the Child and Family Agency Act 2013.

It is of deep concern to me that information reported to Tusla, the Child and Family Agency in confidence, and in relation to Garda Sergeant Maurice McCabe's case, was apparently, so poorly handled. I need to know if there is a more systemic issue that needs to be addressed at a national level as, if so, it is my belief that this constitutes a serious risk to the health and welfare of children. This includes children in respect of whom referrals have been made to Tusla and allegations made to Tusla against adults who may pose a risk to children.

I am therefore requiring HIQA to undertake an immediate investigation, pursuant to section 9 of the Health Act 2007, of Tusla's national practices in the handling of referrals of an allegation of sexual abuse which involves an adult of concern.

Through its intensive inspection process in recent years, HIQA already has a body of evidence regarding Tusla's day to day standards of child protection and corporate governance. I expect that the investigation will draw on this existing work, including management structures, the impact of staff levels, the volume of cases and the processing and oversight of individual cases.

The investigation should focus on the management by Tusla of allegations where these are made about adults of concern, whether this is by children or by adults alleging abuse that occurred when they were a child. The areas that I wish to have addressed in the investigation, and its report, are an assessment of Tusla and its handling at national and area level of:

- Current risk to children
- Fair procedure and due process for persons against whom allegations are made
- Bilateral engagements with An Garda Siochana, including monitoring or co-ordination of efforts

43-49 Bóthar Mespil, Baile Átha Cliath 4, D04 YP52
43-49 Mespil Road, Dublin 4, D04 YP52
Saorphost/Freepost F5055

Fón/Tel (01) 647 3057
R-phost/Email minister@dcya.gov.ie

LoCall 1890 647474
Idirlíon / Web www.dcya.gov.ie

- An assessment of the number and mix of skilled and experience staff involved and if this is sufficient for the purpose
- Allegations being managed in a timely manner and an indication of reasons where they were not
- Management and control of information and data, both received and generated by Tusla.

For your information, the Ombudsman is currently considering some complaints about retrospective cases involving adults of concern and their handling by Tusla. I understand that this report is due to be finalised in the coming weeks. The work of the Ombudsman should not affect the statutory investigation by HIQA but may serve as a useful reference point when considering your report. I am attaching a short briefing note from the Ombudsman for information.

As you are aware, the Tánaiste, following a decision of the Government and the passage of the appropriate resolutions in both Houses of the Oireachtas, has established a Tribunal of Inquiry to inquire into certain protected disclosures made under the Protected Disclosures Act 2014 and other matters. One of those protected disclosures in question was made by Sergeant McCabe. A copy of the terms of reference of the Disclosures Tribunal is attached for information.

I would emphasise that the statutory investigation to be undertaken by HIQA should take all necessary steps to avoid the potential for overlap or interference with the work of the Tribunal of Inquiry. I note, in this regard, your obligation under section 9 of the Health Act 2007 to ensure that an investigation does not interfere, or conflict, with the functions of other statutory bodies. For the avoidance of doubt, I require that the files relating to allegations of child abuse that come within the terms of reference of the Tribunal, and in particular, files concerning allegations of abuse of children against members of An Garda Síochána, are formally excluded from this statutory investigation.

The above matters constitute the broad terms of reference of the investigation which I require to be undertaken and I would be obliged to receive an outline of the approach and methodology as proposed by HIQA in keeping with my request. My officials and Tusla will, of course, co-operate fully with your investigation.

I am assured by your standing as a statutory independent body that we will have a fair and impartial assessment of Tusla's involvement in these matters, and I look forward to hearing from you on how this matter will be progressed expeditiously.

Yours sincerely,

Dr. Katherine Zappone TD
Minister for Children and Youth Affairs

Appendix 3
Members of the External Advisory Group appointed in line with Section 9(1) of the Health Act 2007

Name of External Advisory Group member	Role and experience
Tanya Ward	**Chief Executive, Children's Rights Alliance, Ireland** Tanya Ward is the Chief Executive of the Children's Rights Alliance since 2012. Previously, she was the Deputy Director at the Irish Council for Civil Liberties (ICCL) where she worked for eight years. She has also worked with the: ■ Irish Centre for Migration Studies ■ Irish Refugee Council ■ Curriculum Development Unit City of Dublin Vocational Education Committee ■ City of Dublin Vocational Education Committee. A former lecturer in human rights on the MPhil in Ethnic and Racial Studies, TCD and the Masters in Equality Studies in the UCD School for Social Justice, she is a former board member with Campaign for Children and played a major role in campaigning for the children's referendum which was a passed in 2012. She has served on the boards of the International Federation of Human Rights, Law Centre for Children and Young People and Stand Up for Children. She represented children's interests on the Government Working Group on the Reception Process and Direct Provision. She was appointed to the National Advisory Council for Children and Young People in 2014 and is a Board member of Mental Health Reform. Tanya has graduate and post-graduate degrees from UCC and a LLM in Human Rights from Queen's University Belfast, as well as a Certificate in Managing Community and Voluntary Organisations from the National College of Ireland.

Name of External Advisory Group member	Role and experience
Andrew Lowe FRSA CQSW	**Consultant, Director of Social Work for Scottish Borders Council (retired), Scotland** Andrew originally trained for a career in law, and worked for a firm of solicitors at the High Court in London until he moved to Scotland in 1974 where he began his social work career with Fife County Council as a day-centre officer in learning disability. Andrew qualified at Dundee University in 1979 and worked for Tayside Region. He has worked for Nottinghamshire and Nottingham City in a variety of roles culminating in acting Director of Social Services before being appointed Director of Social Work for Scottish Borders in 2004. ■ In 2006, Andrew was invited by the Scottish Government to chair the Changing Lives Practice Governance change programme, and developed guidance in that area. ■ In May 2011, Andrew was elected as President of the Association of Directors of Social Work. ■ In 2013, he led work on the collaborative paper: "Four Nations United: Critical learning from four different systems for the successful integration of social care and health services" across the four UK nations and Ireland. ■ Andrew retired from Scottish Borders Council in November 2013 and established a consultancy in 2014. ■ In 2016, he conducted an inquiry into the circumstances of the death of a schoolboy, Bailey Gwynne, from stabbing. ■ Andrew has provided expert testimony for the Scottish Social Services Council. ■ He is currently the independent chairperson of child and adult protection for the Orkney Islands.

Name of External Advisory Group member	Role and experience
Paul Morgan	**Director of Children and Young People's Services and Executive Director of Social Work** Paul Morgan was appointed as Director of Children and Young People's Services, The Southern Trust in Northern Ireland in May 2011. Paul has over 30 years' experience in a range of child care services and over 12 years' senior management experience. He qualified in 1979 with a BA Hons Degree in Social Work. He was Acting Director in the Craigavon & Banbridge Community Trust from 2004–2007 and was the Southern Trust's Assistant Director for Safeguarding and Family Support from April 2007–May 2011. Paul is a member of the Regional Safeguarding Board for Northern Ireland (SBNI) and chairs the Southern Outcomes Group, established to take forward integrated planning and service delivery for children and families. He represented the Association of Directors on the Children Order Advisory Committee in Northern Ireland, established to progress work linked to Family Law, Private Law and Court Services. Paul now sits on the Regional Public Protection Arrangements Northern Ireland (PPANI) Strategic Forum. He has significant experience of service reform and represents the Trust on a number of regional forums, including the Regional Children's Services Improvement Board. Paul also chairs the Trust Community Information System Project Board and sits on the Regional Electronic Health Care Record (EHCR) Board, both aimed at introducing new information technology (IT) and software to support more effective and efficient service delivery. Paul is also the Southern Trust representative on the Armagh City, Banbridge and Craigavon Borough Council's Strategic Partnership, for taking forward community planning.

Name of External Advisory Group member	Role and experience
Ian Sutherland	**Director of Children and Adult Services, UK** Ian Sutherland has worked at Medway Council in North Kent for two years where he is Director of Children and Adult Services. He was previously the Director of Children's Services and Social Work at the South Eastern Health and Social Care Trust in Northern Ireland, and was a member of the Safeguarding Board for Northern Ireland. He served for six years as a Trustee on the Social Care Institute for Excellence in London. He qualified as a social worker in Nottingham in 1986 and has worked in a range of social work, managerial and executive roles within England and Northern Ireland since then, both in health and local authority settings.
Freda McKittrick	**Head of Barnardos Guardian ad Litem Service, Barnardos, Ireland** Freda qualified as a social worker in 1985 and since then has over 30 years' experience as a social worker, social work trainer, guardian ad litem and service manager in both the statutory and voluntary sector in Ireland and the UK. Freda has been the manager of the Guardian ad Litem Service within Barnardos since 2002. Between 2009 and 2016 Freda sat as a lay member on tribunals convened under the Mental Health Act. Since 2015, she has been a complaints committee member of CORU, the social care regulator's Preliminary Proceedings Committee to consider complaints against registrants. Freda is currently a member of the Board of the Legal Aid Board. She is a registered social worker and a member of the Irish Association of Social Workers.

Name of External Advisory Group member	Role and experience
Marcella Leonard	**Consultant** Marcella Leonard: BSc (Hons) C.Q.S.W., MSc AASW, PG Dip ATSO, ASW, ASI, PT qualified as a social worker in 1989 and is director of a consultancy firm. Marcella has specialised in assessment and treatment in the fields of sexuality, sexual deviancy and sexual trauma. She has two areas of specific interest: developing the understanding of those working within criminal justice and risk management in using the knowledge of normal sexual development to understand sexual deviancy; and her role as a psychosexual therapist to assist victims of sexual trauma to regain a healthy sexual life without re-experiencing trauma. As director of a consultancy firm, Marcella works in New Zealand, Abu Dhabi, Australia, Gibraltar and Canada as well as throughout the UK and Ireland in delivering specialist training, consultancy and programme development. She completed three years as Co-ordinator of Public Protection Arrangements Northern Ireland (PPANI). Marcella has assisted National Offender Management Service (NOMS) and the College of Policing in their roll out of the Active Risk Management Systems (ARMS) risk-assessment training for public protection policing in England and Wales. She is an external public and child protection consultant with the Royal Gibraltar Police, Prison, Probation and Care Agencies as they further develop their multiagency public protection arrangements. She also provides clinical supervision for senior social work and psychology personnel throughout Ireland in their work with victims and offenders of sexual abuse.

	Marcella is currently the Vice Chairperson of the Northern Ireland Association of Social Workers and Director of the British Association of Social Workers, Chairperson of NI NOTA, (Northern Ireland National Organisation for the Treatment of Abusers), Conference and Training Committee. Marcella has written several book chapters and co-authored articles in professional journals, and she regularly provides expert opinion to media outlets, as well as being an expert advisor to several documentaries for television productions.

Appendix 4
Formal HIQA data and document requests to Tusla

Data from Tusla service area level

Open child sexual abuse referrals against an adult

Total number of child sexual abuse referrals against an adult (excluding those relating to members of An Garda Síochána*) as of 1 May 2017 and the number that:

- were screened in line with Tusla Standard Business Processes
- had a preliminary enquiry completed in line with Tusla Standard Business Processes
- were closed and re-opened following a further child sexual abuse allegation
- were referred to the service by An Garda Síochána
- were notified by the service to An Garda Síochána
- had resulted in immediate action being taken
- required an initial assessment
- had an initial assessment completed in line with Tusla standard business processes
- for which an initial assessment was ongoing
- for which an initial assessment has not yet commenced
- had a further assessment completed in line with Tusla standard business processes
- for which a further assessment was ongoing
- for which a further assessment has not yet commenced.

* See Terms of Reference Appendix 1.

In the 12-month period from 1 May 2016 to 1 May 2017, the number of:

- applications for a supervision order made by the service
- applications for a supervision order made by the service that related to child sexual abuse
- supervision orders obtained by the service in relation to child sexual abuse cases
- applications for care orders made by the service
- applications for care orders made by the service in relation to child sexual abuse cases
- care orders obtained by the service in relation to child sexual abuse referrals.

As of 1 May 2017, the number of children that were the subject of a child sexual abuse referral involving an adult of concern, and the number:

- allocated a social worker
- awaiting allocation of a social worker
- referred for a Garda Síochána specialist interview
- awaiting a Garda Síochána specialist interview
- referred for an internal or an external assessment of sexual abuse
- awaiting an internal or an external assessment of sexual abuse.

Closed child sexual abuse referrals against an adult

Total number of child sexual abuse referrals against an adult that were closed during the 12-month period from 1 May 2016 to 1 May 2017 and the numbers that were closed:

- on completion of a preliminary enquiry
- on completion of initial assessment
- on completion of a further assessment.

Child Protection Notification

As of 1 May, 2017, the number of children that were the subject of a child sexual abuse referral against an adult and the number:

- listed on the Child Protection Notification System
- closed to the Child Protection Notification System in the period 1 May 2016 to 1 May 2017.

Retrospective allegations of child sexual abuse

The number of retrospective allegations of child sexual abuse open to the service (excluding those relating to members of An Garda Síochána)* as of 1 May 2017 and the number:

- that were received by the service in the period 1 May 2016 to 1 May 2017
- that were closed by the service in the period 1 May 2016 to 1 May 2017
- that were open to the service for:
  - up to one year
  - one to two years
  - two to three years
  - over three years
- that had an initial assessment completed in line with Tusla standard business processes
- for which an initial assessment was ongoing
- for which an initial assessment had not yet commenced
- that had a further assessment completed
- for which a further assessment was ongoing
- for which a further assessment was not yet commenced.

* See Terms of Reference Appendix 1.

Adults of concern

The number of adults of concern open to the service (excluding those relating to members of An Garda Síochána)* as of 1 May 2017 and the number that:

- had a completed risk assessment
- for which a risk assessment was ongoing
- for which a risk assessment had not yet commenced.

Protected disclosures/notifications

For the period 1 May 2016 to 1 May 2017, the number of:

- protected disclosures received by the service
- "Need to Know" reports related to child sexual abuse cases against an adult
- "Need to Know" reports related to child sexual abuse retrospective referrals
- "Need to Know" reports related to adults of concern
- notifications made to HIQA related to child sexual abuse cases.

* See Terms of Reference Appendix 1.

Workforce

As of 1 May 2017, the number of approved whole-time equivalent posts and the number of vacant whole-time equivalent posts for each of the following roles:

- principal social worker
- social work team leader
- senior social work practitioner
- social worker
- social care leader
- social care worker.

Workforce training

As of 1 May 2017, the number of staff who had received up-to-date Children First training.

In the 24-month period from 1 January 2015 to 1 January 2017, the number of managers who had:

- received specialist training in the management of child sexual abuse assessments
- received specialist training in the management of risk assessments of adults of concern
- completed Tusla/An Garda Síochána specialist interview training.

In the 24-month period from 1 January 2015 to 1 January 2017, the number of staff members (excluding managers) who had:

- completed specialist training in assessment of child sexual abuse
- completed specialist training in the risk assessments of adults of concern
- completed joint Tusla/An Garda Síochána specialist interview training.

Information management:

In the 24-month period from 1 January 2015 to 1 January 2017, the number of data breaches in the service:

- related to child sexual abuse cases
- related to retrospective allegations of child sexual abuse
- related to adults of concern.

In the 24-month period from 1 January 2015 to 1 January 2017 the number of:

- Freedom of Information requests received by the service that related to child sexual abuse cases and
- the number that were waiting to be processed on 1 May 2017.

Documentation from Tusla, national and regional level

Governance

Governance arrangements for the management of child sexual abuse referrals (to include child sexual abuse allegations against an adult, retrospective child sexual abuse allegations and adults of concern). The following information was requested.

- As of May 2017, an organogram to reflect the corporate governance structure within Tusla, to include clear lines of accountability and reporting arrangements to the board of Tusla.
- List of the subcommittees or working groups of the board of Tusla that relate to the management of child protection referrals — in particular those concerned with allegations of child sexual abuse against an adult or retrospective child sexual abuse allegations and or adults of concern, if applicable.
- Terms of reference for the above subcommittees or working groups of the board of Tusla (to include membership).
- Agendas and minutes of the above subcommittees and or working groups of the board of Tusla for the six-month period up to 1 May 2017.
- As of May 2017, an organogram to illustrate the interface between the corporate, regional and local governance structures in relation to the management of child protection referrals — in particular, those concerned with allegations of child sexual abuse against an adult or retrospective child sexual abuse allegations and or adults of concern, if applicable.

- List of committees and designated groups in place within Tusla at regional and national level that relate to the management of child protection referrals — in particular, those concerned with allegations of child sexual abuse against an adult or retrospective child sexual abuse allegations and or adults of concern, if applicable.
- Terms of reference for the above committees or designated groups (to include membership).
- Agendas and minutes of the above committees or designated groups for the six-month period up to 1 May 2017.
- Agendas and minutes of meetings of the Senior Management Team of Tusla for the six-month period up to 1 May 2017.
- Tusla National Risk Register as of January 2018.
- Revised Policies and Procedures for Responding to Allegations of Child Abuse and Neglect.
- Strategic Development Initiative document.
- An update on the action plan for the implementation of the recommendations of the national Quality Assurance Review of Child Protection and Welfare Cases and the Child Protection and Notification System 2016, to include timelines for completion.
- Service improvement plans 2017–2018 for each service area.
- Systems analysis completed in relation to failures of internal escalation processes.
- Minutes of bi-monthly meetings between the Chief Operations Officer (COO) and operational managers for the time period from 1 January 2017 to 31 December 2017.
- Report of the review of service area risk registers completed in 2017.
- Memorandum of understanding between Tusla and An Garda Síochána or other current memoranda of understanding between Tusla and other key external agencies, such as sexual assault treatment units and Validation Unit.
- Report of the audit conducted by the Data Protection Commissioner (draft or otherwise).

Risk management

- As of 1 May 2017, please provide an organogram to reflect the accountability and reporting arrangements in place for the escalation of risks that relate to the management of child protection referrals — in particular those concerned with allegations of child sexual abuse against an adult or retrospective child sexual abuse allegations and/or adults of concern, where applicable.
- List of risk committees in place at national and regional level (to include membership).
- Terms of reference, agendas and minutes of the above meetings of risk committees for the six-month period up to 1 May 2017.
- Corporate risk registers as of 1 May 2017.
- Regional risk registers as of 1 May 2017.
- Tusla internal strategic review of cases identified and escalated by HIQA during this investigation — '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'.

Service level arrangements

- List of existing service level agreements between Tusla and third-party providers of services related to allegations of child sexual abuse against an adult, retrospective child sexual abuse allegations and adults of concern.

Audit

- Reports of quality improvement audits conducted by Tusla in relation to the management of child protection referrals — in particular those concerned with allegations of child sexual abuse against an adult or retrospective child sexual abuse allegations and or adults of concern, if applicable, at national and regional level for the 12-month period up to 1 May 2017.
- Reports of audits of record-keeping (case files) conducted by Tusla at national and regional level for the 12-month period to 1 May 2017.
- Implementation and or action plans developed in response to the above audits to include names, accountability and defined timelines for implementation.

Analysis and or review reports

- Reports of any national or regional needs analysis reviews conducted to inform the resourcing of Tusla child protection services in relation to the management of child protection referrals — in particular, those concerned with allegations of child sexual abuse against an adult or retrospective child sexual abuse allegations and or adults of concern, if applicable, for the 12-month period up to 1 May 2017.
- Reports of any reviews of the governance arrangements in place at national, regional and service-area level conducted and or commissioned by Tusla in the 24-month period up to 1 May 2017.

Reviews, action plans and strategies

- Tusla Workforce Plan 2017 (draft or otherwise).
- Tusla Annual Report 2016 (draft or otherwise).
- Reports (draft or otherwise) of any internal review following the publication of the report of the *Audit of the exercise by An Garda Síochána of the provisions of Section 12 of the Child Care Act 1991* prepared by Geoffrey Shannon (2017).
- Reports (draft or otherwise) of any internal review following the publication of *Taking Stock – An Investigation by the Ombudsman into complaint handling and issues identified in complaints made about the Child and Family Agency (Tusla),* published by the Office of the Ombudsman in 2017.
- Reports (draft or otherwise) of any internal reviews, investigations and or audits conducted by or on behalf of Tusla, in relation to the effectiveness of information governance arrangements in Tusla.
- Reports (draft or otherwise) of any internal reviews, investigations, and or learning exercises conducted by or on behalf of Tusla, relevant to the HIQA Investigation into the management of allegations of sexual abuse against adults of concern, by the Child and Family Agency 'Tusla' upon the direction of the Minister for Children and Youth Affairs.
- Action and or implementation plan development in relation to:
  - the Report of the 'National Quality Assurance Review of Child Protection and Welfare Cases' the report of the 'Child Protection Notification System Quality Assurance Report, Final 2016'.
  - the 'National Audit of Standard Business Processes for Child Protection and Welfare Social intake and initial assessment, Final Report 2015'.
- Tusla HR Strategy 2017–2019.

- Copy of the National Assurance Review of Retrospective cases of abuse.
- Copy of the Tusla internal strategic review of cases identified and escalated by HIQA during this investigation — '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'.
- New or revised standard business process.
- Implementation plan for the approach to 'Signs of Safety'.
- Briefing document on Signs of Safety provided to the Department of Children and Youth Affairs.

Retrospective cases

- Revised procedure for screening and preliminary enquiries of retrospective abuse.
- Retrospective Abuse Form Template.
- Service improvement plan developed in response to the National Assurance Review for Retrospective Cases.
- Update on the Action Plan for the implementation of the recommendations of the National Assurance Review of Retrospective Abuse Cases Awaiting Allocation, 2017, to include timelines of completion.
- Final report of the staff cultural survey conducted in line with the Competing Values Framework.
- Tusla's Quarterly Performance and Activity Data 2017 Quarter 4, 2017 (year to date).
- Tusla's Quarterly Service Performance and Activity Report Quarter 4, 2017.

Service-area level documentation request from Tusla

Governance:

- Organograms as of 1 May 2017 to:
  - reflect clear lines of accountability and reporting for the service area
  - illustrate the operational arrangements in place within the service area to reflect clear lines of accountability and reporting in relation to the management of child protection referrals — in particular those concerned with allegations of child sexual abuse against an adult or retrospective child sexual abuse allegations and or adults of concern, if applicable
  - illustrate the interface between the operational and regional arrangements in place to reflect clear lines of accountability and reporting for the management of child protection referrals — in particular those concerned with allegations of child sexual abuse against an adult or retrospective child sexual abuse allegations and or adults of concern, if applicable.
- List of teams, committees and or regular groups in place within the service area that relate to the management of child protection referrals — in particular those concerned with allegations of child sexual abuse against an adult or retrospective child sexual abuse allegations and or adults of concern, if applicable.
- Terms of Reference of the Service Area Management Team (to include membership) for the six-month period up to 1 May 2017.

Risk management

- As of May 2017, organogram to reflect accountability and reporting arrangements in place at service-area level for the escalation of risks that relate to the management of child protection referrals — in particular those concerned with allegations of child sexual abuse against an adult or retrospective child sexual abuse allegations and or adults of concern
- List of risk committees in place at service-area level.
- Terms of reference for the risk committees in place within the service area (to include membership).
- Service area risk register as of 1 May 2017.

Audit

- Reports of any quality improvements audits conducted by or on behalf of Tusla in relation to the management of child protection referrals — in particular those concerned with allegations of child sexual abuse against an adult or retrospective child sexual abuse allegations and or adults of concern, at service-area level for the 12-month period up to 1 May 2017.
- Copies of implementation and or action plans developed in response to the above audits, to include named accountability and defined timelines for implementation.
- Reports of any audits or record-keeping (case files) conducted by Tusla at service area level for the 12-month period to 1 May 2017.
- Implementation and or action plans developed in response to the above audits, to include named accountability and defined timelines for implementation.

Service-area planning

- Service-area service plan for 2017.
- Service-area workforce development plan.

Complaints

- Report of complaints made to the service area in relation to child protection referrals — in particular those concerned with allegations of child sexual abuse against an adult or retrospective child sexual abuse allegations and or adults of concern.

Appendix 5
Correspondence from HIQA to the Minister for Children and Youth Affairs

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Dr Katherine Zappone TD
Minister for Children and Youth Affairs
Department of Children and Youth Affairs
43-49 Mespil Road
Dublin 4
Email: [redacted]
Sent via email only

Ref: RD8/193

27 October 2017

Dear Minister,

Investigation into the management of allegations of child sexual abuse (CSA) against adults of concern by the Child and Family Agency (Tusla), upon the direction of the Minister for Children and Youth Affairs (the investigation)

On 02 March 2017, the Authority was directed to undertake an investigation under Section 9(1) of the Health Act 2007 based on your belief that the apparent poor handling by Tusla of information provided to it, arising from the Garda Sergeant Maurice McCabe case, indicated a possible serious risk to the health and welfare of children. The HIQA Board considered these concerns with regard to the potential serious risk to the health and welfare of children and agreed the investigation Terms of Reference on 8 March, 2017.

At this juncture of the investigation, having completed fieldwork investigations at six Tusla sites, reviewed and evaluated relevant documentation and data; conducted case record reviews; and carried out individual interviews and group meetings at local and regional level, I am bringing to your attention the findings to date which concur with your belief that there is a risk to the health and welfare of children.

☑ **Head Office:**
Unit 1301, City Gate, Mahon, Cork, Ireland.
Tel: +353 (0) 21 240 9300
Fax: +353 (0) 21 240 9600

☐ Dublin Regional Office:
George's Court, George's Lane, Dublin 7, Ireland
Tel: +353 (0) 1 814 7400
Fax: +353 (0) 1 814 7499

e-mail: info@hiqa.ie **www.hiqa.ie**

Furthermore, it is of significant concern that the operational risks uncovered have been identified through the limited lens of Child Sexual Abuse referrals which utilises the same operational process within the wider context of Child Protection and Welfare.

The investigation has uncovered and escalated to Tusla a series of specific issues related to individual cases, which presented potential and /or actual risk to the safety of children. For each potential risk identified, Tusla was requested to confirm in writing the protective measures that were being taken in response - a reply has been received in all cases.

Analysis of the risks escalated to Tusla raise three specific concerns which include:

1. Screening and Preliminary Enquiries

Poor quality screening and preliminary enquiry of children's referrals was found for example in 64%; 48% and 68% of cases reviewed for screening during fieldwork in three service areas. These issues specifically relate to delays in carrying out initial screening, a lack of internal checks to ascertain if the child is already known to Tusla, and incomplete records, despite being already signed-off by social work team leaders. Poor practice at this stage of the referral process meant that potential and or actual risks related to children may have gone unidentified and unmanaged.

2. Safety Planning

The variation in quality, recording and monitoring of safety planning and/or the absence of safety plans placed some children at potential and /or actual risk. Cases with inadequate safety planning were uncovered and escalated in all service areas investigated. Of those escalated cases, 49% related to children's referrals. The remaining 51% per cent related to children identified during reviews of adult records, the majority of which were uncovered by the investigation team in retrospective case records, none of which had safety plans in place. Additionally, the investigation team found that in some cases, safety plans were inadequate and were not always monitored, reviewed and updated on receipt of new and pertinent information.

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3. Retrospective referrals of CSA

The absence of a defined process for screening retrospective cases resulted in a variation in operational practice across service areas. This variance coupled with the lack of a timely commencement and completion of assessment of Adult Complainants and Persons Suspected of Alleged Abuse, resulted in potential or actual risk to some children remaining unidentified or unmanaged. Furthermore, the investigation team uncovered delays of up to 3 years in some cases in the completion of assessments.

The investigation team will now complete a series of national interviews and the seventh and final fieldwork visit, which we deferred at the request of Tusla, in order to facilitate their preparation for, and attendance at, the Charleton Tribunal. The investigation team will now communicate these interim findings to your officials in the Department of Children and Youth affairs, The Chairperson of the Board of Tusla and the CEO of Tusla.

Yours sincerely,

BRIAN MCENERY
Chairperson
Health Information and Quality Authority

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Appendix 6

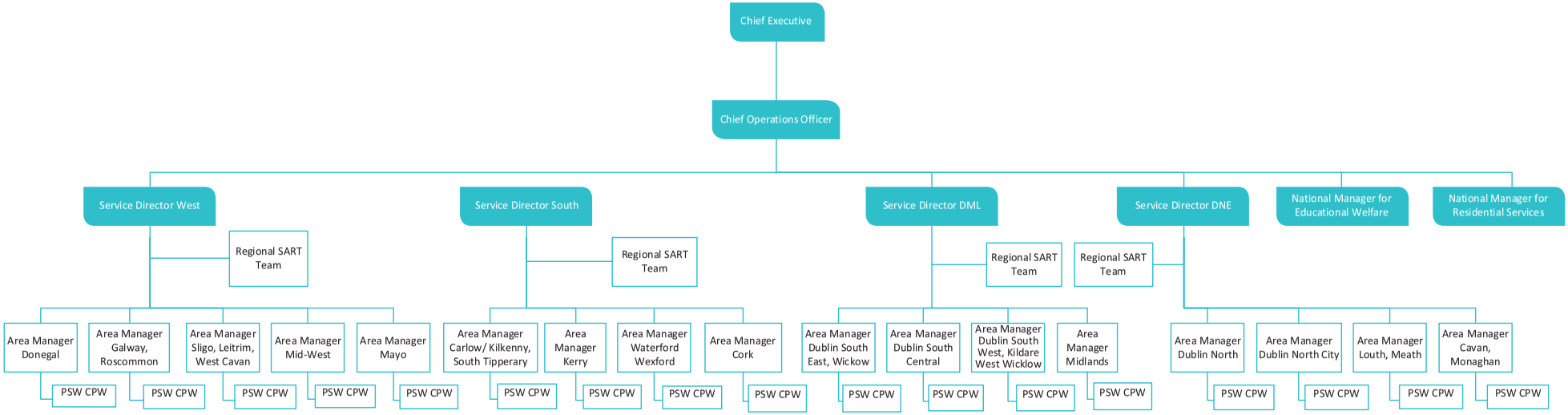
Schedule of inspections by HIQA against the *National Standards for Child Protection and Welfare,* 2014 to 2016 and published inspection reports*

Inspection period	HIQA report on child protection and welfare (CPW) services	Service provider
2014	Donegal	Child and Family Agency (Tusla)
	Kerry	Tusla
	Dublin North City	Tusla
	Cork	Tusla
	Mayo	Tusla
	Asylum-seeking children living in direct provision accommodation: Louth/Meath; Midlands; Sligo/ Leitrim/West Cavan and Dublin North City (in addition to the above listed CPW report)**	Tusla
2015	North Dublin	Tusla
	Louth	Tusla
	Dublin South East/Wicklow	Tusla
2016	Sligo/Leitrim/West Cavan	Tusla
	Midlands	Tusla
	Mid West	Tusla

* The inspection of the Midland's child protection and welfare services was unpublished as it primarily related to a progress report on the action plan of the previous inspection.

** Tusla has a statutory responsibility under the Child Care Act, 1991 to identify children at risk, provide care and family support services and promote the safety and welfare of children not receiving adequate care and protection.

Appendix 7
Tusla organisational chart received as part of this investigation*



SART: Sexual Abuse Regional Team

PSW CPW: Principal Social Worker Child Protection and Welfare

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* Tusla organisational chart based on graphic provided to HIQA as part of this investigation. While four regional SART teams are illustrated, only one such team was in operation at the time of this investigation: SART in Tusla's Dublin North East Region.

Appendix 8

Tusla service areas and An Garda Síochána group meetings with members of the HIQA Investigation Team between September 2017 and January 2018

Location of group meetings	Tusla regional operational area	Date of group meeting
Store Street Garda Station Dublin 1	Dublin North East	18 September 2017
Mullingar Garda Station Co Westmeath	Dublin Mid Leinster	18 September 2017
An Garda Síochána Divisional Headquarters Ballybricken Co Waterford	South	20 September 2017
Drogheda Garda Station Co Louth	Dublin North East	21 September 2017
Monaghan Garda Station Co Monaghan	Dublin North East	10 November 2017
Kilkenny Garda Station Dominic Street Kilkenny City	South	30 November 2017
An Garda Síochána Divisional Office Convent Road Co Roscommon	West	9 January 2018

Appendix 9

Schedule of external agencies represented at group meetings with members of the HIQA Investigation Team between June 2017 and January 2018

Tusla service areas and Sexual Abuse Regional Team	Agency represented	Date of group meeting
Waterford, Wexford	Probation Service	13 June 2017
	Waterford Rape Crisis Centre	
	St Brigid's Family Support Centre	
	Comhar National Counselling Services	
	Squashy Couch	
	HSE Wexford Psychology Services	
	It's Good 2 Talk Counselling Services	
The Midlands	Sexual Assault Treatment Unit (SATU)	13 July 2017
	HSE Community Alcohol and Drugs Service (CADS)	
Carlow Kilkenny South Tipperary	Paediatrics, St Luke's Hospital, Kilkenny	02 Aug 2017
	Kilkenny Rape Crisis Centre	
	Carlow and South Leinster Rape Crisis Centre	
	Tipperary Rape Crisis Centre	

Tusla service areas and Sexual Abuse Regional Team	Agency represented	Date of group meeting
Louth Meath	CARI	07 Sept 2017
	One in Four	
	RIAN Counselling Service	
	HSE Psychology, Co Louth	
	HSE Psychology, Co Meath	
	St Clare's Unit, Temple Street, Children's University Hospital	
Galway Roscommon	Child and Adolescent Sexual Assault Treatment Service (CASATS)	26 and 27 Sept 2017
	HSE Child and Adolescent Mental Health Service (CAMHS)	
	National Learning Network	
	Vita House	
	Sligo Rape Crisis and Sexual Abuse Counselling Centre	
	Psychology Department, Primary Care Centre, Roscommon	
	ATHRU HSE	
	Galway Rape Crisis Centre	
	HSE Adult Mental Health Services Galway Roscommon	
Cavan Monaghan	RIAN Counselling Service	16 Jan 2018
	CARI	

Appendix 10

HIQA's review of Tusla's governance arrangements to ensure an effective, timely and safe service, provided to Tusla in February 2017 and incorporating later amendments following due process (fair procedure) feedback from Tusla

A review of the child protection and welfare service provided by the Child and Family Agency (Tusla) and the governance arrangements in place to ensure an effective, timely and safe service

About the Health Information and Quality Authority

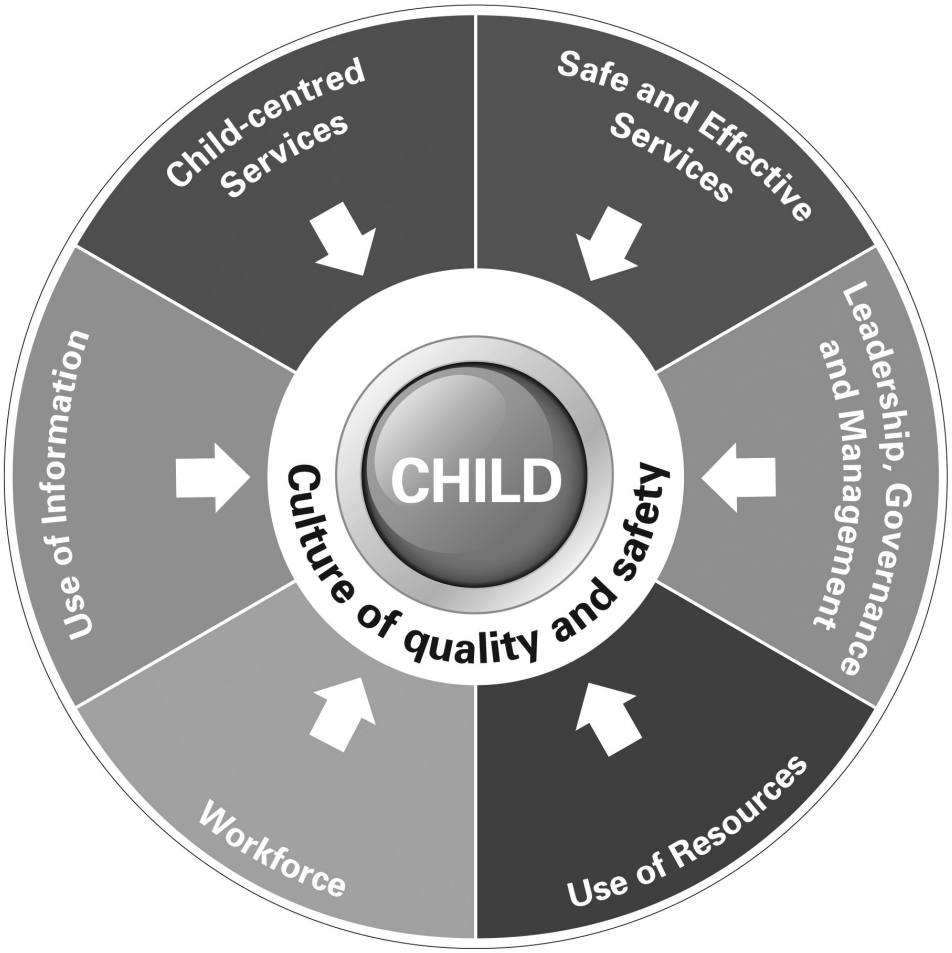
The Health Information and Quality Authority (HIQA) is an independent authority established to drive high-quality and safe care for people using our health and social care services in Ireland. HIQA's role is to develop standards, inspect and review health and social care services and support informed decisions on how services are delivered.

HIQA aims to safeguard people and improve the safety and quality of health and social care services across its full range of functions.

HIQA's mandate to date extends across a specified range of public, private and voluntary sector services. Reporting to the Minister for Health and the Minister for Children and Youth Affairs, HIQA has statutory responsibility for:

- **Setting Standards for Health and Social Services —** Developing person-centred standards, based on evidence and best international practice, for health and social care services in Ireland.
- **Regulation —** Registering and inspecting designated centres.
- **Monitoring Children's Services —** Monitoring and inspecting children's social services.
- **Monitoring Healthcare Safety and Quality —** Monitoring the safety and quality of health services and investigating as necessary serious concerns about the health and welfare of people who use these services.
- **Health Technology Assessment —** Providing advice that enables the best outcome for people who use our health service and the best use of resources by evaluating the clinical effectiveness and cost-effectiveness of drugs, equipment, diagnostic techniques and health promotion and protection activities.
- **Health Information —** Advising on the efficient and secure collection and sharing of health information, setting standards, evaluating information resources and publishing information about the delivery and performance of Ireland's health and social care services.

Themes from the National Standards for the Protection and Welfare of Children



Glossary of terms and abbreviations

An Garda Síochána	Ireland's National Police Service
CEO	Chief Executive Officer
Children and Young People's Services Committee	A committee of senior managers of the main statutory, community and voluntary providers of services to children
Children First (2011)	*Children First: National Guidance for the Protection and Welfare of Children* (2011)
CPNS	Child Protection Notification System
DCYA	Department of Children and Youth Affairs
Duty/Intake	Process for managing incoming referrals to Tusla
Guardian ad litem	Court appointed advocate
HIQA	Health Information and Quality Authority
HSE	Health Service Executive
ICT	Information communication technology
Meitheal	A Tusla service model which enables children and families to receive appropriate support
National Recruitment Service	The service responsible for recruiting staff for the Health Service Executive
National Standards	*National Standards for the Welfare and Protection of Children* (2012)
NCCIS	National Child Care Information System
Need to know	Tusla system of informing senior managers about a particular issue and or case of note
RAM	Resource allocation model
SBPs	Standard business processes are a set of key tasks that need to be completed by staff of Tusla in order to achieve Tusla's goals
Senior practitioner	Senior social worker
The board	Child and Family Agency Board of Management
The Minister	The Minister for Children and Youth Affairs
Tusla	Child and Family Agency (Tusla)
Unallocated cases	Cases awaiting allocation to a named social worker

Chapter 1
Introduction

Introduction

This report presents the findings of a review by the Health Information and Quality Authority (HIQA) of the governance arrangements in place within the Child and Family Agency's (Tusla's) child protection and welfare services to ensure a safe, timely and effective service. This review was undertaken by HIQA between January and December 2016. It was carried out in accordance with section 8(1)(c) and other relevant provisions set out in the Health Act 2007.

The Review Team members included HIQA inspectors and two external representatives with expertise in child protection and welfare, Mr Andrew Lowe, FRSA, CQSW, and Ms Cathleen Callanan, B.Soc.Sc, CQSW. Dip. AFT. MA. PhD, who were engaged to carry out aspects of the review. All were authorised to conduct the review in line with section 70(1)(a) of the Health Act 2007.

In undertaking this review, HIQA used the *National Standards for the Protection and Welfare of Children* (2012) (referred to in this report as the National Standards) to identify specific features that should always be in place in safe, high-quality child protection and welfare services. Further information on the methodology used for this review is contained in Appendix A.

This is the first time that the governance arrangements within the Child and Family Agency's (Tusla) child protection and welfare services have been the subject of a national review by HIQA.

Child protection and welfare legal and policy framework

The Child and Family Agency (Tusla) was established on 1 January 2014 following commencement of the Child and Family Agency Act (2013). This legislation provided for the delivery of child and family services by one agency for the first time in Ireland. Prior to this, child and family services were the responsibility of the Health Service Executive (HSE) and in this context child and family services competed for funding and resources against the wider healthcare sector.

The Child Care Act 1991 (as amended) is the primary legislation governing child care in Ireland. This legislation imposes a duty on Tusla to identify and promote the welfare of children who are not receiving adequate care and protection. In order to meet its statutory obligations, Tusla has developed and increased its range of services and interventions to support families to adequately care for their children. However, there will always be some children who will need to be protected from the risk of serious harm.

The National Children's Strategy (2000–2010), *Our Children – Their Lives*, identified a series of objectives to guide children's policy over the 10-year period in order to listen, understand and act in the best interests of children. This was the first strategic document by a government which stated that children's lives required a coherent and common approach across policy domains.

The current National Policy Framework, *Better Outcomes, Brighter Futures: The National Policy Framework for Children and Young People (2014–2020)*, builds on the previous strategy. Its aim is, '...to lead to a more seamless approach between a range of child, youth and adult services, and provides a unifying policy focus on children and young people.'

Children First: National Guidance for the Protection and Welfare of Children (2011) [referred to in this report as Children First (2011)] promotes the protection of children from abuse and neglect. This national guidance outlines what different statutory and non-statutory bodies, and the general public, should do if they are concerned about a child's safety and welfare.

It also sets out specific protocols for Tusla and An Garda Síochána to protect children from abuse. Critical to the work of Tusla's child protection and welfare services, it highlights how suspected abuse and or neglect of children should be dealt with. It also emphasises the importance of multidisciplinary and interagency working in the management of concerns about children's safety and welfare.

> The Children First Act 2015 puts elements of Children First (2011) on a statutory footing. This legislation forms part of a suite of recent child protection legislation which includes the National Vetting Bureau (Children and Vulnerable Persons) Act (2012) and the Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act (2012). When commenced, the new legislation will operate in tandem with Children First (2011), which outlines the existing non-statutory obligations which will continue to operate administratively for all sectors of society.*

The 2012 *National Standards for the Protection and Welfare of Children* were developed by HIQA to support continual improvements in the care and protection of children in receipt of child protection and welfare services. These outcome-based standards provide a framework for the development of child-centred services in Ireland that protect children and promote their welfare.

* At the time of publishing the investigation report in 2018, elements of the Children First Act, 2015 had commenced.

Background to the review

All children have a right to be safe and to have access to services and supports which enable their growth and development. Children who are not receiving adequate care and protection in their own homes and community are among the most vulnerable in society. It is vital, therefore, that they have access to the right services at the right time which are child-centred, and share a commitment to working together to achieve the best possible outcome for each child.

The setting of standards and the monitoring of compliance with them are important levers in propelling improvements in child protection and welfare services. It is the role of Tusla to assure itself, its service users and the public that it is consistently meeting National Standards in order to provide safe, high-quality services. The role of HIQA is to assess Tusla's compliance with National Standards, and monitor progress in relation to taking required actions to improve the safety and quality of its child protection and welfare services.

Key findings of monitoring and inspection: 2012–2015

This section presents an overview of key findings of HIQA's monitoring and inspection of statutory child protection and welfare services between 2012 and 2015. It provides the rationale for carrying out this review as informed by these findings.

It is acknowledged by HIQA that inspection findings prior to the establishment of Tusla were in relation to the delivery of services under the auspices of the Health Service Executive (HSE). However, these findings remain relevant to Tusla in the current delivery of safe and effective child protection and welfare services. HIQA also acknowledges the changing demographics of Tusla service areas, as their defined geographical areas have been reconfigured over recent years. Having considered these issues and the fact that HIQA does not inspect all service areas on an annual basis, this section does not refer to emerging trends but to recurring findings across services over the period in question.

Following the launch of the National Standards in July 2012, HIQA started its monitoring and inspection programme of statutory child protection and welfare services in Ireland. Between November 2012 and December 2015, HIQA inspected child protection and welfare services delivered in 14 out of 17 Tusla service areas. HIQA also inspected the provision of child protection and welfare services to asylum-seeking children in four Tusla service areas.

These service areas were:

- Louth/Meath
- Dublin North City
- Midlands
- Sligo/Leitrim/West Cavan.

Although there were positive findings and evidence of service improvements over time, HIQA remained concerned about inconsistent and varied practice in aspects of the service, which impacted on Tusla's capacity to deliver safe, equitable and high-quality services to children and families on a national basis.

Over the course of its inspections, HIQA has identified aspects of child protection and welfare services which are delivered well and in a child-centred way. There have been many examples of good quality direct work with children and families by Tusla staff and there has been a consistent finding across service areas of staff advocating strongly for the children and families they work with. The majority of Tusla staff have shown a capacity to maintain good relationships with families and continue to support these families for as long as is necessary in order to improve outcomes for children.

Responses to children at immediate risk of significant harm were found to be timely, while decision-making in relation to these specific cases resulted in immediate actions to reduce risk to these children.

Although children's rights were generally well promoted across the services, and while the views of children and their families were sought and respected, case records did not always reflect these critical elements of day-to-day practice. Tusla acknowledges the right of children and families to access their information and to make a complaint. However, the quality of information provided to them in relation to these rights has varied over time and across service areas. In addition, although there is a willingness by front-line staff to provide children and families with access to their information, and while many staff members facilitate this, Tusla has a national procedure which requires a Freedom of Information request to be made before this happens.

HIQA has over recent years reported on progress made by Tusla in a number of areas, and they include the:

- introduction of a national Child Protection Notification System (CPNS)
- establishment of a 24-seven national out-of-hours social work service
- identification of national thresholds of need for a Tusla service
- introduction of guidance in relation to managing caseloads.

In addition, interagency and collaborative working has been identified as a consistent strength of Tusla's national services, and there have been many examples of children being safe as a result. Inspection findings have also identified a reoccurrence of common issues of concern across multiple service areas since the inspection of these services by HIQA began in 2012.

These findings were of concern as they reflected on Tusla's capacity and capability to ensure all children and families receive the right service at the right time, particularly the high number of cases awaiting allocation to a social worker. Such findings related to:

- an inability to meet service demands
- unsafe and inadequate information systems
- a lack of dependable data
- inadequate resources
- staff vacancies
- limited quality assurance mechanisms and monitoring systems
- inadequate systems of reporting, recording and assessing risk.

In addition to these reoccurring findings, HIQA was concerned by events in the Midlands service area in 2015. In April 2015, HIQA had announced an inspection of child protection and welfare services in the Midlands service area. Prior to the inspection fieldwork, Tusla informed HIQA of a high number of unallocated child protection cases and notifications of alleged abuse received from An Garda Síochána to which no response had been made by the Midlands service area. Although the required actions were taken by Tusla and it provided regular progress reports to HIQA, these events brought aspects of the governance of Tusla's child protection and welfare service into question.

Review aims and objectives

This review aimed to identify if the governance arrangements in place in Tusla's child protection and welfare service support the delivery of a timely, safe and effective service for children and families and to establish how embedded national governance arrangements were at operational level.

The lines of enquiry for this review focused on determining if the following elements were in place and were operationally embedded:

- clear accountability and governance arrangements
- clear strategic direction and planning
- timely and appropriate responses to the assessed level of risk and need of children referred for a service
- risk management systems to support the effective identification and management of risk
- a well-organised workforce and employees who were supported to enhance their skills and levels of competence
- effectively used information to plan, deliver, audit, manage and improve the quality, safety and reliability of the service.

Throughout the review, it was evident that Tusla's child protection and welfare service was undergoing a programme of reform and development to:

- operate effectively as a relatively new independent agency for children and family services
- effectively manage incoming child protection and welfare referrals
- significantly reduce cases awaiting allocation to a social worker
- implement a national child protection strategy
- prepare for service demands following commencement of the Children First Act 2015 and other legislative requirements
- ensure the service is adequately staffed and resourced.

HIQA's Review Team considered Tusla's programme of reform and development in undertaking this review, while Tusla's approach to its reform and change programme informed the findings of this review as it progressed.

The report is structured in a number of parts. Chapters 2–5 outline the Review Team's findings under the themes of Leadership, Governance and Management; Workforce; Resources; Information and information systems. Chapter 6 sets out the conclusions reached.*

* Note as of June 2018: Chapter 6 setting out the conclusions of the HIQA review was not included in the draft governance review report provided to Tusla in February 2017 for its consideration.

Chapter 2
Leadership, governance and management

Introduction

The *National Standards for the Protection and Welfare of Children* (referred to in this report as the National Standards) outline what high-quality and safe child protection and welfare services should look like. In the context of this review, HIQA identified the following essential elements for the delivery of child protection and welfare services in Ireland as follows.

- There is clarity on who is accountable and responsible for the quality and safety of child protection and welfare services
- Children and families have access to services which meet their needs in a timely way
- Staff involved in the delivery of child protection and welfare services are recruited, organised, supported and developed so that they have the skills, competence and knowledge to deliver high-quality, safe and effective care
- Child protection and welfare services are arranged in a reliable way — minimising inconsistencies and variance in how they are delivered nationally and the likelihood of errors
- Accurate and timely information is available to monitor service provision effectively and to promote and encourage improvement
- Child protection and welfare services are:
  - evidence-based
  - strategically planned and implemented
  - monitored to assess performance
  - capable of change in order to improve.

The dimensions of quality that children and families should receive are described in the National Standards and include child-centred, safe and effective services.

The ability of child protection and welfare services to achieve these dimensions of quality is dependent on the capacity and capability of the service in four critically important areas as follows.

- **Leadership, governance and management —** the arrangements put in place by child protection and welfare services for clear accountability, decision-making, risk management, quality assurance as well as meeting their strategic and statutory obligations
- **Workforce —** planning, recruiting, managing and organising a workforce with the necessary numbers, skills and competencies
- **Use of resources —** using resources effectively and efficiently to deliver best outcomes for children and families
- **Use of information —** actively using information as a resource for planning, delivering, monitoring, managing and improving responses to children and families in need.

In reviewing the capacity and capability of Tusla to effectively deliver child protection and welfare services which ensure timely and proportionate responses to children and families in need, HIQA acknowledges the significant governance and operational changes which have occurred in recent years. These included the:

- establishment of Tusla in 2014
- transfer of statutory child protection and welfare services from the HSE to Tusla.

From the outset, the Review Team was aware of the significant programme for change that was underway in Tusla. Changes included standardising practice and setting up a national framework for delivering its child protection and welfare services. Throughout the review process, which started in December 2015, Tusla continued to implement its planned strategies and to work towards providing a service which is timely, effective and responsive to the needs of vulnerable children and families.

This chapter outlines the findings of the Review Team in relation to the governance arrangements in place to effectively deliver a timely and responsive national child protection and welfare service to the children and families in need of its services. These elements include the:

- corporate, leadership and operational management structure
- corporate governance arrangements
- strategic planning, organisational performance arrangements and
- organisational quality assurance mechanisms.

Organisational structure

Corporate and executive

Tusla board

Tusla is governed by a board of management (referred to in this report as the board) which was established on 1 January 2014. The board is responsible for ensuring Tusla has adequate governance arrangements in place to comply with relevant legislation and national policy and to ensure that effective internal systems are in place to inform, deliver, and monitor the service.

The board in place during the review period had seven members from various backgrounds including social care and health,[1] who had been appointed by the Minister for Children and Youth Affairs. The board is led by a chairperson. The Chairperson in place at the time of this review stressed the importance of having the right people with the appropriate skills as part of the board's membership.

Tusla was established by merging three services together: the Children and Family Services previously provided by the HSE; the Family Support Agency; and the Educational and Welfare Board.[2] The Chairperson of Tusla's board described this task as challenging due to the complexities of bringing together three organisations which historically operated under different governance, departmental and organisational structures, with different models of service delivery and organisational cultures. However, she expressed confidence in the resilience of the board to meet this challenge.

Tusla executive

The Chief Executive Officer (CEO) of Tusla reports directly to the Chairperson of the board. The current CEO is in post since 13 February 2016 and prior to this had been Tusla's Chief Operations Officer. Tusla's Senior Management Team includes the following postholders: Chief Operations Officer, Director of Quality Assurance, Director of Policy and Strategy, Director of Human Resources and a Director of Finance. These are provided in Appendix E.

The CEO informed the Review Team at interview in November 2016 that some changes were made in relation to this structure and that education and welfare now report to the Chief Operations Officer. The CEO also explained that the Director of Quality Assurance's responsibilities had been extended to include risk and health and safety. A new post of Director of ICT had been approved and recruitment was underway at the end of the review period.

Members of the Senior Management Team interviewed as part of this review explained that their role was to lead and develop the service, and to manage the implementation of strategy in line with Tusla's Corporate Plan. In order to support the work of the Senior Management Team, several sub-groups had been established which included:

- a quality, risk and service improvement group
- a national policy oversight group and
- an employment monitoring group.

Operational structure in Tusla's child protection and welfare services

There are four Tusla regional operational areas: West, South, Dublin Mid Leinster and Dublin North East. A service director is responsible for each region. Service directors report directly to the Chief Operations Officer. Service directors reported to the Review Team that their roles and responsibilities were set out under the Tusla scheme of delegation.[3] The key areas of responsibility they identified were in relation to line management of area managers, budgets and resources.

The next tier of management within the Tusla child protection and welfare services are area managers. They report to the relevant service director of their respective regions and are responsible for the day-to-day operation of their respective service areas, which are defined geographical areas. These are provided in Appendix E.

Each regional office had management structures that varied slightly. These are provided in Appendix E.

At an operational level, Tusla service areas have principal social workers. Area managers explained at interview that typically, principal social workers have the responsibility of managing different teams within each service area and may be assigned additional duties. Principal social workers report directly to their respective area manager.

Findings

Corporate governance

This review finds that there were good governance arrangements in place for Tusla child protection and welfare services at corporate and executive level. Reporting structures ensured high levels of accountability in key areas of operational and corporate risk, finance and service planning. Considerable progress had been made in relation to providing a well-resourced service with a standardised approach to practice, and there had been significant investment by Tusla to improve the quality of its child protection and welfare services. Despite these positive findings, improvements are required in relation to ensuring governance arrangements are embedded at local level.

The board of management of Tusla holds corporate accountability for the delivery of safe, high-quality services which include child protection and welfare services. The board has reserved functions[4] and has delegated others to the CEO who in turn has delegated functions to members of the Senior Management Team. This scheme of delegation requires a strong set of reporting arrangements to provide the board with assurances on the quality and safety of the service and that the functions of the board are being carried out to their fullest extent possible.

The governance arrangements of the board are clearly set out in Tusla's Code of Governance which states that the CEO is accountable to the board for the implementation of its corporate and business plans and for managing Tusla. The postholder of CEO reports directly to the Chairperson of the board.

A review of board meeting minutes over a 10-month period in 2016 showed that the board met monthly and that meetings had been attended by the CEO on each occasion. The CEO reported on progress against the corporate plan and aligned business plan objectives and on all matters relevant to the functions of Tusla for which it is accountable.

Monthly performance and activity reports are provided routinely to the Board in relation to human resources, finance and operations. A national performance 'dashboard' was introduced in 2015 by the Executive in order to provide this information in a coherent and informative way.

It was evident in board meeting minutes that board members interrogate data and the information provided to them. There were particular examples of this when risk was involved, such as cases awaiting allocation to a social worker, finance and staffing.

The CEO reported, and it was seen from board meeting minutes, that members of the Executive attend board meetings as requested, where they are held directly to account for their responsibilities in relation to meeting corporate and business plan objectives.

Three committees have been established by the board to support its governance of Tusla. Each committee has a charter and terms of reference. The committees are:

- Audit Committee
- Remuneration and Succession Committee
- Quality Assurance and Risk Committee.

The CEO explained at interview that members of the Executive report to these sub-committees on specific areas of practice and service delivery and in turn, each committee reports to the board. The Review Team examined meeting minutes over a seven-month period for the three committees. The Team found evidence that these committees demonstrated a high level of accountability by the Executive to the board on key areas of operational and corporate risk, finance and service planning.

Strategic vision, planning and direction

The strategic direction of Tusla's child protection and welfare service is the overall responsibility of the board of management. The board needs to ensure Tusla operates within its legal parameters and it identifies corporate targets based on recommendations by the CEO. Tusla's corporate plan is subject to approval by the Minister.

The first corporate plan for Tusla spans a three-year period 2015–2017[5] and annual business plans are developed across the service to support it to meet corporate targets. The Tusla corporate plan includes eight high-level strategic objectives focused on improving the quality, integrity and responsiveness of the service. The Review Team examined the corporate plan and found that it took into consideration the wider need to meet Tusla's obligations under the Department of Children and Youth Affairs' performance framework and national policy.

A number of performance indicators, designed to measure progress against actions required to meet its objectives, are included in the corporate plan. Accountability for progress against objectives lies with the Senior Management Team which provides progress reports on a quarterly basis.

Business plans for 2015[6] and 2016,[7] as reviewed by the Review Team, provided detailed accounts of what is to be achieved by Tusla year on year. Ministerial priorities are clearly referenced. The primary focus of 2015 was described in the business plan as building on work already begun by Tusla — and in particular to strengthen its quality assurance arrangements, workforce planning and modernisation of information and communication systems.

The Tusla business plan for 2016 reflected many of the findings of child protection and welfare inspections carried out by HIQA since the end of 2012. These included objectives related to:

- introducing a resource-allocation model to inform the distribution of resources
- planning to address backlogs of unallocated cases
- strengthening of the organisational infrastructure to deliver the maximum service
- developing governance arrangements to include a new commissioning approach
- improving quality assurance processes and
- developing an integrated information system.

The Review Team, with members of the Senior Management Team, explored the successes and challenges in meeting corporate and business objectives up to the time of the review. The reduction in the number of cases awaiting allocation to a social worker was cited as a significant improvement. Other developments highlighted by members of the Senior Management Team were implementing a national Child Protection Notification System and the introduction of a 24-seven out-of-hours social work system.

Additional front-line capacity was given particular reference by senior managers, as was the increased levels of transparency, collaboration and motivation within the service. The ongoing development of national policies and associated procedures and standard business processes — which are driving standardisation of practice on a national level — was also noted. Senior managers expected a new model to underpin an informed response to resource allocation and the introduction of a commissioning strategy[8] (discussed later in the report) to benefit the service greatly.

Senior managers reflected at interview on the continuing challenges to delivering a high-quality service. They were unanimous in their view that ICT systems and supports needed to be significantly improved to ensure they are sufficient to meet current and future service needs.

Senior managers also recognised the need to build on what has been achieved to date in relation to developing a common understanding of risk within the service, while promoting and underpinning a quality improvement agenda.

A radical and sustained reduction of cases awaiting allocation to a social worker was presented by senior managers to the Review Team as critical. The CEO expressed confidence — as a result of allocating additional resources, reconfiguring local areas in 2016, along with increasing accountability — that no high-priority case would be awaiting allocation to a social worker by mid 2017.

The CEO explained that there is a vision for the service which entails significant reform. To support the change process, a transformation programme was under development. The CEO described this programme to the Review Team and explained that it is being developed to support the full and effective implementation of Tusla's child protection strategy. The aim of this strategy, which identified seven themes against which there were identified milestones for the organisation, is to ensure a timely, proportionate and appropriate response to children at risk or in need and to draw on all available internal and external resources to achieve these aims.

Over the course of this review it was evident that managers at all levels across Tusla child protection and welfare services are aiming for a much improved service that they can be proud of. They were enthusiastic about and confident in the programme of reform. Area managers were motivated by the additional resources that they had received and by the vision for the service as a whole.

Many of the managers interviewed reported a change in culture. They said that there is an emerging culture of openness, transparency and collaboration and that this is important to them in terms of collective decision-making about services. They reported that lines of communication are clearer and that regular meetings between operational and senior managers promote good communication within the service. They also expressed their satisfaction with the emergence of a learning culture within Tusla and they informed the Review Team of increased opportunities for shared learning.

Operational managers reported to the Review Team that, overall, they were supported well by their directorates and that there is better involvement by these supports in decisions about local services. For example, area managers informed the Review Team that regional finance officers attend local management meetings and that this contributes to child-centred decisions about how and where money is spent at service-area level. They expressed satisfaction with the level of support and accessibility in relation to the Finance Department and that this was valued by them.

Operational managers reported to the Review Team that there are increased levels of accountability within the service. They explained that they are contacted directly at times by senior managers to explain particular trends or fluctuations in activity figures. Several area managers said that they experienced increased levels of monitoring of their service to ensure improvements are made and sustained. They said, however, that additional resources allocated to their teams were welcome and would support them going into the future.

Policy and strategy

The Policy and Strategy Directorate has an advisory function to the Senior Management Team to inform long-term planning and the development of key policies to ensure that Tusla achieves its strategic objectives. Within this Directorate there were several national managers and two temporary officers who held a lead role in relation to specific projects, all of whom report to the Director of Policy and Strategy.

The Director of Policy and Strategy told the Review Team that Tusla is in the process of introducing a national approach to social work and aligned staff practice through a child protection and welfare strategy. The Director of Policy and Strategy informed the Review Team of the significant consultation programme which took place over 2016 to ensure this strategy reflects national need and is based on learning from experience. This strategy was presented to the Review Team and was found to be evidence-based and multi-faceted. It takes into account Tusla's requirements to meet legislation and in particular commencement of aspects of the Children First Act 2015 and the introduction of mandatory reporting by key professionals. Senior managers interviewed by the Review Team were confident that full implementation of the strategy will enhance the performance of its child protection and welfare services.

Since being established, Tusla has made significant strides in relation to standardisation of social work practice on a national scale. To support this, a suite of Tusla policy, procedure and guidance has been introduced along with a review process. A policy catalogue has also been developed to support accessibility across the service. Senior managers described a well-governed process being in place to identify where policy is required and to ensure that it is developed as part of a consultative process. A Policy Oversight Group is in place to assist in this area.

When asked about the implementation of national policy and procedure, senior managers explained that no policy is finalised until an implementation plan is in place and agreed. It is then the role of operational managers to implement these at local level.

Standardisation of practice has led to the development of a suite of standard business processes. They form part of the wider development of an integrated electronic information system for the service. Standard business processes are subject to measurement within the integrated information system that was being developed and as a result, they are supplemented by measures to support practitioners to record information and data in the same format. The quality of recording is essential for correct measurements. However, some area managers told the Review Team that the recording aspect of standard business processes was burdensome on staff and as a result, records were not always kept up to date.

The Review Team explored the implementation of policy and procedures across service areas. Area managers reported to the Review Team that they understood the need for a standardised approach to practice but were dissatisfied at times with the rate of development and change. They explained that sometimes the pace was too fast and too much for the system to absorb and that several policies and procedures have been introduced too close together. The Director of Policy and Strategy informed the Review Team that it was recognised at a corporate level that the rate of policy and process development did not always match the rate at which it could be implemented at a local level. He informed the Review Team that this issue was being addressed in the current system for policy development and implementation.

Updated action plans provided to HIQA and interviews with Tusla area managers indicated that the introduction of key national policies had negated the need for local policy. The Review Team found that this was significant in the drive towards consistency of practice.

The Director of Policy and Strategy and the Director of Quality Assurance were interviewed separately and said that a systems approach was being taken to assess the implementation of policy at operational level. They explained that if underperformance in a particular area of practice was identified as a national trend, then part of the process to examine the cause of the underperformance included how well policy and procedures are implemented and adhered to.

Service areas inspected by HIQA in 2016 acknowledged the growth in national policies and procedures, and although these were not always fully implemented, the action plans they returned to HIQA indicated they were working towards the full implementation of national policies and procedures. These plans also indicated strengthening of the local arrangements in place to ensure national policies and procedures were provided to staff and that staff had good awareness of their content.

Meeting legislative requirements and managing risk

This review finds that Tusla was not prepared to meet the requirements of new legislation. Despite progress made, risk reporting systems were not embedded at operational level and could not provide sufficient assurances at a corporate level on the safety of the service.

Meeting legislative requirements

Tusla has a wide range of legislation to comply with (see Appendix B). The Review Team explored with the senior managers interviewed how well Tusla is prepared to meet the requirements of new legislation. They informed the Review Team that Tusla was not fully prepared at the time of interview and that preparations were underway to meet the requirements of incoming legislation in relation to aftercare, adoption and the Children First Act 2015. The CEO informed the Review Team that unallocated cases within the service had to be reduced, and the reductions sustained, before Tusla would be ready to deal with the expected increase in referrals due to the introduction of mandatory reporting by key professionals. He also explained that changes were also required to ensure children's services teams around the country were set up appropriately and had increased expertise in managing incoming referrals so as to ensure the system was not unduly overburdened by inappropriate referrals.

Senior managers explained to the Review Team that Tusla's child protection strategy has been developed to ensure this happened. Senior managers also informed the Review Team that the date for commencement of further elements of the Children First Act 2015 had been deferred and they explained that this additional time would give Tusla scope to prepare fully.

At the time of the review, Tusla was not fully meeting its legislative requirements under the Freedom of Information Act 2014. The inability to comply with this legislation was deemed a significant risk by Tusla. It was placed on the corporate risk register where it remained for the duration of the review period.

Corporate and operational risk management

The Review Team found that the governance arrangements that Tusla has in place and which provide Tusla with oversight of organisational and high-level operational risks are evolving. Operational practice in relation to reporting and managing risk was diverse and required a common approach.

At a corporate level, the board has established a Quality Assurance and Risk Committee. This committee reports to the board and advises on Tusla's risk management strategy and risk tolerance. The Review Team examined minutes of four committee meetings and found that relevant risks filtered through the system and were brought before this committee.

Risks reported over a 10-month period included those related to ICT, cases awaiting allocation to a social worker, finance and service capacity. Central to the work of this committee is a focus on how risk is used by Tusla as an opportunity to learn and improve.

The Chairperson of the board explained at interview that monthly risk reports are received from the Executive and they are accompanied by a plan and a strategy to address identified risks. Individual high risks are communicated immediately to the board by the Executive.

The Senior Management Team had systems and processes in place in relation to risk management. It had established a sub-group called the Quality, Risk and Service Action Group[9] in 2015. The purpose of this group includes examining information and data collected by Tusla to identify risks in the service and ways in which they can be addressed. A national Quality, Risk and Service Improvement Working Group is also in place, which brings together representatives of the national service to drive improvement in the areas of risk and quality. Similar groups are also established at regional and service-area levels.

There is a corporate response mechanism in place to respond to levels of high risk identified in service areas. The CEO explained that the purpose of this response is to bring about rapid improvement in service delivery. This rapid improvement response was triggered in two service areas over 2014 and 2015: Louth Meath and the Midlands. It was prompted following a HIQA inspection of Louth Meath child protection and welfare services, when significant risks were identified in relation to service safety, management and information systems.

A rapid improvement response was prompted for the Midlands service area following the identification by Tusla of a backlog of notifications of suspected abuse or welfare concerns made by the Gardaí to the service between 2007 and 2013. There was also a significant number of unallocated cases.

A 'rapid improvement' progress report for the Midlands service area provided to the Review Team indicated that the response had resulted in strengthened governance arrangements, additional and targeted resources to address the issue creating the risk or risks and an assurance mechanism to report on safety concerns and to closely monitor the service. Updated action plans provided to HIQA for these two service areas during Phase Three of the review indicated improvements to the quality and safety of aspects of its service.

At an operational level, Tusla was in the process of changing from operating in line with the HSE's risk management policy to one developed for Tusla[10] by its Quality Assurance Directorate. This policy was launched by Tusla for implementation in January 2017. The Director of Quality Assurance informed the Review Team that a risk management framework was in the process of being developed.

In the absence of a risk management framework to inform risk management nationally, the Review Team found that local services struggled to consistently and effectively identify and report risk.

There was a system in place by which risks were reported through the system; however, this was not as effective as it could be. Senior managers reported that identified risks are placed on risk registers at service-area level, regional level and directorate level. Risks that cannot be resolved by those holding the register, for example, the service director, are raised to next level. The Director of Quality Assurance collates the information on directorate risk registers and places suggested relevant risks on the corporate risk register.

The corporate risk register is then brought to the Senior Management Team for discussion and on to the Quality Assurance and Risk Committee of the board, before being reported to the board once every three months.

Senior managers acknowledged the diversity in practice across the service in relation to risk registers. They explained that standardisation of risk registers was under way and that a strategy has been developed for their introduction, starting with directorate and corporate risk registers. This is due for full implementation across Tusla in 2017.

In the interim, there were inconsistencies at an operational level. Risk registers in 17 service areas were requested by the Review Team as part of the review. While 14 out of 17 service areas had a risk register, three did not. Risk registers in place were found to vary in relation to the quality of the description of the risk involved and the level of detail in relation to the controls in place. Fluctuations in risk over time were not always recorded and periodic reviews of risks were not always evident.

In addition, some service areas did not rate the level of risk involved and others had continued to rate risks as high, despite the relevant issue being resolved. This means that information about risk held in service areas may not adequately inform regional, directorate or corporate risk registers. Furthermore, risk registers across the service are not accessible at every level. Service directors said at interview that they could not, therefore, be assured that risks they have identified are reflected on risk registers maintained at a higher level.

Each region had a quality, risk and service improvement manager who reported directly to their respective service directors, but their role at service area level differed. Some operational managers reported at interview that the quality, risk and service improvement manager for their region provided advice and support in relation to developing and maintaining the service area risk register. Others, however, said they had limited contact with their regional quality, risk and service improvement manager and were not clear about their role in relation to local risk.

There were some established processes in place to report and escalate risk through the service but they differed and were not implemented in a standardised way. The Review Team found that there is a process called 'Need to know', which is for information only and is a way of informing senior managers of a particular case or issue of note. However, some area managers used this information process as way of escalating risk. The Review Team found two additional and different ways of escalating risk. They were the 'risk escalation' and 'incident reporting' systems. Both had individual report templates which required different levels of detail in relation to a similar risk.

Formal written responses to escalated risk were not always evident in service area records. Some area managers provided the Review Team with evidence of emailed responses from their service director, but others informed the Review Team that responses were usually verbal. In a minority of service areas, responses to escalated risks were briefly recorded on the local risk register.

Most recent inspections of three service area child protection and welfare services in early 2016 continued to find varied methods of recording and reporting risk. Risk registers continued to lack detail in relation to service risks, and systems to review these registers were not vigorous enough. A number of risk-reporting methods were in place, but some risks went unreported. In addition, while there was an awareness of risk in these service areas, systems to manage and review risks were not always sufficient.

Nonetheless, action plans provided to HIQA following these inspections showed some systems were put in place at a local level to address the deficiencies. For example, systems of reviewing risk had been put in place in two service areas with the support and or oversight of the respective quality, risk and service improvement managers.

Incident management

It is a regulatory requirement of Tusla to report incidents through the National Incident Management System to the State Claims Agency, and Tusla had recently introduced a system to do so. However, this had not been embedded operationally. The Quality Assurance Directorate had developed policy and procedure for incident management,[11] which was launched by Tusla for implementation in January 2017. This policy and procedure was supplemented by guidance on conducting system analysis and reviews and was accompanied by a single national incident report form.

The Review Team explored how incidents are reported at an operational level and found that practice varied and required improvement. This was acknowledged by senior managers.

The Director of Quality Assurance told the Review Team that more work was required in this area as significant under-reporting had been identified across the service.

Cases awaiting allocation to a social worker

This review finds that although some progress had been made in relation to reducing the number of cases awaiting allocation to a social worker, a high number remained and this posed a potential risk to children and a significant risk to the organisation.

Senior managers informed the Review Team that one aim crucial to the Tusla programme of reform is the timely allocation of cases to a social worker to ensure their needs are met and risks are managed. It is also critical to ensuring Tusla is prepared for mandatory reporting by key professionals (such as general practitioners, teachers and youth workers). Members of the Senior Management Team informed the Review Team that the number of high-priority cases awaiting allocation to a social worker would be reduced to zero by mid 2017. At the time of the review, a project team was reviewing all cases awaiting allocation across the service to gain a better understanding of why they existed and how practice could be improved.

Table 1 indicates that progress had been made by Tusla in reducing the number of cases awaiting allocation and this is a welcome finding. However, significant numbers remain and these cases potentially present unnecessary risk to the children involved and ongoing risk to the service.

Each referral to Tusla is assigned a level of priority for a service. Once prioritised as high, then it is a priority for allocation. Table 1 below provides an overview of figures published by Tusla in its 2015 Annual Report and performance figures for September 2016.[12] These figures demonstrate a year-on-year reduction in cases awaiting allocation to a social worker.

However, at the end of September 2016, there were 4,361 cases which remained unallocated and of these, 576 were high priority.

Table 1. Cases awaiting allocation

Year	Number of referrals	Number of cases open to the service	Number of unallocated cases
Year End 2014	43,179	27,651	8,542 (2,836 — high priority) (5,620 — medium/low priority)
Year End 2015	43,596	26,655	6,718 (999 — high priority) (5,719 — medium/low priority)
End of September 2016	N/A	25,363	4,361 (576 — high priority) (3,785 – medium/low priority)

Children who are assessed by Tusla child protection social workers as being at ongoing risk of significant harm are placed on Tusla's Child Protection Notification System (CPNS). This means that Tusla has identified these children as those who are most vulnerable to risk of harm.

Table 2 below shows a year-on-year decrease in the number of these children without an allocated social worker. Although quarterly performance figures published by Tusla have shown some children listed on the CPNS have been without an allocated social worker for very short periods of time (days) between 2015 and 2016*, at the end of September 2016 all children on the CPNS had been allocated a social worker.**

In addition to the children's cases referred to above as awaiting allocation to a social worker, HIQA has consistently found adult cases awaiting allocation to a social worker. These cases are primarily related to retrospective allegations of abuse. Although Tusla's published performance figures do not include these unallocated adult cases, senior managers indicated to the Review Team that there are approximately 900 such cases nationally.

* Tusla Integrated Performance and Activity Report Quarter 4 2015

** Tusla Integrated Performance and Activity Report Quarter 3 2016

The Review Team finds that their existence presents potentially unidentified and unmanaged risk to children and the organisation.

Table 2. Number of children listed on the Child Protection Notification System (CPNS)

Year	Total number of children listed on CPNS	Number of children unallocated listed on the CPNS
2015	1,349	26
2016 (end September)	1,251	0

Quality assurance and monitoring

This review finds that quality assurance mechanisms were not fully embedded at operational level. Information collected and analysed by Tusla was not always dependable, and information systems were not fit for current or future purposes. These were aspects of the service which could not provide sufficient assurances at a corporate level on the quality and safety of the service and required considerable improvement.

Effective quality assurance and monitoring mechanisms are needed by Tusla's child protection and welfare service to identify where it is performing well and where it needs to improve. This review found that although progress has been made in establishing quality assurance mechanisms, more work is needed to sufficiently embed these processes at local level. Limited levels of internal monitoring, along with limited quality assurance mechanisms in place locally, cannot adequately provide Tusla with the necessary assurances in relation to the safety and quality of all aspects of its service.

At the time of this review, there were arrangements in place in relation to driving service improvement across Tusla and promoting and facilitating the collection of data in daily work processes. The Quality Assurance and Risk Committee established by the board focuses on the integration of quality assurance procedures and practice across Tusla. The Review Team examined minutes of four committee meetings and found meetings were attended by various members of the Executive as required and that the Director of Quality Assurance reported to this Committee at each sitting.

Agenda items in relation to quality assurance and monitoring included among other items:

- updates on national audits
- information on specific services provided by Tusla
- progress on actions related to recommendations of external agency reports and
- areas of practice being monitored by the Quality Assurance Directorate.

It is the function of the Quality Assurance Directorate to lead and promote the quality improvement agenda across Tusla and Tusla-commissioned and funded services. The Directorate is responsible for the monitoring and review of all services provided by Tusla, including its child protection and welfare services.

In an effort to further strengthen governance in this area, the Quality Assurance Directorate has developed a Quality Improvement Framework.[13] This Framework had been piloted and was awaiting approval by Tusla senior managers and subsequent sharing across Tusla services. The 2017 draft business plan for the Quality Assurance Directorate set out the arrangements in place to support the implementation of this Framework during 2017. It provides for assessment, including self-assessment of Tusla services, which may be carried out at a local, regional or national level. This Framework is a significant initiative for Tusla, as it has the potential to embed a culture of gathering and reflecting on information and data at operational level for the purpose of improving services.

A theme across HIQA inspections of Tusla services up to 2015 was the limited monitoring and quality assurance mechanisms in place at local level. Although some monitoring was carried out, it was limited to areas such as cases awaiting allocation to a social worker and staffing, monitoring of the quality of case files and ensuring the voice of the child was reflected in social work records and reports. However, despite being highlighted not just by HIQA but also in reports such as the Ryan Report,[14] monitoring systems or quality checks were not in place to improve case chronologies, which are crucial to mapping service interventions and critical-case decisions. This remained the case in inspections carried out in 2016 and returned action plans for the service areas involved showed that measures were being taken to address this deficiency.

Audit and review

Several national reviews were carried out over 2015 and 2016. They included a review of cases awaiting allocation to a social worker, a review of the CPNS and a review of the management of unallocated cases. A review of the application of standard business processes in child protection and welfare services was also undertaken in 2015.

A review of retrospective cases was carried out during 2016 and at the time of reporting it remained in draft form and will be provided to HIQA on completion. In addition, Tusla was in the process of reviewing all unallocated cases open to the child protection and welfare service. The Director of Quality Assurance informed the Review Team that this would be followed by an examination of practice in relation to closing cases appropriately, as this may impact on the number of unallocated cases.

Some area managers expressed the view that they would like more input into determining the aspects of service provision which are audited at a national level. They held the view that on balance, audits should be carried out on good quality aspects of the service as well as areas which require improving, as there is learning from both approaches.

Senior managers individually identified data on key performance indicators, practice audits and reviews, financial audits and reports from external agencies, as key quality assurances mechanisms.

Service areas appeared to benefit from national audits, but, in the judgment of the Review Team, their capacity to address the deficiencies in both local and national audits lacked a clear strategy. The national framework for quality assurance was awaited by service areas for guidance and tools to assist in this regard.

Performance indicators

Key performance indicators are specific and measurable elements of practice that can be used to assess and benchmark the quality of the service. They are used to measure the way in which the service is provided, the effects of the service delivered and the structure of the service. This review found that notwithstanding the ICT challenges faced by Tusla, measuring performance through limited but routine data collection was established practice at a corporate and operational level.

Tusla has developed a set of key performance indicators which provide a valuable source of information on crucial elements of the service and a full list is provided in Appendix C [of this governance review]. Data gathered in relation to child protection and welfare services nationally focus on:

- activity related to referrals to the service
- the Child Protection Notification System (CPNS)
- the crisis intervention service and out-of-hours service
- the number of cases open to the service

- the number of cases allocated and or awaiting allocation
- the number of cases awaiting allocation by priority level
- the number of cases awaiting allocation by length of time
- staff data.

This data is analysed by the Quality Assurance Directorate and published on a quarterly basis by Tusla. These reports are presented at Board and subcommittee level. Senior and operational managers reported to the Review Team that this data has significant influence on planning and improvements to service delivery and in identifying pressure points in the service. The Director of Quality Assurance reported that it is this data — along with other information available — that has provided the impetus to carry out practice audits and reviews to propel service improvement.

It was acknowledged by senior managers that the metrics collected are not currently reflective of all areas of social work activity. This data does not include adult cases typically related to retrospective allegations of abuse, which has been an area of practice assessed as requiring significant improvement by HIQA. The Director of Quality Assurance informed the Review Team that this information would be included in 2017 metrics as it was an area of practice which required monitoring at an operational and corporate level.

In addition, over the course of its inspections of Tusla child protection and welfare services, HIQA has identified the limited and, in many service areas, lack of information and data collected in relation to re-referrals to the service. This data has the potential to provide an indication of performance in relation to appropriate and timely case closure and the ability of the service to recognise long-term neglect of children.

Complaints

Tusla had introduced an electronic system of reporting complaints along with incidents using the National Incident Management System in 2016.

Senior managers told the Review Team they valued learning from complaints and Tusla had begun the process of reflecting service-user experience through an analysis of complaints made to the service. A Service User Division of the Quality Assurance Directorate has been established and information provided to HIQA about this division shows that it operates at a national level. It quality assures the functions of Tusla in relation to complaints and feedback, parliamentary affairs and Freedom of Information.

The Review Team examined a report on service-user experience produced in the April to June quarter of 2016 and found that it provided an analysis of complaints entered on the National Incident Management System between April and June 2016. It identified areas of practice and services which were the focus of complaints. However, while this has the potential to promote quality improvement across the service, as mentioned previously, this system is dependent on input of data at a local level which has been acknowledged as inconsistent across the country.

External reports

External reports and resultant recommendations were described by senior managers as a source of learning in relation to improving the quality of Tusla's services. The Chief Operations Officer, for example, cited HIQA inspections as providing valuable qualitative information on how the service performs and said that inspection is welcomed at operational level for this very reason.

Other senior managers referred to external reporting by the National Review Panel and the State Claims Agency as a source of information about the service which can be used to its fullest effect. In order to do this, senior managers are responsible for ensuring recommendations are acted on, and progress is tracked using a tracking system developed and maintained by the Quality Assurance Directorate. A copy of the tracking system record was found to be well maintained, up to date, and sufficiently detailed to provide adequate oversight of progress being made.

Stakeholder engagement

At interview, there was recognition at a corporate level of the value in gathering the views and experiences of children and families and other stakeholders of the service in order to promote better services. The Review Team found that the initiative of the Quality Assurance Directorate in relation to complaints was one way of capturing this rich information at a corporate level. The Review Team also found that a review of child protection case conferences in 2015 also took into account the views of children and families when improving aspects of the service.

However, HIQA inspections carried out in 2015 and 2016 found that there was limited consultation with children and families in relation to their experience of local services.

Chapter 3
Tusla National Child Protection and Welfare Service Workforce

Introduction

Providing a child protection and welfare service is a complex and demanding task and as with any other organisation, the workforce of Tusla's child protection and welfare service is its main resource and strength. A well-trained, capable and organised complement of staff is vital to providing a high-quality service to children and families in need. Furthermore, Tusla has a duty to ensure the structures in place are supportive of staff and that workforce planning and the development of staff competence is seen as an integral part of the delivery of the highest quality care.

Findings

This review finds that Tusla had committed significant resources to training its workforce and to develop a culture of learning and evidence-based practice. Staff planning and recruitment had improved and there were systems in place to supervise staff.

This review finds that despite progress made, recruitment processes had not improved sufficiently to ensure staff recruitment kept pace with service demands. As a result, Tusla did not have the workforce to provide an optimum service to children and families.

Staffing levels

End-of-year staffing figures related to child protection and welfare services for 2016 were not published at the time of writing, but data provided to HIQA over the course of the review period showed there was some increase in the child protection and welfare workforce over that time (see Table 3). Senior managers pointed out that the expected increase in the complement of staff over 2016 and 2017 would increase the capacity and capability of the service to adequately manage incoming referrals and allocate all cases to a social worker, and would support the implementation of its new child protection and welfare strategy.

There is a wide range of staff posts across Tusla. Information provided for this review showed that its current workforce includes managers, social workers of various grades, family support workers, social care leaders and administrative staff. The majority of staff are part of the complement of social workers, who manage incoming referrals and work directly with children and families once they have met the national threshold of need for a service. Social workers within the service are required to be registered with their professional regulatory body, while ongoing professional development is necessary to maintain their registration status and assure the public of their continued competence.

Strategic workforce planning

Workforce planning for an agency such as Tusla is crucial to ensuring it has sufficient numbers of competent staff in the right locations to meet service demands. This review examined the governance arrangements in place for planning its workforce.

In order to meet Tusla's corporate plan objectives (2015–2017), Tusla presented a business case to the Department of Children and Youth Affairs which determined the investments required to recruit on the necessary scale. Essentially, this document, 'Survival to Sustainability' 2015 was a capacity review of the service. It identified the need for additional whole-time equivalents in social work and associated posts to address shortfalls in the service and highlighted its incapacity to allocate a social worker to all children at risk.

Table 3 below shows the category and number of staff working in Tusla child protection and welfare services over a 10-month period in 2016. Figures demonstrate an increase in numbers in relation to social workers of all grades. These figures also indicate a significant reduction in the use of agency staff, which was a strategic aim of Tusla over 2015–2016. Table 3 indicates that as of 1 November 2016, there were 121 staff vacancies in Tusla child protection and welfare services nationally, which had reduced from 275 in January 2016.

This review found that although chief operations officer, area manager and service director posts were filled during the review period, several were on an interim basis. Tusla was interviewing for the post of chief operations officer at the end of the review period in November 2016. The Review Team was informed that recruitment for permanent service directors would start once the permanent chief operations officer was in post. For a relatively new agency with a significant medium- to long-term improvement agenda, these delays are not ideal.

Table 3. Staff employed by Tusla's child protection and welfare service by type, number and date.

Staffing category	Number as of January 2016	Number as of October 2016
Principal social worker	84.96	88.07
Independent chair child protection conference	25	30
Team leader	228.04	246.27
Social worker	998.82	1,029.16
Social care leader	163.11	189.05
Family support workers	128.04	114.48
Administrative staff	352.49	359.06
Child protection and welfare agency staff	202.00	132
Other relevant	452.46	447.69
Staff vacancies	275	121

Source: Tusla (individual figures provided by Tusla for each service area were calculated by HIQA for a national total).

Operational workforce planning

The recruitment drive to fill vacant posts within Tusla's child protection and welfare service had not kept pace with demand. This was identified by Tusla in September 2015, and operational and senior managers interviewed as part of this review remained critical of the recruitment arrangements in place. Tusla managers explained that the impact of delayed recruitment processes was that staffing local child protection and welfare services was increasingly dependent on the use of agency staff.

A programme of improvement was instigated by Tusla in 2015. It aimed to address staffing deficiencies and improve recruitment processes, so as to reduce the number of agency staff in use and increase service stability. According to a Human Resource Department document provided to the Review Team, this programme of improvement included an accelerated recruitment procedure, the expansion of Tusla's capacity to recruit directly using its own recruitment license and targeted recruitment campaigns.

There was also a revision of panel arrangements (Tusla staff can be placed on a panel for transfer to another location if an appropriate vacancy arises) and the development of a specific service level agreement with the HSE's National Recruitment Service which reflected Tusla as a legal entity and its need for bespoke campaigns. The CEO informed the Review Team that this has improved the ability of Tusla to recruit staff and to run recruitment drives on a cross-border basis, but that 'Tusla Recruit' (Tusla's recruitment service) is not adequately resourced to recruit on the scale required by the service.

Operational managers said that they had experienced benefits from changes to recruitment processes. They reported to the Review Team that they currently have greater involvement in recruitment of their staff and that local campaigns which meet local needs have reduced dependency on agency staff. HIQA requested data in relation to agency staff in use in Tusla over the review period, and figures provided showed a significant reduction over a 10-month period (see Table 3 above).

Area managers reported that established panels and Tusla's internal transfer process facilitated high levels of movement within the service nationally and that they had lost experienced staff as a result. It was explained to the Review Team that the first person on the panel was offered a post no matter where the vacancy was located, and despite the fact that a vacancy also existed in the service area in which they were currently placed.

Despite improvements to staff recruitment times and the ability to hold bespoke recruitment campaigns, 121 staff posts remained vacant at the time of this review.

Staff training and development

This review finds that Tusla is committed to upskilling of its workforce and has established a workforce development unit, while a 'Workforce Development (Staff Learning and Development) Work Plan' is also in place. Responsibility for the workforce development plan sits with the Human Resource Directorate but is closely aligned to other strategic areas such as policy and strategy.

The Review Team found that Tusla had committed considerable resources to training its workforce over the course of this review and more was planned. This was reflected in the level of activity within the Policy and Strategy Directorate and the progress it had made in relation to policy and strategic development. Senior managers reported to the Review Team that there is a training element to almost every new process and policy developed at a national level. They said each directorate works closely together to ensure the training provided is timely and effective.

Much of this training was organised by the Workforce Development Unit. Area managers informed the Review Team that they have the autonomy to buy in specific training to meet additional local needs. Local processes are in place for the identification of individual and team training requirements, summaries of which were submitted to the national workforce development unit.

The Chief Operations Officer informed the Review Team that the service was getting better at identifying training needs across the service. The majority of area managers reported at interview that a training needs analysis was carried out for their service area, some of which had been undertaken following a HIQA inspection, and in most cases it had been carried out in conjunction with the Workforce Development Unit.

A number of training and development initiatives are in place in Tusla. The CEO reported that there is significant investment in training managers and that all current managers had received leadership and management training. Area managers reported that front-line staff are trained in aspects of service delivery such as Meitheal, which is a key element of the child protection and welfare services strategy.

Furthermore, staff were facilitated to take part in national conferences specific to their practice areas, while training on empowering social workers in their practice was being implemented nationally. Rolling programmes of training related to child protection, attachment theory, supervision, thresholds of need and courtroom skills were also being provided on a national basis.

Staff supervision

Regular, structured supervision provides the opportunity for staff support on an individual basis and it is a forum in which staff are held to account by their managers. In 2013, a national supervision policy was introduced and has been implemented for social work staff and managers. However, this HIQA review found that supervision is not provided consistently and this has the potential to dilute its effectiveness.

The CEO provides regular, formal supervision to senior managers and this is also the case for the Chief Operations Officer who provides supervision to service directors on a consistent basis. Area managers expressed confidence that formal supervision was provided across their individual teams. They said they had a high level of expectation about the quality of supervision of their staff, as this formal process supports informed and safe decision-making about individual cases. Area managers said that they provide formal supervision to the staff that they line manage on a four- to six-weekly basis and it is at these meetings that they hold their managers to account for progress.

Child protection and welfare inspections carried out in 2016 found that the quality of supervision varied. Supervision records were not always maintained and not all staff had personal development plans in place. In response, service areas took actions such as revisiting Tusla's supervision policy with staff, addressing the four functions of supervision with staff and auditing supervision records to ensure improvement happened. There was evidence of national supports being drawn on to assist service areas to improve practice and increase learning in this area.

There are additional supports aligned to supervision in place for some staff grades. As part of piloting a national initiative to improve the quality of management, some area managers informed the Review Team that they were being provided with the support of an external management coach. Others said that an external consultant has provided coaching to their local management team and that this is expected to continue for some time.

In 2015, Tusla introduced a national strategy for continuing professional development which was established in the context of Tusla's corporate plan by its Workforce Development Unit. This strategy aids Tusla staff members' development by enabling the workforce to meet national objectives. Personal development planning is central to the success of this strategy, and area managers said that although this is part of the supervision process, personal development plans were in the early stages of implementation.

Performance management

At the time of this review, Tusla has yet to develop its own performance management development system (PMDS). Managers across the service reported to the Review Team that ongoing professional development is promoted within the service. They said, however, that current processes are not sufficient to manage underperformance on an ongoing and supportive way by line managers, prior to formal processes being applied.

Chapter 4
Resource allocation and management

Introduction

The effective management and use of available financial and human resources is fundamental to delivering a child protection and welfare service that meets the needs of children and families. The quality and safety of the delivery of the service is the personal and professional responsibility of the workforce. However, national governance arrangements must ensure the adequate deployment of resources so that organisational objectives can be achieved.

Findings

This review finds that Tusla had made considerable progress towards ensuring its child protection and welfare services were resourced based on demand and local needs, and strategies were in place to support the service to achieve this goal.

Improvements were required in relation to resource management and allocation. Aspects of the service remained under-resourced and available resources were not always fully utilised or well managed. Oversight of funded services was not adequate and could not assure Tusla that these services were well managed and provided value for money.

Resource allocation

The delivery of Tusla's child protection and welfare services depends on the availability of a wide range of local and national resources designed to respond to the needs of children and their families. Within this model, child protection and welfare services require adequate resources to manage incoming referrals, monitor and intervene in cases of suspected or confirmed child abuse, respond to child welfare issues, support families and provide for children received into the care of the State.

Where services are not delivered directly by Tusla, it may commission community and voluntary providers to do so on its behalf. Previous HIQA inspections of child protection and welfare services have emphasised that planning and allocation of resources and services is dependent on understanding the need and demand for a service.

In 2015, Tusla produced a business case outlining the investment required to deliver a safe and effective national child protection and welfare service. This highlighted the mounting need for a broad range of child protection and welfare services with the capacity to respond proportionately to concerns raised about children and improve their care and welfare outcomes. It demonstrated the inability of the national child protection and welfare service to do this and to meet increasing demands for a service with the resources it had at that time.

In its corporate plan, Tusla states that it has an objective of developing 'an organisation that lives within its means and utilises its resources in an efficient and cost-effective way'. An action associated with this objective was developing an evidence-based resource allocation model (RAM), which was introduced by Tusla in 2015. The CEO stated this is not just a resource allocation model but a profiling tool for services. He went on to explain that Tusla will allocate resources based on need and not solely on poor performance indicators, as he believed these figures can also indicate poor management of resources as opposed to insufficient resources.

The Chief Operations Officer explained that this is an independent model of ensuring the allocation of resources across service areas based on need. Central to the application of this model is quality data and information which includes current budgets, urban and rural deprivation scores, population under 18 years of age, number of referrals to each service area and cases awaiting allocation for a service.

Although some dissatisfaction was expressed at operational level in relation to the criteria used to inform the resource allocation model and the resultant allocation of resources, the majority of Tusla managers viewed it as a positive first step towards ensuring local child protection services were adequately resourced. They said that it provides the opportunity to re-balance service delivery year on year, towards one that is based on need and not what is available.

In addition to the resource allocation model, Tusla has introduced a national system which provides operational managers with the opportunity to make a case for securing resources that they may require. Area managers explained to the Review Team that they can present a 'business case' to their service director, outlining the need and the benefits of that resource. Some said that they had secured resources through this route and others were awaiting approval. Area managers viewed this national mechanism as a positive and supportive one which contributes to their capacity to develop services which meet local needs.

Updated action plan provided by area managers to HIQA as part of this review, identified the extra posts secured through the resource allocation model as an essential remedy to difficulties within their services and to mitigate risk on a sustained basis. However, filling these posts proved a challenge for some areas, attributed by some Tusla managers interviewed to insufficient numbers of qualified social workers and local difficulties attracting prospective staff.

As stated in Chapter 3 [of this governance review], there were some local initiatives in place to try and fill vacant posts, including the use of temporary and agency staff. Despite this, several area managers did not consider their service area as being resourced to an adequate or sustainable level within the context of temporary or agency staff and felt this does not allow for informed resource planning and service stability.

Effective use of resources

There was evidence that Tusla took national steps to ensure resources at operational level are targeted towards those who require them. In April 2014, it produced national guidance on thresholds,[15] intended to support decision-making at the screening and intake stage of processing a referral. Its overarching aim is to support the identification of children and families who need a service and the level of priority which should be assigned to their need. This guidance provided a standardised approach to the criteria to be considered in relation to incoming referrals.

The impact of this initiative has been a national reduction in cases being brought unnecessarily into the child protection and welfare system. Area managers acknowledged that this tool was used to promote the effective use of limited social work resources, but they were still aware of the challenges ahead in relation to the expected increase in referrals once sections of the Children First Act 2015 are commenced in relation to mandatory reporting by key professionals.

The need for defined, manageable caseloads in order to provide an effective and safe service to children and families is well established in social work practice. In 2014, Tusla introduced national guidance for managing caseloads. This provided a common approach to the identification of an appropriate number of cases on a social work caseload which is informed, for example, by the intensity of work associated with each case and the social worker's experience and skills. At the time of the review, this national guidance was being implemented in 16 out of 17 service areas.

This meant that social workers typically held caseloads which included cases of different levels of priority and complexity. The merits of this approach were described by the majority of area managers as positive as it promoted safe and effective practice and was supportive of staff. While area managers were satisfied with the system of managing caseloads, they stressed the need to fill vacant posts to ensure the appropriate allocation of social work staff to all unallocated cases, including high-priority cases.

The Review Team found, however, that in the interim, some service areas remained insufficiently resourced to allocate all high-priority cases. On a national scale, this amounted to considerable levels of risk within the service. The deployment and management of local resources is an operational function which is carried out by area managers.

They found this challenging due to their limited capacity to respond to the high levels of demand on their service and in some cases, the geographical spread of the service area. In order to manage available resources effectively, baseline knowledge of current service needs and available resources, coupled with a level of flexibility within the system to respond, is required. These elements were present to varying degrees across service areas.

Area managers had some systems in place to gather and analyse data and information about the need for services within their own communities and this supported them to identify some of the gaps in service provision and to prioritise their work. Most service areas had a child and young people's services committee in place, which was chaired by a Tusla area manager and included representatives of local statutory and voluntary agencies. Tusla managers said that when functioning well, these committees were a good example of coordinating and planning resources on an interagency level.

At interview, area managers said that through these committees they were provided with valuable statistics, demographic profiles of their communities and information on current services and service gaps. Some areas were in the process of setting up new committees, but the area managers involved said that they were experiencing challenges in getting representatives of various agencies involved. Nonetheless, they were confident this would happen in due course. Full-time coordinators were in place for these committees in some service areas but not all.

In order to inform decisions about where local resources would be best deployed, managers had some systems in place to assist them. Data collected locally informed managers of pressure points on their service which indicated an unmet need. This data was reported on a monthly basis to the national office. This review found that similar pressure points existed nationally, although some service areas experienced inflated pressures when compared with others.

Data routinely collected included numbers of cases allocated and awaiting allocation by their priority level and length of time waiting. Area managers confirmed that figures related to these elements of their service were very influential on the decisions they made about resources. For example, this review found that data collected influenced the formation of some designated teams to manage specific types of referrals and influenced the number of staff allocated to managing incoming referrals.

Some area managers said that they had temporarily allocated additional staff to managing elements of the system where pressures existed and that they would re-deploy them to other areas once these pressures had been alleviated. This was evident in action plan updates they provided to HIQA following inspection findings in this regard.

This review found that in order to meet national objectives through effective and efficient resource management, there had been a national shift towards a common configuration of social work departments into three 'pillars', each with its own team. These pillars included child protection and welfare; alternative care; and partnership, prevention and family support.

The Review Team found that reconfiguration was ongoing in some service areas, but vacant posts were a contributing factor to delays in this configuration. However, the area managers involved were confident that having teams dedicated to each pillar would enhance performance of their service and increase levels of accountability.

Several area managers described initiatives of redeploying staff resources to teams that managed incoming referrals in order to reduce the number of cases awaiting allocation and waiting times. These reductions were reflected in annual figures produced by Tusla for many service areas. However, some area managers described their service as being overwhelmed by the amount of existing cases and incoming referrals in ratio to the number of staff in place. They explained that their service did not have the staff to redeploy to this area of service delivery.

Area managers differentiated between deploying newly allocated posts and the re-deployment of staff currently in post to areas of greatest need. For some, no change or limited change would happen until new or vacant posts were filled, and for others, moving current staff would or had created difficulties in providing other elements of the service. For example, one service area had developed a strategy to allocate current resources to manage referrals and to ensure all children were allocated a social worker on a consistent basis. This had the required impact of all children having an allocated social worker.

However, the area manager said that as a result, other elements of their service were not as advanced as they should be. Additionally, the geographical spread of some service areas meant that services were delivered across several counties. This impacted somewhat on the ability of area managers to redeploy staff from one county to another. The majority said that this was managed through expressions of interest by staff to move location or indeed from one team to another.

Commissioning of resources

In responding to the diverse needs of children and families, voluntary and community-based providers receive funding from Tusla to deliver services on its behalf. Provision of services via community and voluntary organisations is a cornerstone of Tusla's national service delivery model. A significant part of that model is responding to welfare referrals and re-directing families away from social work departments to community-based supports if appropriate.

Some service areas were under-resourced in terms of community and voluntary-based services and this limited their capacity to deliver the breadth of services that children and families needed. On a national scale, there were significant numbers of medium- and low-priority cases awaiting allocation to a social worker and with no community-based interventions or supports in place.

Area managers said that these deficiencies had also impacted on their ability to meet some national objectives and to deliver the national service delivery model in the form it is intended. As such, the commissioning of targeted community- and voluntary-based services is a priority on a national and local level and is crucial to the success of Tusla's child protection strategy as outlined to the Review Team.

In November 2016, a draft Tusla Commissioning Strategy[16] was in place, which relates to both internal and external services. The Chief Operations Officer explained that six service areas were identified as pilot sites to implement this strategy and adopt a common approach to commissioning external services. At the time of this review, Tusla planned to roll out this approach nationally in 2017.

This is a welcome initiative as HIQA has repeatedly recognised the need for greater equity and responsiveness to inform the provision of support services on a national basis. Senior managers informed the Review Team that that this approach provides a framework for ensuring services that they commission are targeted, needs-based and well monitored for effectiveness and efficiency. Strengthened governance arrangements are inbuilt within this new approach.

At an operational level, area managers informed the Review Team that they had begun the process of reviewing service level agreements with providers to ensure they met local needs. Some area managers said that they had withdrawn or reduced funding of some services where there had been duplication or where the service being provided was no longer required. This was evident in updated action plans they provided to HIQA. All of the area managers interviewed had systems in place to monitor funded providers, including ways of holding them to account for spending and assessing their performance against key performance indicators. Area managers said that they met with these services regularly to ensure local needs were being met and to monitor their effectiveness. However, the Review Team found that systems of monitoring of these services were not always strong enough.

Chapter 5
Information and Communication systems

Introduction

The effective use of both information and information systems is central to the quality and safety of any child protection and welfare service. Information systems must be fit for purpose to ensure the safety, storage and availability of up-to-date quality information in order to protect children and support decision-making about their safety.

The information systems required to support child protection services need to perform several key functions:

- to record information about children and families who come in contact with child protection and welfare services
- to protect information about children and families held by the service
- to make appropriate information available to those who require it for the protection of children.

Findings

This review finds that current information communications technology (ICT) systems pose a significant risk to Tusla, both in relation to the delivery of safe services and ensuring its ongoing programme of reform. Current systems do not facilitate adequate sharing of information nationally to protect children. In addition, these systems are not sufficient to support the full implementation of Tusla's child protection and welfare strategy going forward. Information collected and analysed by Tusla services is limited and not always dependable. In this regard, information and information systems cannot provide the necessary assurances in relation to the safety and quality of the service.

Information systems in Tusla child protection and welfare services

At the time of this review, Tusla had identified significant shortcomings in relation to the safety, provision and support of ICT systems across the service. These risks resulted in ICT being placed on Tusla's corporate risk register and it remained there over the course of the review period.

The introduction of an integrated information system is critical for Tusla child protection and welfare services. At the time of this review, 3 out of 17 service areas continued to operate a paper-based system.

The remaining 14 use electronic systems — but they are not the same systems and cannot be integrated. Area managers explained to the Review Team that where electronic information systems are in place, they vary in terms of the functions they can provide and that some are more advanced than others. Furthermore, the geographical boundaries of some service areas have changed which means some offices within the same service area have electronic systems while others do not.

Monthly performance figures provided to the Senior Management Team can be generated in a timely and efficient way by some service areas but not others. The collection of this data for several service areas entails a manual process of collecting, reviewing and validating data, which is cumbersome, resource intensive and open to error.

The Chief Operations Officer explained to the Review Team that interim remedial actions were taken between 2015 and 2016 to support the collection of data in service areas which had experienced serious difficulties in this regard, and that as a result, quality and dependability of the data collected had improved. This was evident in updated action plans provided by service areas in relation to judgments of significant risk made by HIQA following inspection.

The CEO informed the Review Team that a new integrated information system has been piloted in one service area and will go live in that area in January 2017. Members of Tusla's senior management team expected that this system will be introduced across all service areas by the end of 2018. An ICT strategy[17] has been developed for the service from 2017 onwards and enhanced governance arrangements were being put in place, including the recruitment of a director of ICT and the recruitment of additional ICT support staff.

The CEO also explained that its arrangements with the HSE — who at the time of the review provided a significant portion of ICT supports to Tusla — would be strengthened in 2017, including, as outlined in the ICT Strategy, the need for an adequate service level agreement between the two organisations.

The majority of area managers informed the Review Team that they have access to an information officer at local or regional level and that their role is to validate and analyse information. However, several area managers informed the Review Team that although the data they collect is reviewed, given the systems they have in place, they cannot be assured of its accuracy. The Review Team examined monthly data collected across 14 service areas between June and September 2016 and found discrepancies in relation to two of the service areas' data. Tusla acknowledged that errors had occurred and they were corrected.

The overall impact of not having an integrated information system in Tusla child protection and welfare services is that data collected by Tusla is not always timely, accurate or dependable. Furthermore, information about children known to the service cannot be appropriately shared and accessed on a national scale and this did not support the service to protect children.

Considering ongoing concerns about the accuracy and dependability of data currently collected by Tusla, the Review Team explored the governance arrangements in place to migrate current data to the new integrated information system. The Chief Operations Officer and the Business Manager (of Operations) said this was being led by a project team. A process of cleansing and validating current data was underway at the time of the review in preparation for migration of data onto the new system to ensure it is populated with correct data from the date it goes live in each service area.

Child Protection Notification System

Children who are identified by child protection and welfare services as being at risk of ongoing harm are listed on a Child Protection Notification System (CPNS) in accordance with Children First (2011).

Prior to 2015, each service area maintained individual child protection notification systems which were not integrated and could not be accessed on a national basis. These systems were not available on a 24-hour basis, and oversight arrangements by senior managers were inadequate.

In 2015, Tusla implemented a National Child Protection Notification System. This review found that the new system has good governance arrangements in place which ensure it is well maintained and is effective. There are appropriate mechanisms in place to protect information the system holds about these children. The CEO and Chief Operations Officer told the Review Team that the new system is accessible nationally and is working well.

It is accessible on a 24-hour basis, seven days a week by agencies such as hospitals and An Garda Síochána. Area managers explained that although this system is maintained at a national level, each area has a super-user who inputs local data and keeps information about children updated. They informed the Review Team that they receive reports on enquiries made about children in their service and that they are alerted, for example, if a child on the system does not have an allocated social worker.

Data about children placed on this system was examined in each service area by the Review Team. They found there had been prompt responses to unallocated cases, and the reason they are unallocated had been closely monitored by the area manager and senior managers. In essence, this system has greatly improved local and national oversight of children who are placed on the CPNS and has improved the appropriate sharing of information between key agencies for the purpose of protecting children. This has increased the level of accountability for decisions about children at risk of ongoing harm. At the time of writing, and as stated earlier, all children on the CPNS had an allocated social worker (see Table 2).

Additional information systems

Tusla has a range of other information which is accessible in electronic format. For example, there is an electronic 'hub' which provides staff with ready access to information on policy, procedures and business practices. There is also a website which provides essential information about Tusla services to the general public and supports them to report concerns about children or make a complaint about service provision. This website also provides contact information on social work offices and recruitment opportunities within the service.

Quality information

Tusla's child protection and welfare service requires quality data and information to measure its performance to identify what it is doing well and where it most needs to improve. In the context of building a culture of quality improvement and the lack of a nationally integrated information system as discussed previously, Tusla has identified a limited but important set of figures which service areas routinely return on a monthly basis. This data is outlined in the section related to performance indicators. It is used to identify pressures on various points in the child protection and welfare system and to monitor for performance in key areas.

In order to plan and deliver a service based on data gathered and analysed, quality data is needed and systems of validation are necessary. There are information officers in place in most service areas and regions who have developed systems of validation. Where primarily paper-based systems are in place (Midlands, Louth/Meath and Cavan/Monaghan), the potential margin of error increases, and the ability of the service area to generate a wide range of reports based on manually collected data is limited.

Some service areas have advanced systems which support them to collect a wide range of additional data relevant to their service. Area managers for these service areas told the Review Team that they could and did generate reports on various areas of performance to support decision-making and practice improvements. The ability to generate this level of data in relation to local service performance is not a facility which is readily available to service areas with less advanced or paper-based information systems, as the manual processes involved are too burdensome.

Record-keeping

The Review Team found that local quality assurance mechanisms related to record-keeping are not robust and are not driving improvements at the pace and scale required.

Maintaining good quality, up-to-date records in relation to children and their families is central to ensuring information about children can contribute to good decisions about their welfare and ongoing safety.

Tusla has standard business processes in place to guide practitioners on maintaining good quality records on children and families. At the time of the review, Tusla continued to operate under the HSE's records management policy.

Monitoring and review of case files is carried out by principal social workers and team leaders. However, service directors and area managers acknowledged to the Review Team that practice is not consistent in this regard. Service directors confirmed at interview that many children do not have an individual case file — rather, their records form part of a family file. This is not in line with good practice.

Several area managers identified standard business processes as a contributing factor to delays in updating case records as they are administrative processes which take time to complete and strain social work resources. Furthermore, service directors noted a lack of improvement in maintaining case chronologies across Tusla child protection and welfare records. This is a shortcoming in record-keeping that has well been established as one which can diminish the ability of child protection and welfare services to recognise issues such as long-term neglect. It was envisaged by managers that additional resources allocated in the latter stage of this review would promote improvements in this area, as would an integrated information system.

Maintaining confidential case records securely and archiving of files was a concern reported by service directors to the Review Team. They pointed out that space was at a premium within Tusla offices and that archiving was not always adequate. For example, they explained that in some service areas there was an archiving contract, but that this was not available across Tusla. Some records were held locally and some off-site and they considered a comprehensive archiving and storage system as a priority.

In relation to ICT and best use of information, HIQA child protection and welfare inspections carried out in 2016 identified ongoing risks. Information systems in two of the service areas remained inadequate and in one, information systems were found to be unfit for purpose. A third service area was piloting the new ICT system for Tusla and although this was progressing well, dual systems, electronic and paper based, were being used. Neither was identified as the master system. Where risks were identified, remedial actions were taken, but Tusla service areas continued to await the full implementation of the National Child Care Information System (NCCIS).

Appendix A
Methodology*

Review Team

The Review Team members included HIQA staff — who are authorised persons to conduct the review, in line with section 70(1)(a) of the Health Act 2007 — and external representatives with expertise in child protection and welfare from Ireland and Scotland were engaged in aspects of the review.

Assessment framework

An assessment framework was developed by HIQA in accordance with the scope of the review. The lines of enquiry set out in the assessment framework were based on four of the six themes provided in National Standards for the Protection and Welfare of Children. They reflect the dimensions related to the service provider's capacity to deliver high-quality and safe services.

The capacity and capability dimensions are:

- Leadership, governance and management
- Use of resources
- Workforce
- Use of information.

Phases of the Review

The Health Information and Quality Authority's review process took place over four phases. These four phases are outlined here.

Phase one

Phase one included inspections of child protection and welfare services in three Tusla service areas and a review of documentation and data (January 2016 to February 2016).

* Appendix A of HIQA Governance Review.

The Review Team issued formal data, information and document requests to Tusla covering the following areas:

- corporate governance and management arrangements
- corporate and operational strategy and planning
- operational policies, procedures and guidance
- workforce and staffing levels
- information systems
- reports on data related to social work activity.

It reviewed all documentation provided by Tusla and analysed returned data. In addition, HIQA carried out a detailed analysis of published Tusla performance reports for the previous 12 months.

Phase two

Phase two involved individual interviews with the Chairperson of the Tusla board of management, its CEO, and selected members of the Tusla Senior Management Team; and senior operational managers (February 2016) whose roles related to aspects of the governance structure.

This provided the Review Team with the opportunity to gather information about the governance and management of the service; seek clarification on issues identified during the review of data and information; and to inform the findings of the review. This phase ensured that senior managers at various levels within the organisation were met by the Review Team.

Phase three

Phase three involved follow-up monitoring activity in relation to updated actions plans issued by HIQA to 14 service areas inspected by HIQA between 2012 and 2015, to assess progress against actions required following these inspections. It also involved on-site visits to all 17 service areas to carry out individual interviews with area managers and a review of local data on risk and performance activity (March 2016 – October 2016).

During this phase, members of the Review Team carried out on-site visits to all 17 service areas, which involved interviewing area managers and reviewing local documents and data. This ensured the Review Team had sought the views of managers at both corporate and operational levels and enabled the Review Team to gain insight into how embedded governance arrangements were across the organisation nationally.

Phase four

In phase four, individual follow-up interviews took place with selected members of the Tusla senior management team, while this phase also included a review of additional data and information (December 2016).

The Review Team conducted individual follow-up interviews with selected members of Tusla's senior management team who had been interviewed during Phase two. Considering the time lapse between the review phases, this provided the Review Team with an opportunity to clarify any issues identified during the third phase; seek further information or data; provide senior managers with the opportunity to update the Review Team on progress in areas identified during Phase two; and to inform the review findings.

The Review Team wish to thank all staff involved for their assistance and cooperation over the course of this review.

Triangulation process

The review process involved the receipt and analysis of information from different sources, including interviews with a broad range of managers and documentation and data. In making a review judgment, HIQA used a process of gathering and analysing information from different sources of information such as documents, interviews and data to ensure the judgment was well informed. This is a process known as 'triangulation'.

Table 5 below illustrates the on-site aspect of the HIQA review which was carried out by members of the Review Team. Appendix E provides an account of the documentation and data reviewed as part of the review process.

Table 5. Areas covered by the HIQA review team

Note: The Midlands, Sligo/Leitrim/West Cavan and Mid West service areas were also subject to a full inspection of their child protection and welfare services carried out by HIQA inspectors between January and March 2016.

Service Area	Tusla Region	Number of on-site visits
Donegal	West	1
Galway	West	1
Sligo/Leitrim/West Cavan	West	1
Mayo	West	1
Mid West	West	1
Kerry	South	1
Cork	South	1
Carlow/Kilkenny	South	1
Waterford/Wexford	South	1
Dublin South East/Wicklow	Dublin Mid Leinster	1
Dublin South Central	Dublin Mid Leinster	1
Dublin South West/Kildare/West Wicklow	Dublin Mid Leinster	1
Midlands	Dublin Mid Leinster	1
Dublin North	Dublin North East	1
Dublin North City	Dublin North East	1
Louth/Meath	Dublin North East	1
Cavan/Monaghan	Dublin North East	1

Appendix B
Legislation — Tusla*

- Child and Family Agency Act 2013
- The Guardianship of Infants Act 1964
- The Status of Children Act 1987
- The Adoption Act 2010
- Adoption (Amendment Act) 2013
- The Child Care Acts 1991 (As Amended)
- Children and Family Relationships Act 2015
- Children First Act 2015
- Health Act 2007
- Freedom of Information Act 2014
- National Vetting Bureau (Children's and Vulnerable Persons) Act 2012
- Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act 2012
- The Family and Child Relationships Act 2015
- The Children Act 2001 (As amended)
- Data Protection Act 1998
- Data Protection Act (Amendment Act) 2003
- The Domestic Violence Act 1996
- The Education Welfare Act 2000
- Youth Work Act 2001
- Protections for Persons Reporting Child Abuse Act 2008

* Appendix B of HIQA Governance Review.

Appendix C
List of data collected by Tusla*

Child Protection and Welfare Services

- Referrals (Child Welfare and Child Abuse)
- Child Protection Notification System
- Crisis Intervention Service / Out-of-hours Service

Children in Care

- Number of Children in Care
- Number of Children in Care by Care Type
- Children in Private Placements
- Children in Care with an Allocated Social Worker
- Children in Care with a Written Care Plan
- Children in Care in Education

Social Work Activity Information

- Open Cases
- Open Cases Allocated / Awaiting Allocation
- Cases Awaiting Allocation by Priority Level
- Cases Awaiting Allocation by Waiting Time

Aftercare Services

- Young adults in receipt of aftercare services
- Children in care with an aftercare plan / allocated aftercare worker
- Young adults discharged from care by reason of reaching 18 years

* Appendix C of HIQA Governance Review.

Adoption Services

- Information and Tracing Service
- Adoption

Foster Carers

- Number of foster carers
- Foster carers approved and on the Panel of Approved Foster Carers
- Foster carers (relative) unapproved

Quality Assurance

- Internal Inspection and Monitoring
- HIQA Inspections

National Early years Inspectorate

- New Developments
- Activity Data

Educational Welfare Services

- Number of New Children
- School Attendance Notices and Summonses under Section 25
- Children educated in places other than recognised schools
- Applications and Assessments under Section 14
- Educational Welfare Officers – Workforce Position

Human Resources

- Workforce Position
- Absence Rate
- Social Work Staff (whole-time equivalent [WTE])
- Residential Services Staff (WTE)
- Workforce Learning and Development

Finance

- Financial Performance

Appendix D
Documents reviewed as part of the HIQA Governance review process* **

1. Child and Family Agency (Tusla). *Draft Information Governance - Validation and Quality Assurance of Data Returns Procedure*. Unpublished. Dublin: Child and Family Agency (Tusla); 2015.
2. Child and Family Agency (Tusla). *Tusla Corporate Risk Register February 2016*. Unpublished. Dublin: Child and Family Agency (Tusla); February 2016.
3. Child and Family Agency (Tusla). *Draft Creating a culture of quality. The Child and Family Agency's Quality Assessment and Improvement Framework.* Dublin: Child and Family Agency (Tusla); 2015.
4. Child and Family Agency (Tusla). *Review of the Caseload Management Tool for Social Workers-National Survey-Area Managers and Principal Social Workers.* Unpublished. Dublin: Child and Family Agency (Tusla); 2016.
5. Child and Family Agency (Tusla). *Review of the Caseload Management Tool for Social Workers and Team Leaders.* Unpublished. Dublin: Child and Family Agency (Tusla); 2016.
6. Child and Family Agency (Tusla). *Caseload Management Review Outline Methodology for Presentation to the Steering Group.* Unpublished. Dublin: Child and Family Agency (Tusla); 2016.
7. Child and Family Agency (Tusla). *Corporate Plan 2015–2017*. Dublin: Child and Family Agency (Tusla); 2015.
8. Child and Family Agency (Tusla). *Business Plan 2015*. Dublin: Child and Family Agency (Tusla); 2015.
9. Child and Family Agency (Tusla). *Tusla's Child Protection Processes and systems are responding to children at risk in a timely manner.* Unpublished. Dublin: Child and Family Agency (Tusla); 2015.
10. Child and Family Agency (Tusla). *Business Plan 2016.* Dublin: Child and Family Agency (Tusla); 2016.
11. Child and Family Agency (Tusla). *Regional Business Plan — DNE 2015.* Unpublished. Dublin: Child and Family Agency (Tusla); 2015.

* Appendix D of HIQA Governance Review.

** All online references accessed at time of preparing this review. Web addresses may change over time.

12. Child and Family Agency (Tusla). *Regional Business Plan — South 2015.* Unpublished. Dublin: Child and Family Agency (Tusla); 2015.

13. Child and Family Agency (Tusla). *Regional Business Plan — West 2015*. Unpublished. Dublin: Child and Family Agency (Tusla); 2015.

14. Child and Family Agency (Tusla). *Regional Business Plan — Mid-West 2015*. Unpublished. Tusla; 2015.

15. Child and Family Agency (Tusla). *Regional Business Plan — Mid-West 2015*. Unpublished. Dublin: Child and Family Agency (Tusla); 2015.

16. Child and Family Agency (Tusla). *Regional Business Plan — Galway/ Roscommon 2015*. Unpublished. Dublin: Child and Family Agency (Tusla); 2015.

17. Child and Family Agency (Tusla). *Regional Business Plan — Donegal 2015*. Unpublished. Dublin: Child and Family Agency (Tusla); 2015.

18. Child and Family Agency (Tusla). *Regional Business Plan — Sligo/Leitrim/ West Cavan 2015*. Unpublished. Dublin: Child and Family Agency (Tusla); 2015.

19. Child and Family Agency (Tusla). *West HR Business Plan*. Unpublished. Dublin: Child and Family Agency (Tusla); 2015.

20. Child and Family Agency (Tusla). *List of other Child and Family Agency Strategy Documents*. Unpublished. Dublin: Child and Family Agency (Tusla); 2016.

21. Quinlan, C. *Child Protection and Welfare Policy Catalogue.* Unpublished. Dublin: Child and Family Agency (Tusla); 2015.

22. Child and Family Agency (Tusla). *Criteria to Determine Categorisation of Policy Review*. Unpublished. Dublin: Child and Family Agency (Tusla); Undated

23. Child and Family Agency (Tusla). *Tusla Senior Management Team Structure*. Dublin: Child and Family Agency (Tusla); 2015.

24. Child and Family Agency (Tusla). *Quality, Risk and Service Improvement Team and Committee Structure*. Unpublished. Dublin: Child and Family Agency (Tusla); 2015.

25. Child and Family Agency (Tusla). *DNE Organogram*. Unpublished. Dublin: Child and Family Agency (Tusla); 2015.

26. Child and Family Agency (Tusla). *DML Organogram*. Unpublished. Dublin: Child and Family Agency (Tusla); 2015.

27. Child and Family Agency (Tusla). *South Organogram*. Unpublished. Dublin: Child and Family Agency (Tusla); 2015.

28. Child and Family Agency (Tusla). *West Organogram*. Unpublished. Dublin: Child and Family Agency (Tusla); 2015.

29. Child and Family Agency (Tusla). *Code of Governance*. Dublin: Child and Family Agency (Tusla); 2016.

30. Child and Family Agency (Tusla). *The Standards of Integrity and Codes of Conduct*. Dublin: Child and Family Agency (Tusla); Undated

31. Child and Family Agency (Tusla). *The Child and Family Agency Internal Audit Committee, Internal Audit Charter*. Dublin: Child and Family Agency (Tusla); Undated

32. Child and Family Agency (Tusla). *Ireland's Child and Family Agency 'Towards a Shared Purpose'*. Dublin: Child and Family Agency (Tusla); 2014.

33. Child and Family Agency (Tusla). *Participation of Children and Young People – Our Approach*. Dublin: Child and Family Agency (Tusla); Undated

34. Child and Family Agency (Tusla). *Expectations, Rights, Responsibilities.* Dublin: Child and Family Agency (Tusla); 2014

35. Child and Family Agency (Tusla). *Talk to us — Information for Children on the Child Protection Case Conference and Child Protection Notification System.* Dublin: Child and Family Agency (Tusla); 2015.

36. Child and Family Agency (Tusla). *National Audit of the Standard Business Processes for Child Protection and Welfare Social Work Services: Intake and Initial Assessment.* Unpublished. Dublin: Child and Family Agency (Tusla); 2015.

37. Child and Family Agency (Tusla). *Report of the 2015 National Review of Cases Awaiting Allocation.* Dublin: Unpublished. Child and Family Agency (Tusla); 2015.

38. Child and Family Agency (Tusla). *National Assurance Review of Retrospective Abuse Cases Awaiting Allocation — Review Proposal*. Unpublished. Dublin: Child and Family Agency (Tusla); Undated

39. Child and Family Agency (Tusla). Who are the children on the Child Protection Notification System? — Developing a profile of children who are listed as active on the CPNS to better inform the delivery and development of child protection services. Dublin: Child and Family Agency (Tusla); Undated

40. Buckley, H. National Review Panel — Annual Report. National Review Panel; Dublin: 2014.

41. Child and Family Agency (Tusla). Overview of Performance from HIQA's 2014 Inspection Reports: Tusla Child Protection and Welfare Services. Dublin: Child and Family Agency (Tusla); 2014.

42. Child and Family Agency (Tusla). *Louth/Meath Implementation Template*. Unpublished. Dublin: Child and Family Agency (Tusla); 2015.

43. Child and Family Agency (Tusla). *Midlands Implementation Template*. Unpublished. Dublin: Child and Family Agency (Tusla); 2015.

44. Child and Family Agency (Tusla). Registration, Inspection and Monitoring Service - National Significant Event Notification Data. Dublin: Child and Family Agency (Tusla); 2015.

45. Health Service Executive. *Integrated Risk Management Policy*. Unpublished. Dublin: Health Service Executive; 2013.

46. Child and Family Agency (Tusla). *Draft Tusla Risk Management Policy and Procedure*. Dublin: Unpublished. Child and Family Agency (Tusla); 2016

47. Child and Family Agency (Tusla). *Policy and Procedure for the Escalation and Notification of Reportable Events (including Child Deaths, Serious Incidents and Need To Know Events)*. Unpublished. Dublin: Child and Family Agency (Tusla); 2016.

48. Health Service Executive. Guideline for Systems Analysis Investigation of Incidents and Complaints. Dublin: Health Service Executive; 2012.

49. Child and Family Agency (Tusla). *Standardised Operation Procedures Risk Systems Administration.* Unpublished. Dublin: Child and Family Agency (Tusla); 2016.

50. Child and Family Agency (Tusla). *DRAFT Incident Management Policy and Procedure For Tusla Child and Family Agency.* Unpublished. Dublin: Child and Family Agency (Tusla); 2015.

51. Child and Family Agency (Tusla). *Integrated Performance and Activity Report —Quarter 3 2015*. Dublin: Child and Family Agency (Tusla); 2015.

52. Child and Family Agency (Tusla). *Guidance for Caseload Management — for Child and Family Agency Social Work.* Unpublished. Dublin: Child and Family Agency (Tusla); 2015.

53. Child and Family Agency (Tusla). *''Survival to Sustainability" Business Case for Investment in Children.* Unpublished. Dublin: Child and Family Agency (Tusla); 2015.

54. Child and Family Agency (Tusla). *Information Governance — Validation and Quality Assurance of Data Returns.* Dublin: Child and Family Agency; 2015.

55. Child and Family Agency (Tusla). *Workforce Learning and Development Work Plan 2016.* Unpublished.

56. *Workforce Learning and Development. National Office (Internal management).* Dublin: Child and Family Agency; 2016.

57. Child and Family Agency (Tusla). *Implementation Tracker*. Unpublished. Dublin: Child and Family Agency; Undated

58. Child and Family Agency (Tusla). *HR Strategy Business Plan 2016*. Dublin: Child and Family Agency; 2016

59. Child and Family Agency (Tusla). *Corporate Professional Development Strategy*. Dublin: Child and Family Agency; 2015.

60. Child and Family Agency (Tusla). *Policy Catalogue*. Unpublished. Dublin: Child and Family Agency; 2015.

61. Child and Family Agency (Tusla). *The Standards of Integrity and Codes of Conduct.* Dublin: Child and Family Agency; Undated

62. Child and Family Agency (Tusla). *Minutes of the Remuneration & Succession Management Committee 5th June*. Unpublished. Dublin: Child and Family Agency; 2015.

63. Child and Family Agency (Tusla). *Minutes of the R & S M Committee 16th July 2015. Unpublished.* Dublin: Child and Family Agency; 2015.

64. Child and Family Agency (Tusla). *Minutes of the R & S M Committee 27th July 2015.* Unpublished. Dublin: Child and Family Agency; 2015.

65. Child and Family Agency (Tusla). *Minutes of the R & S M Committee 16th July 2015.* Unpublished. Dublin: Child and Family Agency; 2015.

66. Child and Family Agency (Tusla). *TAG Charter.* Dublin: Child and Family Agency; 2015.

67. Child and Family Agency (Tusla). *CPNS Info for Young Child*. Dublin: Child and Family Agency; 2015.

68. Child and Family Agency (Tusla). *CPNS Info for Older Child*. Dublin: Child and Family Agency; 2015.

69. Child and Family Agency (Tusla). *CPNS Info for Teens*. Dublin: Child and Family Agency; 2015.

70. Child and Family Agency (Tusla). *Oct–Dec CPNS Report*. Dublin: Child and Family Agency; 2015.

71. Child and Family Agency (Tusla). *Social Work Activity Jan–Aug*. Dublin: Child and Family Agency; 2015.

72. Child and Family Agency (Tusla). *Social Work Activity Jan–Sept*. Dublin: Child and Family Agency; 2015.

73. Child and Family Agency (Tusla). *Social Work Activity Jan–Oct*. Dublin: Child and Family Agency; 2015.

74. Child and Family Agency (Tusla). Review Proposal — National Assurance Review of Retrospective Abuse Cases awaiting allocation. Unpublished. Dublin: Child and Family Agency; 2015.

75. Child and Family Agency (Tusla). *CPW and CPNS Proposal*. Unpublished. Dublin: Child and Family Agency; 2015.

76. Child and Family Agency (Tusla). *CPNS Profile*. Unpublished. Dublin: Child and Family Agency; 2015.

77. Child and Family Agency (Tusla). *HIQA Overview*. Unpublished. Dublin: Child and Family Agency; 2015.

78. Child and Family Agency (Tusla). *National Significant Event Notification Data*. Dublin: Child and Family Agency; 2015.

79. Child and Family Agency (Tusla). *HSE Systems Analysis*. Dublin: Child and Family Agency; 2015.

80. Child and Family Agency (Tusla). *Tusla Incident Management Policy – version 12*. Dublin: Child and Family Agency; 2015.

81. Child and Family Agency (Tusla). Policy for the Management of Consumer Feedback to include Comments, Compliments and Complaints in the Health Service Executive (HSE) — HSE Advocacy Services. Dublin: Child and Family Agency; 2015.

82. Child and Family Agency (Tusla). *Tell Us Policy*. Dublin: Child and Family Agency; 2015.

83. Child and Family Agency (Tusla). *Tell Us Children's version*. Dublin: Child and Family Agency; 2015.

84. Child and Family Agency (Tusla). *Tell Us Guide*. Dublin: Child and Family Agency; 2015.

85. Child and Family Agency (Tusla). *Tell Us Unreasonable*. Dublin: Child and Family Agency; 2015.

86. Child and Family Agency (Tusla). *Tusla procedure for developing policies, procedures and guidelines.* Unpublished. Child and Family Agency; 2015.

87. Health Service Executive. *Performance Management in the HSE*. Dublin: Health Service Executive; 2015.

88. Health Service Executive. *HSE Performance Management Form*. Dublin: Health Service Executive; 2015.

89. Health Service Executive. *HSE Performance Improvement Action Plan*. Unpublished. Dublin: Health Service Executive; 2015.

90. Commission for Public Service Appointments (CPSA). *Code of Practice Appointment*. Dublin: Commission for Public Service Appointments (CPSA); 2007.

91. Commission for Public Service Appointments (CPSA). *Code of practice – Emergency short-term Appointments to positions in the HSE – (CPSA)*. Dublin: Commission for Public Service Appointments (CPSA); 2007.

92. Commission for Public Service Appointments (CPSA). Code of practice – Appointments of people with disabilities to positions in the civil service and certain public bodies — (CPSA). Dublin: Commission for Public Service Appointments (CPSA); 2007.

93. Commission for Public Service Appointments (CPSA). *Code of practice – Atypical appointments to positions in the civil service and certain public bodies — (CPSA)*. Dublin: Commission for Public Service Appointments (CPSA); 2007.

94. Health Service Executive. *HSE Recruitment and Selection Procedures*. Dublin: Health Service Executive; 2007.

95. Commission for Public Service Appointments (CPSA). *Commission for Public Service Appointments (CPSA) Supervision Policy.* Dublin: Commission for Public Service Appointments (CPSA); 2012.

96. Child and Family Agency (Tusla). *Priority Summary TN*. Unpublished. Dublin: Child and Family Agency (Tusla); 2016.

97. Child and Family Agency (Tusla). *Training Needs Analysis*. Unpublished. Dublin North East. Dublin: Child and Family Agency (Tusla); 2016.

98. Child and Family Agency (Tusla). *Training Needs Analysis Dublin Mid Leinster*. Unpublished. Dublin: Child and Family Agency (Tusla); 2016.

99. Child and Family Agency (Tusla). *Training Needs Analysis South*. Unpublished. Dublin: Child and Family Agency (Tusla); 2016.

100. Child and Family Agency (Tusla). *Training Needs Analysis West*. Unpublished. Dublin: Child and Family Agency (Tusla); 2016.

101. Child and Family Agency (Tusla). *Work Force Development 2015*. Unpublished. Dublin: Child and Family Agency (Tusla); 2015.

102. Child and Family Agency (Tusla). *Work Force Development 201*5. Unpublished. Dublin: Child and Family Agency (Tusla); 2016.

103. Child and Family Agency (Tusla). *ICT Board Paper*. Unpublished. Dublin: Child and Family Agency (Tusla); 2015.

104. Child and Family Agency (Tusla). *ICT Power Point*. Unpublished. Dublin: Child and Family Agency (Tusla); 2015.

105. Health Service Executive. *Record Retention*. Unpublished. Dublin: Health Service Executive; 2013.

106. Health Service Executive. *Record Management Standards*. Unpublished. Dublin: Health Service Executive; 2011.

107. Health Service Executive. HSE National Financial Regulation – Retention of Financial Records. Dublin: Health Service Executive; 2014.

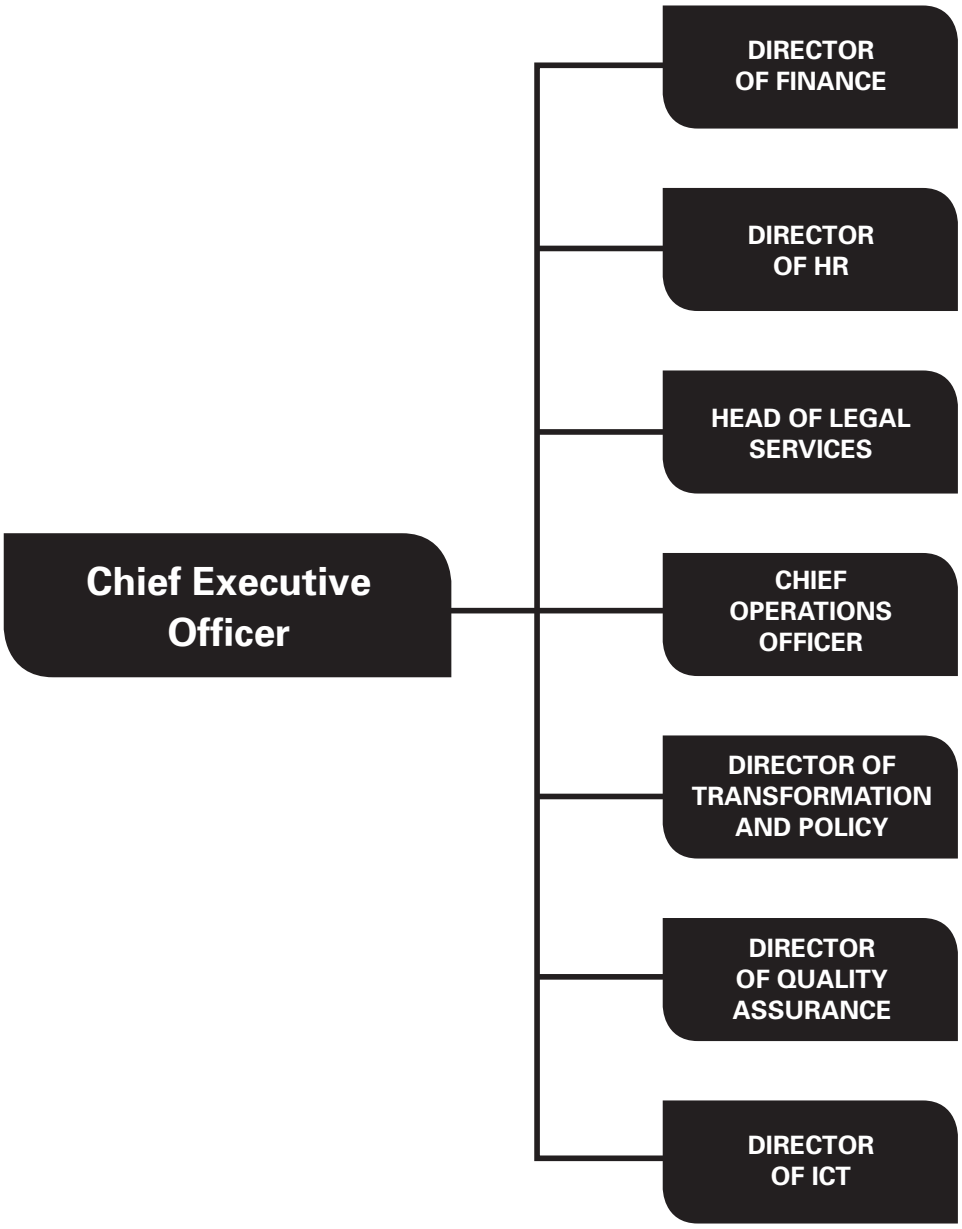
108. Health Service Executive. *Staff Guide to Data Protection and Freedom Of Information*. Unpublished. Dublin: Health Service Executive; 2004.

109. Child and Family Agency (Tusla). *Integrated Performance & Activity Report*. Dublin: Child and Family Agency (Tusla); 2015.

110. Child and Family Agency (Tusla). *Survival to Sustainability- Business Case for Investment in Children*. Unpublished. Dublin: Child and Family Agency (Tusla); 2015.

Appendix E
Organisational charts*

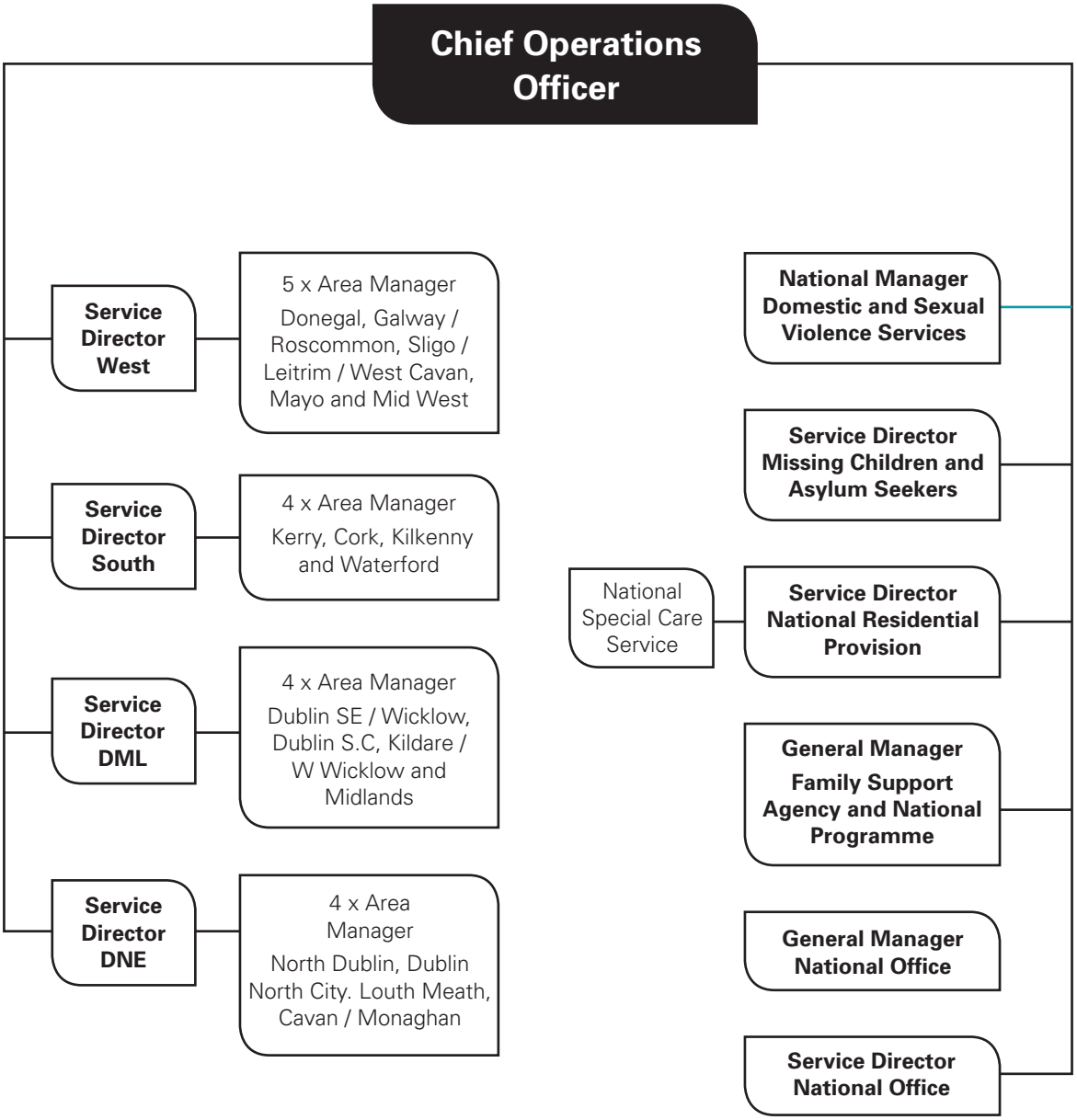
Tusla Senior Management Team Structure and governance structure for Tusla's child protection and welfare services**



* Appendix E of HIQA Governance Review.

** Based on hyperlink provided to HIQA by Tusla as part of due process feedback for the HIQA Governance Review: http://www.tusla.ie/about/organisation-chart/.

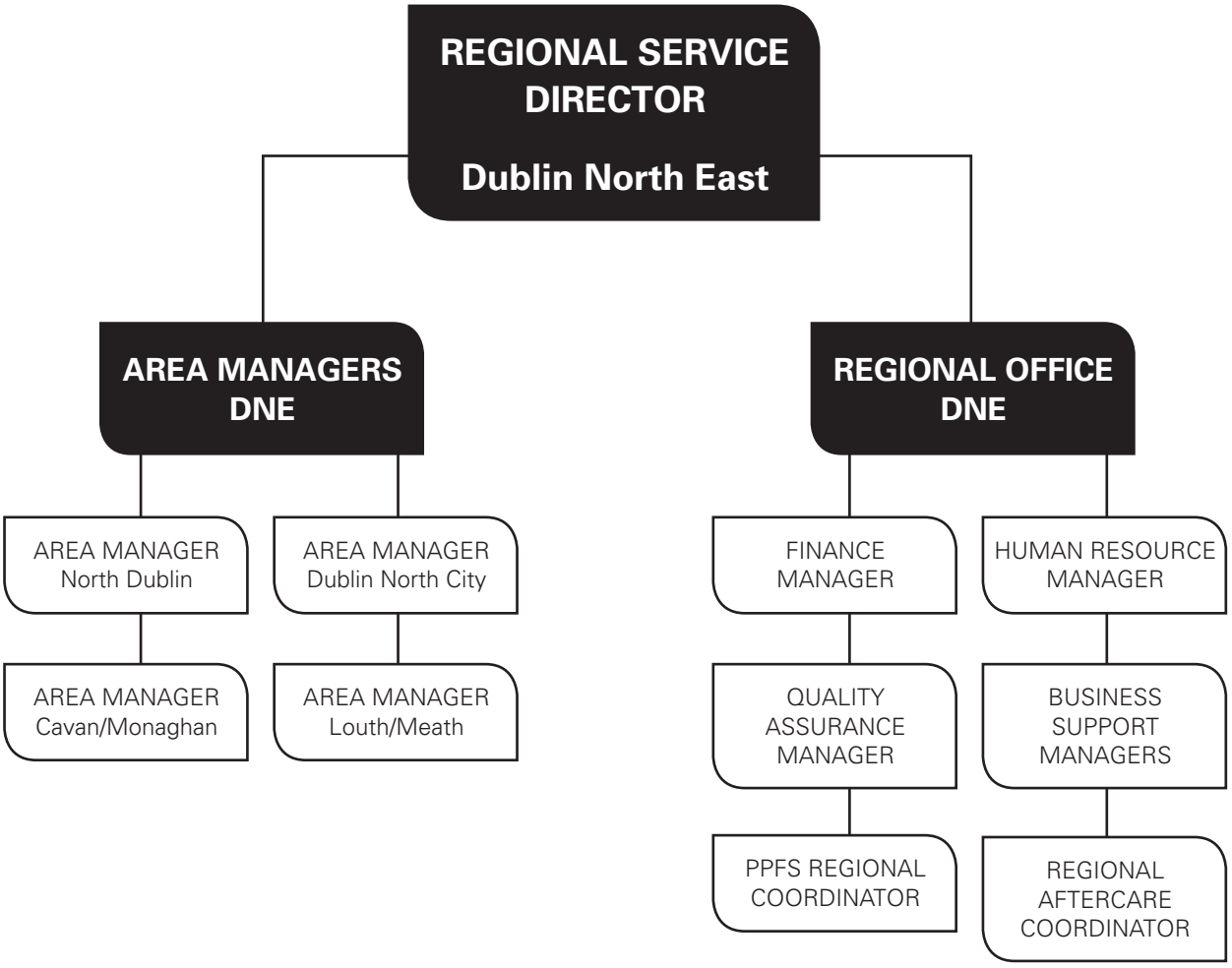
Tusla operational management team structure*



Key: DML = Dublin Midlands; DNE = Dublin North East.

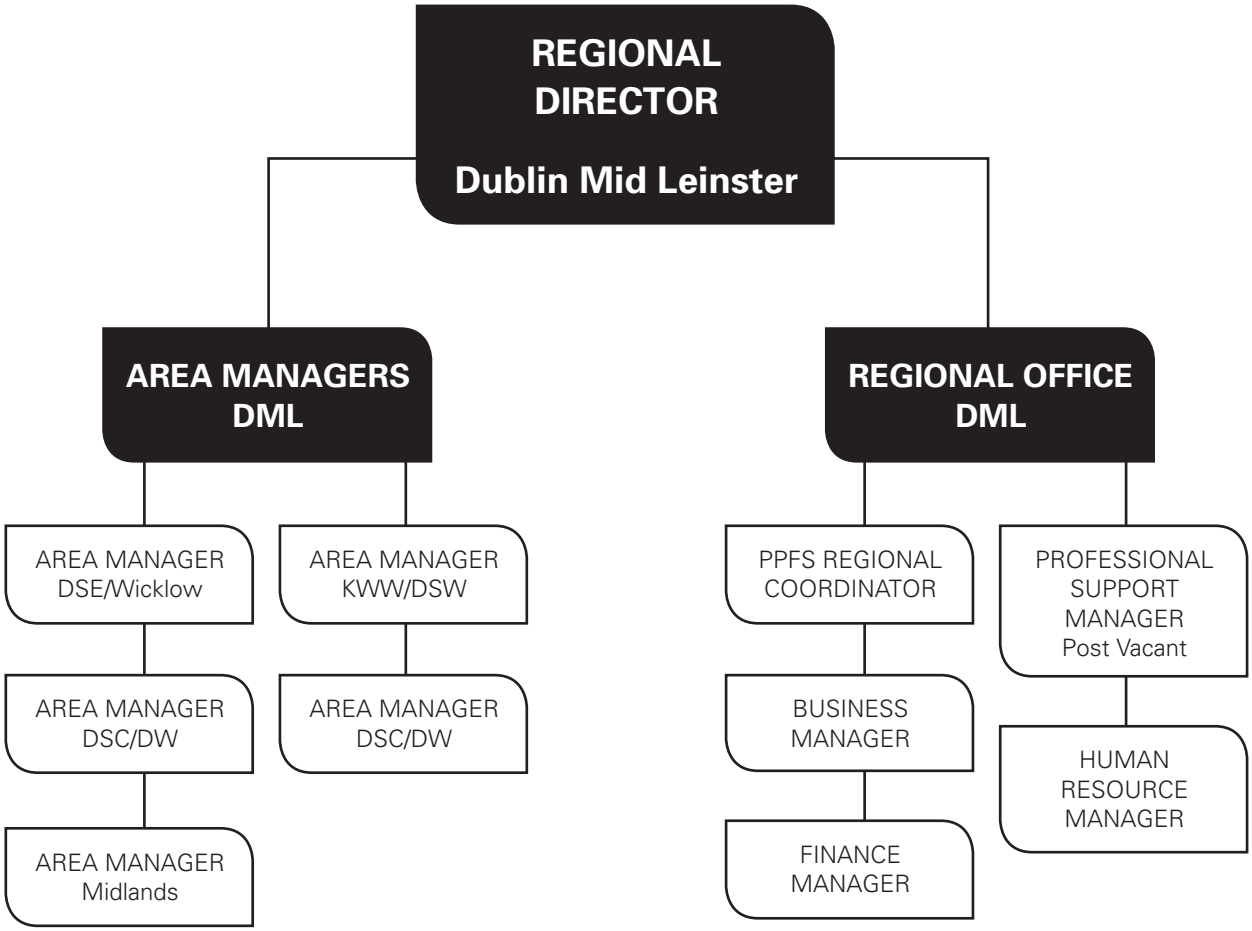
* As provided to HIQA during HIQA Governance Review.

Management structure Tusla Dublin North East*



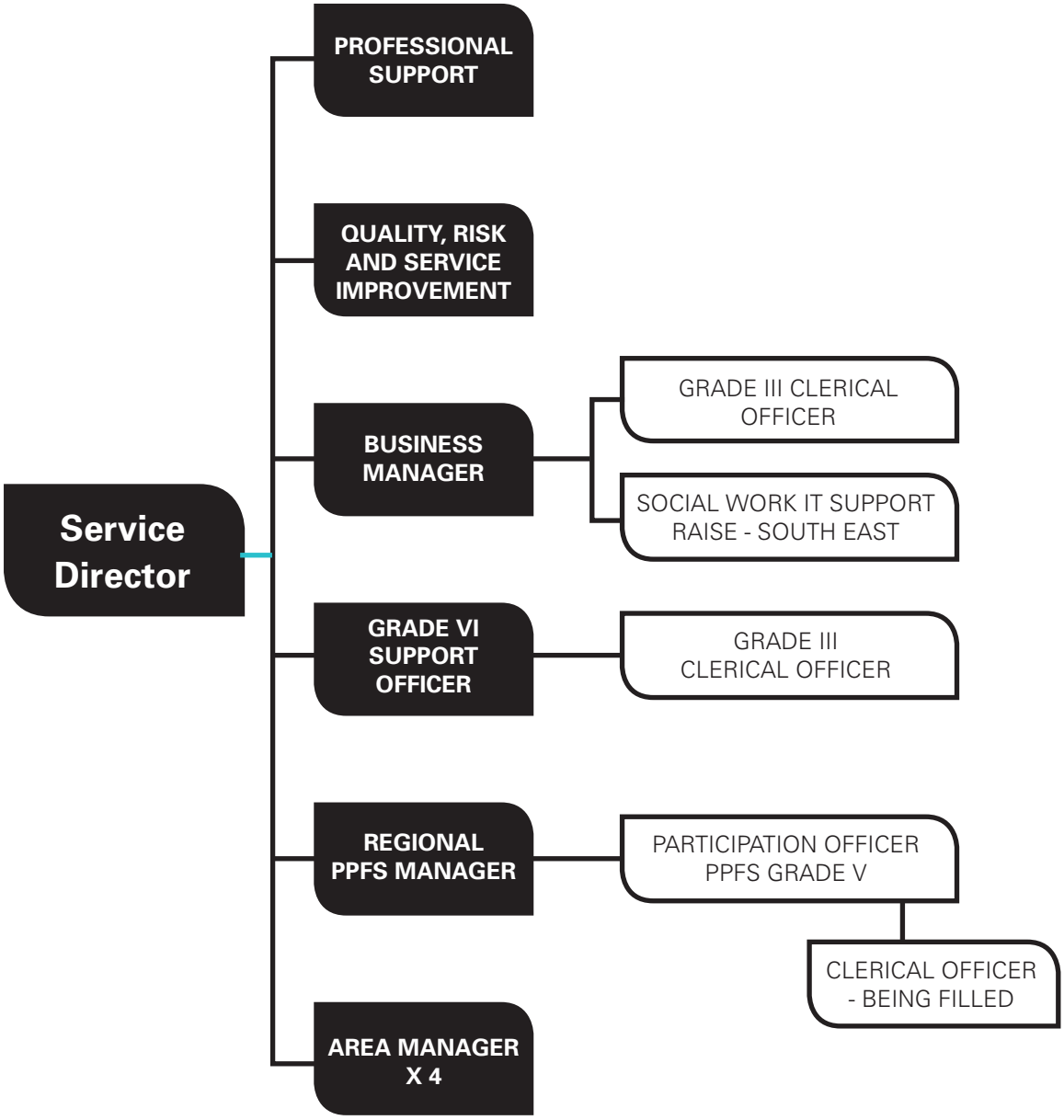
* As provided to HIQA during HIQA Governance Review.

Management structure Tusla Dublin Mid Leinster*



* As provided to HIQA during HIQA Governance Review.

Organisational structure for the South as at January 2016*

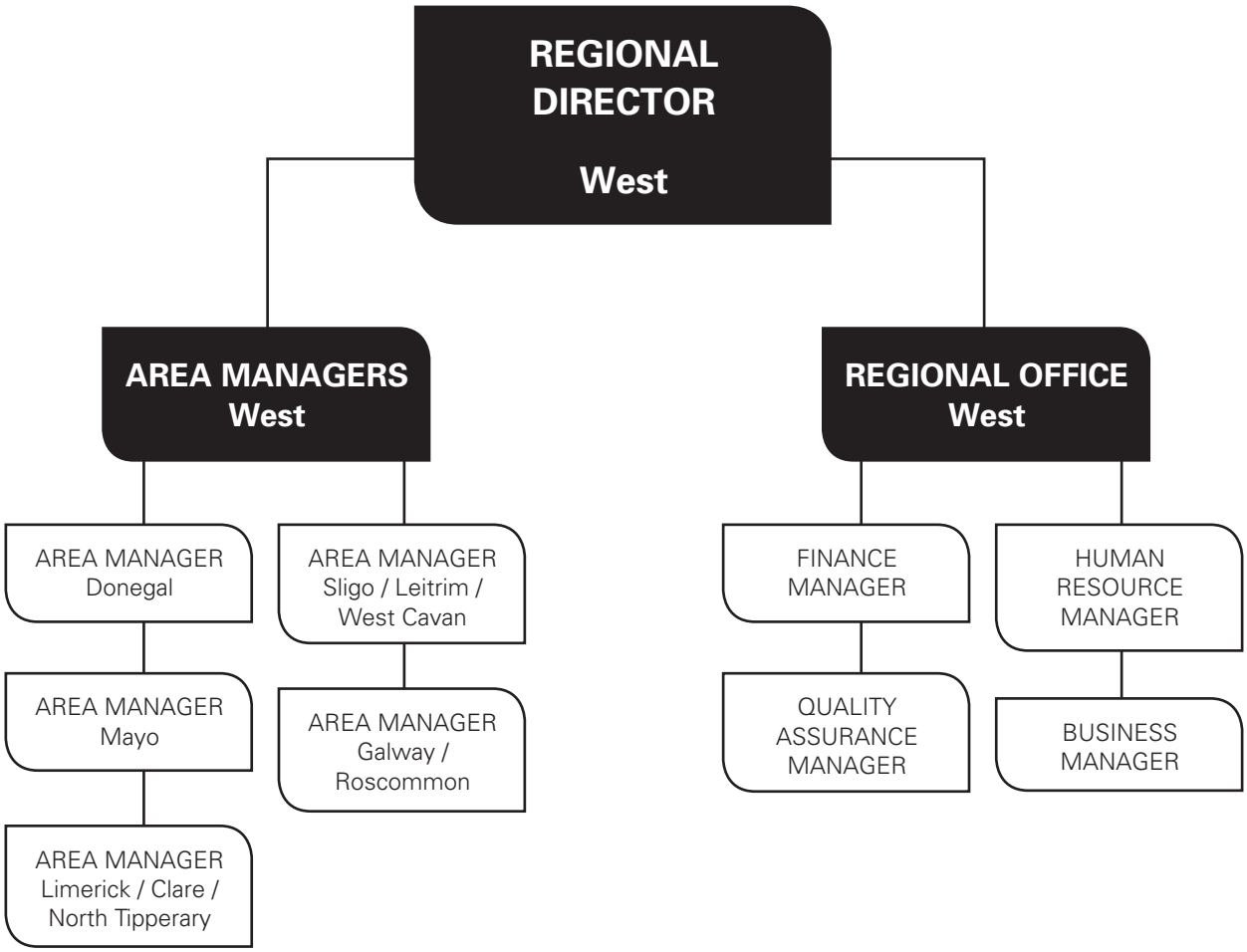


Notes:

- A Grade III for Prevention, Partnership and Family Support (PPFS) is awaiting appointment.
- Business Manager has been covering Human Resources (HR) due to vacancy in that post for past year (HR and Finance report nationally)

* As provided to HIQA during HIQA Governance Review.

Management structure Tusla West*



* As provided to HIQA during HIQA Governance Review.

References*

1. Child and Family Agency (Tusla). *Child and Family Agency (Tusla) Annual Report 2015*. Dublin: Child and Family Agency (Tusla); 2015.
2. Child and Family Agency (Tusla). *"Survival to Sustainability" Business Case for Investment in Children*. Dublin: Child and Family Agency (Tusla); 2015.
3. Child and Family Agency (Tusla). *Annual Financial Statements 2015*. Dublin: Child and Family Agency (Tusla); 2015.
4. Child and Family Agency (Tusla). *Tusla code of governance*. Dublin: Child and Family Agency (Tusla); 2015
5. Child and Family Agency (Tusla). *Tusla corporate plan 2015–2017*. Dublin: Child and Family Agency (Tusla); 2015.
6. Child and Family Agency (Tusla). *Tusla business plan 2015*. Dublin: Child and Family Agency (Tusla); 2015.
7. Child and Family Agency (Tusla). *Tusla business plan 2016*. Dublin: Child and Family Agency (Tusla); 2016.
8. Child and Family Agency (Tusla). *Tusla Commissioning strategy – November 2016*. Dublin: Child and Family Agency (Tusla); 2016.
9. Child and Family Agency (Tusla). *Annual report 2016*. Dublin: Child and Family Agency (Tusla); 2016.
10. Child and Family Agency (Tusla). *Organisational Risk Management Policy and Procedure*. Dublin: Child and Family Agency (Tusla); 2016
11. Child and Family Agency (Tusla). *Tusla Incident Management Policy and Procedure*. Dublin: Child and Family Agency (Tusla); 2016.
12. Child and Family Agency (Tusla). *Monthly Management Data Activity report October 2016*. Child and Family Agency (Tusla); 2016. Dublin: Child and Family Agency (Tusla); 2016.
13. Child and Family Agency (Tusla). *Tusla Quality improvement Framework – A Tusla Approach to improving the Quality and Safety of Services*. Dublin: Child and Family Agency (Tusla); 2016.
14. Office of the Minister for Children and youth Affairs. *The Report of the Commission to Inquire into Child Abuse* (The Ryan Report). Dublin: Office of the Minister for Children and Youth Affairs; 2009.

* To HIQA Governance Review. For references of the investigation report, see Chapter 9.

15. Child and Family Agency (Tusla). *Threshold of Need Guidance for Practitioners in Tusla Social Work Services 2014*. Dublin: Child and Family Agency (Tusla); 2014.

16. Child and Family Agency (Tusla). *Tusla Commissioning strategy – November 2016*. Dublin: Child and Family Agency (Tusla); 2016.

17. Child and Family Agency (Tusla). *Tusla ICT Strategy*. Dublin: Child and Family Agency (Tusla); 2016.

Glossary of terms and abbreviations used in the context of this investigation report

Adult of concern: a person who has had allegations of child abuse made against them and or who has been convicted of child sexual abuse in the past.

Actual risk: Potential risk is understood by Tusla to refer to risk which has not been assessed, whereas actual risk is an assessed risk an or a systems risk.

Allocated cases: cases allocated to a named social worker.

An Garda Síochána: Ireland's National Police Service.

Assessment: the purposeful gathering and structured analysis of available information to inform evidence-based decision-making. Although assessment is an ongoing process, key junctures in the child protection and welfare process require the recording of formal assessments.

Case management: the coordination of services for children and families by allocating a social worker to be responsible for the assessment of need and implementation of the child protection plan. The underlying tasks of case management include: initial and ongoing assessment, planning, implementation and regular review.

Child: a child is defined under the Child Care Act, 1991 and in Children First 2011 as a person under the age of 18 years other than a person who is or has been married.

Child protection: the process of protecting individual children identified as either suffering, or likely to suffer, significant harm as a result of abuse or neglect.

Child protection conference (CPC): an interagency and interprofessional meeting, convened by the designated person in Tusla. The purpose of the child protection conference is to facilitate the sharing and evaluation of information between professionals and parents and or carers; to consider the evidence as to whether a child has suffered or is likely to suffer significant harm; to decide whether a child should have a formal child protection plan; and if so to formulate such a plan.

Child Protection Notification System (CPNS): a Tusla record of every child about whom there are unresolved child protection issues, resulting in the child being the subject of a child protection plan. The decision to place a child on the Child Protection Notification System is made at a child protection conference.

Child protection concern: the term is used when there are reasonable grounds for believing that a child may have been, is being or is at risk of being physically, sexually or emotionally abused or neglected.

Child sexual abuse (CSA): sexual abuse occurs when a child is used by another person for his or her gratification or sexual arousal, or for that of others.

Child and Family Agency (Tusla): the dedicated State agency in Ireland responsible for improving wellbeing and outcomes for children.

Children First 2017: the national guidance for a member of the public, a professional employee or volunteer in identifying and reporting child abuse and neglect. It also sets out the statutory responsibilities for mandated persons and organisations under the Children First Act 2015 and provides information about how the statutory agencies respond to reports of concerns made about children.

Closed cases: a 'closed case' is where Tusla has completed all necessary work and or circumstances have changed and the services of Tusla are no longer required. In such cases, the matter has either been brought to a satisfactory conclusion or, for example, a person has died and a social work service is no longer required. Before a case can be closed, the social work manager must review the case and agree that it can be closed.

Complaint: an expression of dissatisfaction with any aspect of service provision.

Complainant: a child or adult who has made allegations of child abuse.

Corporate governance: the system by which services direct and control their functions in order to achieve organisational objectives, manage their business processes, meet required standards of accountability, integrity and propriety and relate to external stakeholders.

Culture: the shared attitudes, beliefs and values that define a group or groups of people and shape and influence perceptions and behaviours.

Duty intake: the process for managing incoming referrals to Tusla about reports of concern for the safety and wellbeing of a child. The duty intake team receives all new referrals and completes screening and preliminary enquiries on these. Where a referral is held on a duty or intake team, work is being completed on it, including meeting the child and or parents, but the case has not been allocated to a named social worker

Effective: a measure of the extent to which a specific intervention, procedure, treatment or service, when delivered, does what it is intended to do for a specified population.

Emotional abuse: the systematic emotional or psychological ill-treatment of a child as part of the overall relationship between a caregiver and a child. This abuse occurs when a child's basic need for attention, affection, approval, consistency and security are not met, due to incapacity or indifference from their parent or caregiver.

Evaluation: a formal process to determine the extent to which the planned or desired outcomes of an intervention are achieved.

Evidence: data and information used to make decisions. Evidence can be derived from research, experiential learning, indicator data and evaluations.

Evidence-based practice: practice which incorporates the use of best available and appropriate evidence arising from research and other sources.

Extrafamilial abuse: abuse occurring or alleged to have occurred to a child outside of the immediate family or caregivers.

Founded: there is sufficient evidence of abuse or neglect to support a finding that on the balance of probability it is likely to have occurred.

Further assessment: a further assessment will be undertaken when, following initial assessment or at any other juncture in the child protection and welfare process, it is necessary to carry out a more specific or comprehensive analysis of a child's circumstances. A further assessment may be in the form of a core social work assessment or may be based on specialist assessment by an allied health or social care service — such as addiction services, child psychology or adult mental healthcare.

Garda: the term for a police officer in Ireland.

Garda Notification: where a member of An Garda Síochána has reasonable ground for concern that a child has been, or is at risk of being, the victim of emotional, physical or sexual abuse or neglect, Tusla must be formally notified on a standardised Notification Form. Where Tusla suspects that a child has been or is being physically or sexually abused or wilfully neglected, An Garda Síochána must be formally notified.

Governance: the function of determining the organisation's direction, setting objectives and developing policy to guide the organisation in achieving its objectives and stated purpose. Effective governance arrangements recognise the interdependencies between corporate and clinical governance and integrate them to deliver high-quality and safe services to children and families.

HIQA: the Health Information and Quality Authority.

Information governance: the arrangements that service providers have in place to manage information to support their immediate and future regulatory, legal, risk, environmental and operational requirements.

Initial assessment (IA): is a time-limited process to allow the gathering of sufficient information on the needs and risks within a case so that informed decisions and recommendations can be made and actions that will result in better outcomes for children taken.

Intake record (IR): the standardised information record where Tusla is made aware by whatever means about a concern regarding a child.

Investigation: a formal enquiry to find out the facts in relation to a particular matter of public concern, which has been identified by its terms of reference.

Investigation Team: team members appointed by the Minister for Health as authorised persons under Section 70 of the Health Act 2007 for the purposes of conducting this investigation in accordance with Section 9 of the Act.

Key performance indicator (KPI): specific and measurable elements of practice that can be used to assess quality and safety of care.

Legislation: written and approved laws. Legislation can be subdivided into primary legislation (statutes, acts and bills) and secondary legislation (regulations and rules).

Methodology: a system of methods, rules and procedures used for the delivery of a process.

Multidisciplinary: an approach to the planning and delivery of care to children and families by a team of health and social care professionals who work together to provide integrated care.

National child care information system (NCCIS): an integrated and secure information system within Tusla to support the delivery of effective child protection and welfare services.

National incident management system (NIMS): the State Claims Agency's reporting system by which State authorities such as Tusla are obliged to report adverse incidents promptly.

National Review Panel: this is an independent panel established to review the deaths of children who are or have been in the care of the State.

Need to know (NTK): Tusla's system of informing senior managers about an issue or case that may, for example, draw media attention.

Neglect: an omission of care, where a child's health, development or welfare is impaired by being deprived of food, clothing, warmth, hygiene, medical care, intellectual stimulation or supervision and safety.

Open cases: are where referrals are either waiting for a service or are being actively worked on by Tusla. It includes cases held on intake, allocated, unallocated child welfare and protection and children in care cases. See also **Closed cases**.

Performance management: process which includes activities that ensure that goals are consistently being met in an effective and efficient manner. Performance management can, for example, focus on the performance of an organisation, a department, service, or the processes to deliver a service.

Person subject of an allegation of abuse (PSAA): a person who has had allegations of child abuse made against them and or whom have been convicted of child sexual abuse in the past.

Physical Abuse: is when someone deliberately hurts a child physically or puts them at risk of being physically hurt. It may occur as a single incident or as a pattern of incidents.

Policies, procedures, protocols and guidelines: a set of statements or commitments to pursue courses of action aimed at achieving defined goals.

Policy: a written operational statement of intent which helps staff make appropriate decisions and take actions, consistent with the aims of the service provider, and in the best interests of service users.

Preliminary enquiry: a process to support and help a social worker to make a decision on the action to take in response to the information reported that will result in the best outcome for the child who is the subject of the referral.

Principal social worker (PSW): the person assigned by the Child and Family Agency (Tusla) to carry out its statutory responsibilities for the safety and welfare of a child in a line management role.

Protection: process of protecting individual children identified as either suffering, or likely to suffer, significant harm as a result of abuse or neglect.

Protected disclosures: defined by 2014 legislation as protection for people who raise concerns about possible wrongdoing in the workplace.

Quality assurance: the systematic process of checking to see whether a product or service is consistently meeting a desired level of quality.

Record: includes any memorandum, book, plan, map, drawing, diagram, pictorial or graphic work or other document, any photography, file or recording (whether of sound or images or both), any form in which data are held, any other form (including machine-readable form) or thing in which information is held or stored manually, mechanically or electronically and anything that is part or a copy, in any form, of any of the foregoing or is a combination of two or more of the foregoing.

Retrospective abuse: abuse which occurred, or is alleged by adults to have occurred in the past when they were children, and the person who has had allegations of child abuse made against them is now believed to pose a current risk to children.

Retrospective disclosure: a disclosure made by an adult of abuse suffered during their childhood.

Risk: the likelihood of an adverse event or outcome.

Risk assessment: following the initial interview with the person subject of an allegation of abuse (PSAA), a decision may be made that a more substantial and forensic type of risk assessment is required. This may occur where the person subject of an allegation of abuse admits to the abuse or where there has been a conviction and further assessment is required.

Risk management: the systematic identification, evaluation and management of risk. It is a continual process with the aim of reducing risk to an organisation and individuals.

Risk register: a risk register is a risk management tool. It acts as a central repository for all risks identified by an organisation and, for each risk, includes information such as risk probability, impact, controls and risk owner.

Screening: the evaluation of a referral made for a child and or family to assess which service the referral should be forwarded to.

Service: the term in this document refers to the Child and Family Agency (Tusla).

Service level agreement (SLA): a framework for the provision of services, including details of quality and governance arrangements.

Sexual Abuse: occurs when a child is used by another person for his or her gratification or arousal, or for that of others. It includes the child being involved in sexual acts or exposing the child to sexual activity directly or through pornography.

Sexual Abuse Regional Team (SART): a dedicated team within Tusla's Dublin North East Region which deals with only retrospective cases of child sexual abuse and adults of concern.

Signs of safety: national approach to practice within Tusla which provides a range of tools for assessment and planning, decision-making and engaging children and families.

Skill-mix: the combination of competencies including skills needed in the workforce to accomplish the specific tasks or perform the given functions required for high-quality and safe care.

Social worker (SW): the person assigned by the Child and Family Agency (Tusla) to carry out its statutory responsibilities for the safety and welfare of a child.

Staff: the people who work in, for or with the service provider. This includes individuals that are employed, self-employed, temporary, volunteers, contracted or anyone who is responsible or accountable to the organisation when providing a service to children and families.

Stakeholder: a person, group or organisation that affects or can be affected by the actions of, or has an interest in, the services provided.

Standard: a statement which describes the high-level outcome required to contribute to quality and safety.

Standard business processes (SBP): a set of activities and tasks that, once completed, will accomplish an organisational goal.

Standard operational procedure (SOP): is a set of step-by-step instructions compiled by an organisation to help workers carry out routine operations relevant to the quality of the organisation.

Statement of purpose: describes the aims and objectives of the service including how resources are allocated to deliver these objectives. It also describes in detail the range, availability and scope of services provided by the overall service.

Strategy meeting: at any point during the child protection process, a strategy meeting may be called to secure the safety of the child. The purpose of this meeting is to facilitate the sharing and evaluation of information between professionals and to prepare a plan of action for the protection of a child, and their siblings if necessary.

Terms of reference: a set of terms that describe the purpose and structure of a project, committee or meeting.

The board: the Child and Family Agency's (Tusla's) board of management.

Timely: refers to action taken within a time frame which meets the welfare and protection needs of any particular child and his or her circumstances. Particular time frames are outlined in Tusla's standard business processes.

Tusla: the Child and Family Agency, the dedicated State agency in Ireland responsible for improving wellbeing and outcomes for children.

Unallocated cases: cases awaiting allocation to a named social worker.

Unfounded: there is insufficient evidence of abuse or neglect to support a founded conclusion.

Workforce: all people working in a service.

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