Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

OVERVIEW REPORT

MONITORING AND REGULATION OF CHILDREN'S SERVICES IN 2022

July 2023

Safer Better Care

About the Health Information and Quality Authority

The Health Information and Quality Authority (HIQA) is an independent statutory authority established to promote safety and quality in the provision of health and social care services for the benefit of the health and welfare of the public.

HIQA's mandate to date extends across a wide range of public, private and voluntary sector services. Reporting to the Minister for Health and engaging with the Minister for Children, Equality, Disability, Integration and Youth, HIQA has responsibility for the following:

- **Setting standards for health and social care services** — Developing person-centred standards and guidance, based on evidence and international best practice, for health and social care services in Ireland.

- **Regulating social care services** — The Chief Inspector within HIQA is responsible for registering and inspecting residential services for older people and people with a disability, and children's special care units.

- **Regulating health services —** Regulating medical exposure to ionising radiation.

- **Monitoring services** — Monitoring the safety and quality of health services and children's social services, and investigating as necessary serious concerns about the health and welfare of people who use these services.

- **Health technology assessment** — Evaluating the clinical and cost-effectiveness of health programmes, policies, medicines, medical equipment, diagnostic and surgical techniques, health promotion and protection activities, and providing advice to enable the best use of resources and the best outcomes for people who use our health service.

- **Health information** — Advising on the efficient and secure collection and sharing of health information, setting standards, evaluating information resources and publishing information on the delivery and performance of Ireland's health and social care services.

- **National Care Experience Programme** — Carrying out national service-user experience surveys across a range of health services, in conjunction with the Department of Health and the HSE.

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A message from the Chief Inspector of Social Services

Carol Grogan, Chief Inspector of Social Services, Health Information and Quality Authority

I am pleased to present this report on the regulation, monitoring and inspection of children's services in Ireland in 2022 by the Health Information and Quality Authority (HIQA) and the Chief Inspector of Social Services. These services include foster care, child protection and welfare, Oberstown Children Detention Campus, special care units and statutory children's residential centres. Importantly, it outlines what children have told us about their experiences of these services, and it also provides an overview of the factors which have influenced their quality and safety.

Overall, we found improved levels of compliance against national standards and regulations in children's services in 2022, and where risks were identified, providers were generally responsive in addressing them. The majority of children who had an allocated social worker, social care worker or keyworker spoke positively about their experience of services they received.

2022 was once again a challenging year for many children's services. There was an increase in referrals post-COVID-19 and an increase in the numbers of children from Ukraine seeking refuge. This increase in demand for services has put significant additional pressure on the Child and Family Agency (Tusla), the statutory provider of child protection and welfare services in Ireland. These additional challenges, together with existing resourcing gaps in staffing of children's services and in alternative care placements for children, impacted on the timeliness and quality of service received by some children. This affected both children in care and children availing of child protection and welfare services. The workforce planning challenges experienced by Tusla require a collaborative national strategic approach to ensure that Tusla is resourced and enabled to ensure children receive the right support and service at the right time.

The majority of children who used child protection and welfare services and were assessed as being at significant risk of harm were found to have been provided with a responsive service. Interagency working was effective, and family networks worked with Tusla to safeguard children. Despite this, children were waiting to access or receive services in many areas, and inspectors completed a number of risk-based inspections due to these ongoing challenges.

HIQA's quality improvement thematic programme, which reviewed the efficacy of the governance of foster care services, found that, overall, there were appropriate governance arrangements in place, and services were committed to continuous improvement. Similar to other services, statutory foster care services experienced common resourcing challenges around the recruitment of sufficient numbers of foster carers and social workers.

Oberstown Children Detention Campus provided children with good quality care. Children actively participated in decision-making about their care, and were also consulted in a meaningful way about the running of the campus. Children in statutory residential care also received good quality services, but it was concerning that some younger children were being admitted to residential care. This will be kept under close scrutiny.

Children in special care were generally well cared for, but providers' governance systems required strengthening to ensure full and sustained compliance with the regulations.

This overview report will provide a summary of key findings from inspections conducted in 2022.

I want to acknowledge the ongoing participation and contribution of providers, foster carers and staff during our inspections. You continue to work in challenging circumstances with children and their families to provide safer and better services. I would like to thank the children, their families and advocates for their participation and the time they gave to our inspectors, which has helped contribute to this report.

Carol Grogan

Chief Inspector of Social Services, Health Information and Quality Authority

Introduction by the Head of Programme - Children's Services

Eva Boyle, Head of Programme - Children's Services, Health Information and Quality Authority

This overview report sets out the work and findings of inspections of children's services during 2022. Fifty-four inspections were completed during 2022. Overall, inspectors found that children received a good standard of care in foster care, statutory residential care, detention, special care services and children assessed as at ongoing risk of significant harm in child protection services.

Hearing the voices and experiences of children, young people, their families and carers is at the centre of the work completed by inspectors. A children's version of this overview report has also been published, and it provides a summary of this report and highlights the views of children, young people, their parents and foster carers. One hundred and eighty children met or provided their views to inspectors and the majority were positive about the service they received, but unfortunately, some children experienced multiple changes of social worker, which has been a recurring theme. Some parents and foster carers also raised the challenge of experiencing changes in social workers for children.

The appropriate resourcing of services remains a challenge, not only in terms of staff vacancies but also the insufficient availability of appropriate children's alternative care placements. This means that some children experienced delays in receiving a service, and other children were not in the right placement and experienced delays in moving to a more appropriate service

During 2022, inspectors found good practice completed by staff across all children's services. Staff routinely advocated on behalf of children. They were supported by their leadership teams to promote children's consultation and participation in relation to their support or care. Children were routinely consulted by social work and social care staff during assessments and in their day-to-day lives. They were given the choice to participate in meetings and, when they chose not to attend, their views were presented to the meeting, therefore services endeavoured to keep the child at the centre of decision-making.

In 2023, HIQA will complete a consultation with children in Oberstown Children Detention Campus and statutory children's residential services to ask them about what they want to receive feedback on after inspections.

I want to thank the children, young people, their families and advocates for the time that they give to our inspectors when they visit children in their homes or when living temporarily in special care or detention. I also want to acknowledge the ongoing support and co-operation of providers, foster carers and staff during our inspections. You work diligently with children and their families to provide safer and better services.

Eva Boyle

Head of Programme - Children's Service, Health Information and Quality Authority

1. Introduction to regulation and monitoring

About this overview report

This report provides an overview of HIQA's and the Chief Inspector's inspection, monitoring and regulation of children's services in 2022. It also includes:

- how HIQA and the Chief Inspector regulate and inspect the services within their legal remit
- what children told inspectors during the course of the year
- engagement with stakeholders and informed and interested parties
- a concluding statement in relation to work undertaken in 2022 and the focus for future inspections.

Introduction to the work of the Children's Team

HIQA and the Chief Inspector of Social Services within HIQA are responsible for regulating and monitoring the quality and safety of a range of adult and children's health and social care services across Ireland.

HIQA and the Chief Inspector fulfils its statutory obligations set out in the Health Act 2007 (as amended) under the stewardship of the Chief Inspector of Social Services, which oversees the regulation, monitoring, and registration (where applicable) of following services:

- child protection and welfare services
- statutory and non-statutory foster care services
- statutory children's residential services
- special care units
- Oberstown Children Detention Campus.

This overview report also outlines how the Chief Inspector met the business plan objectives[(2)] in 2022 in relation to children's services, including the:

- receipt and assessment of all solicited and unsolicited information across children's centres and services and response to risk in a proportionate and timely manner
- completion of the final year of phase three of a three-phase thematic programme of monitoring inspections of statutory foster

care services to review the efficacy of governance arrangements across foster care services and the impact these arrangements have on children in receipt of foster care

- a programme of inspection of non-statutory foster care services
- an inspection of Oberstown Children Detention Campus
- a programme of focused inspections of child protection and welfare services to assess the quality of service provided to children deemed to be at ongoing risk of harm who are placed on the Child Protection Notification System (CPNS)[1] across all Tusla service areas
- a programme of inspections of statutory children's residential centres to assess leadership, governance and management, staffing resources, child protection and standards relating to planning for children in care
- a programme of inspections against the Child Care (Placement of Children in Care) Regulations 1995, focusing on the responsibilities of the child's social worker
- a programme of regulation in special care units to include monitoring and inspection of all units and the processing of all applications to vary conditions of registration received.

[1] A national record of all children who have reached the threshold of being at ongoing risk of significant harm and for whom there is an ongoing child protection concern, resulting in each child being the subject of a child protection plan.

2. How we regulate services

2.1 The statutory framework — monitoring and regulating

The Chief Inspector carries out three different types of inspections:

- inspections to assess compliance with statutory regulations, in children's residential centres and of special care units (registered designated centres)
- inspections which monitor ongoing compliance with specified nationally-mandated standards, and monitoring against the rights framework of the Oberstown Children Detention Campus
- thematic quality improvement programmes which aim to promote quality improvement by focusing on national standards relevant to particular aspects of care and to improve the quality of life of people using services.

Each different type of children's service has its own statutory framework that gives authority to HIQA and the Chief Inspector to inspect, monitor and or regulate the service using standards and regulations which set out what is expected from the service.

Table 1 shows the statutory framework for each type of children's service monitored by HIQA or regulated by the Chief Inspector.

Table 1. Statutory basis for inspection and monitoring of children's services by HIQA and regulation by the Chief Inspector

Functions	Authority to inspect	Primary legislation	Regulations (where applicable)	National standards
Child protection and welfare services	Monitored under Section 8(1)c of the Health Act 2007 (as amended)	Health Act 2007 (as amended)		*National Standards for the Protection and Welfare of Children* (HIQA, 2012)
Foster care services	Regulated and monitored under Section 69 of the Child Care Act, 1991 as amended by Section 26 of the Child Care (Amendment) Act 2011	Child Care Act, 1991, as amended	Child Care (Placement of Children in Foster Care) Regulations, 1995 Child Care (Placement of Children with Relatives) Regulations, 1995	*National Standards for Foster Care* (Department of Health and Children, 2003)

Functions	Authority to inspect	Primary legislation	Regulations (where applicable)	National standards
Special care units for children and young people	Regulated and monitored under Section 41 of the Health Act 2007 (as amended)	Health Act, 2007 (as amended)	Health Act 2007 (Registration of Designated Centres) (Special Care Units) Regulations 2017 Health Act 2007 (Care and Welfare of Children in Special Care Units) Regulations 2017 Health Act 2007 (Care and Welfare of Children in Special Care Units) (Amendment) Regulations	*National Standards for Special Care Units: November 2014* (published 2015) (HIQA)
Children's detention campus	Inspected under Section 185 and Section 186 of the Children Act 2001, as amended by Criminal Justice Act, 2006	Children Act, 2001 as amended by Criminal Justice Act, 2006		*Oberstown Children's Rights Policy Framework* (2020)

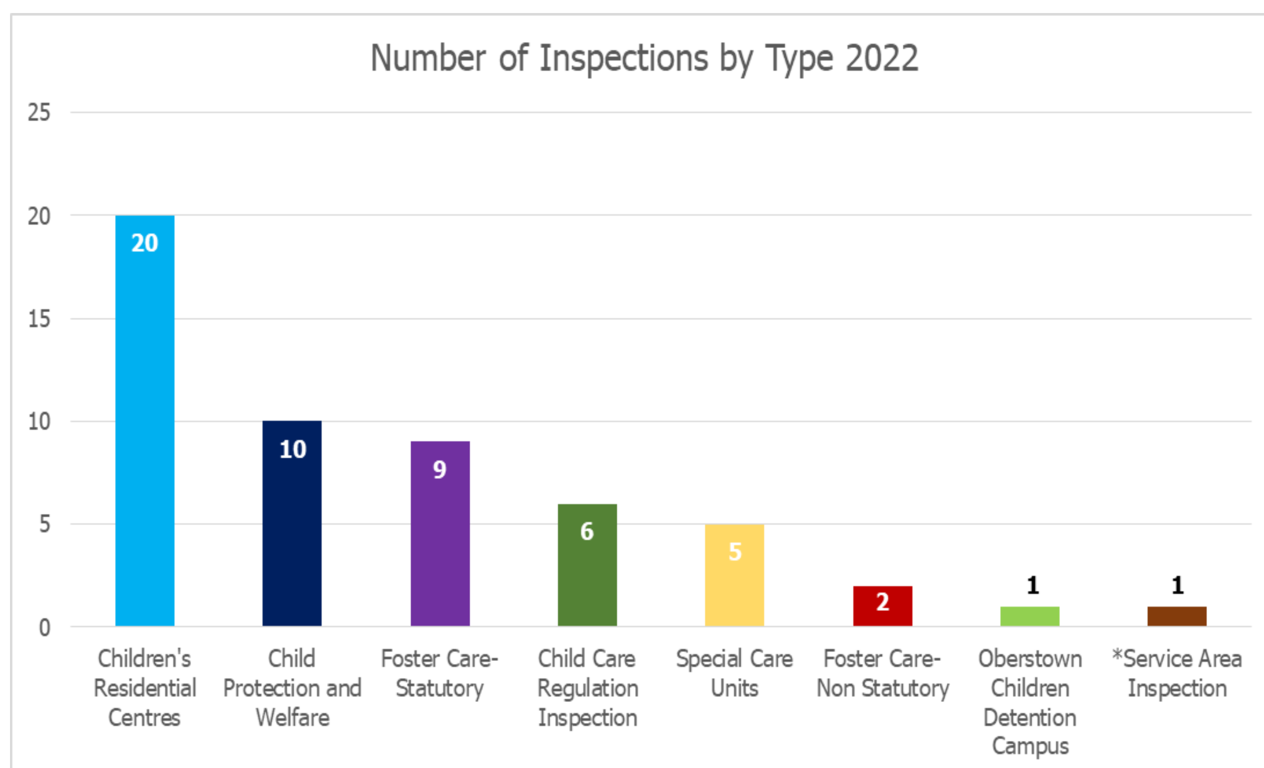
Functions	Authority to inspect	Primary legislation	Regulations (where applicable)	National standards
Children's residential centres	Regulated and monitored under Section 69 of the Child Care Act, 1991 as amended by Section 26 of the Child Care (Amendment) Act 2011	Child Care Act, 1991, as amended	Child Care (Placement of Children in Residential Care) Regulations, 1995	*National Standards for Children's Residential Centres* (HIQA, 2018)

2.2 Regulation and monitoring activity 2022

During 2022, HIQA and the Chief Inspector conducted 54 inspections of the various children's services under their remit (as illustrated in Figure 1).

This included inspections of statutory children's residential centres, special care units, statutory and non-statutory foster care services, child protection and welfare services, and Oberstown Children Detention Campus.

Figure 1. Inspection activity 2022 by service and inspection type



* Service area inspections incorporate both child protection and foster care services.

2.3 Receipt of information

HIQA receives regulatory notifications (solicited information) and unsolicited information from people who provide feedback about their experiences of children's social care services. This feedback is referred to as unsolicited receipt of information (UROI) and can be received from children, their family members or advocates, health and social care professionals, employees and the general public.

2.3.1 Solicited Information (Regulatory Notifications)

The Chief Inspector receives notifications from Tusla relating to designated centres for special care as well as non-regulated children's services. The Chief Inspector also receives unsolicited information from people who have a concern about services

provided to children. These notifications are reviewed and risk-rated by an inspector, and are used to inform the most appropriate regulatory response.

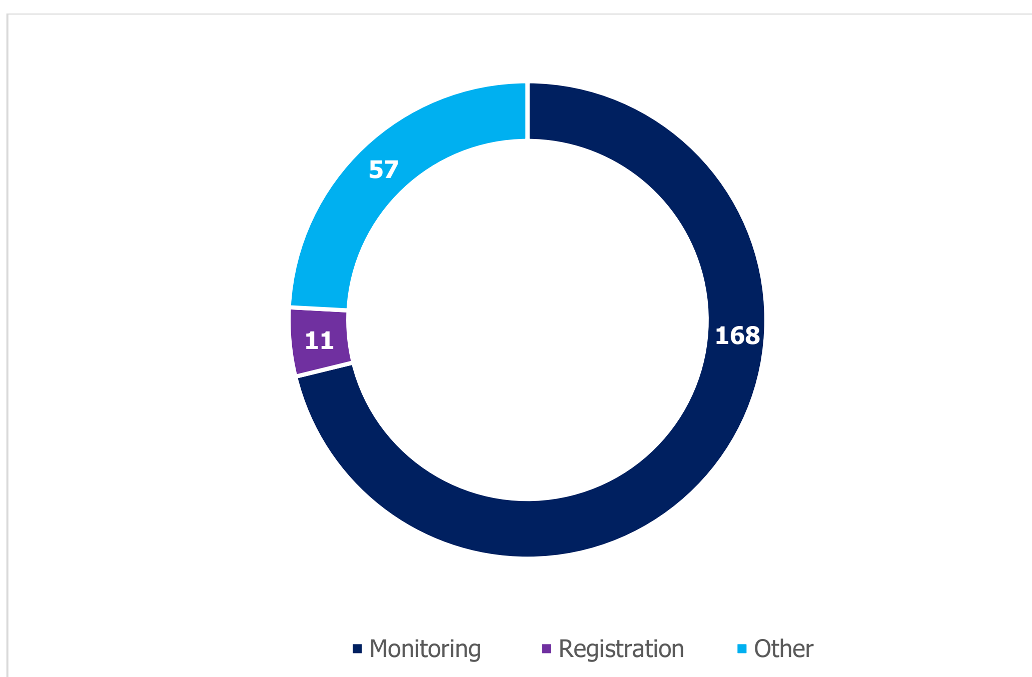
2.3.2 Regulated children's services (special care units)

During 2022, 238 notifications were received from Tusla relating to designated special care units. These are notifications that special care units are required to submit to the Chief Inspector within specified time frames.

The majority of notifications received in 2022 were those defined in the care and welfare regulations for special care units and which are termed 'monitoring notifications'. They primarily related to issues such as absconsions, allegations of abuse and times when children were injured and required medical attention. Figure 2 below provides a breakdown of these notifications.

Notifications categorised as 'other' relate to reports received from Tusla with regards to their monitoring of special care units, and quarterly notifications received.

Figure 2. Number of notifications received from designated special care units by type of notification



2.3.3 Non-regulated children's services

Notifications of serious incidents involving children who are known to Tusla's child protection and welfare services, including the deaths of children in care, must be submitted to HIQA by Tusla within three working days of the death or serious incident happening.

In 2022, HIQA received 44 notifications: 19 related to serious incidents and 25 related to the deaths of children in care or deaths of children or young adults known or previously known to the child protection and welfare service. Rapid or local reviews are carried out by Tusla following such incidents. These incidents are also referred to the National Review Panel[2] for a decision in relation to carrying out a further review.

As with all information received in 2022, six reports of rapid or local provider-led reviews into these incidences completed by the National Report Panel were risk assessed by HIQA and informed HIQA's regulatory activity with regard to the specific service area concerned.

2.3.4 Unsolicited information (information of concern or compliments about services)

HIQA welcomes feedback about people's experiences of services to inform the assessment of the quality of care received within children's social care services. This feedback is referred to as unsolicited receipt of information (UROI) and can be received from children, their family members or advocates, health and social care professionals, employees and the general public.

While HIQA has no legal remit to investigate an individual complaint about care received or provided under the Health Act 2007 (as amended), it uses this information to monitor the quality and safety of care. All information received is reviewed and risk rated and used alongside the other information gathered about a service to inform regulatory judgments.

This section of the report sets out a detailed analysis of all unsolicited information HIQA received in 2022 about children's social care services under its remit. It also sets out how HIQA used this information to inform its work.

During 2022, the Chief Inspector received 1,353 pieces of unsolicited information, of which 84 (6%) related to children's social care services. This was a 6% increase on the number of pieces of feedback received in 2021.

[2] This is an independent panel established in 2010 to review serious incidents, including the deaths of children in care and those known to the child protection system.

On average, just over seven pieces of feedback were received per month about children's services, with a peak in June (14) and the fewest number received in January and December (3).

Of the 84 pieces of feedback received, 41 (49%) related to child protection and welfare services, 28 (33%) related to foster care services, nine (11%) related to special care units, four (5%) related to children's residential centres and two related to Oberstown Children Detention Campus (see Figure 1).

Figure 3. UROI received by service type for children's services in 2022

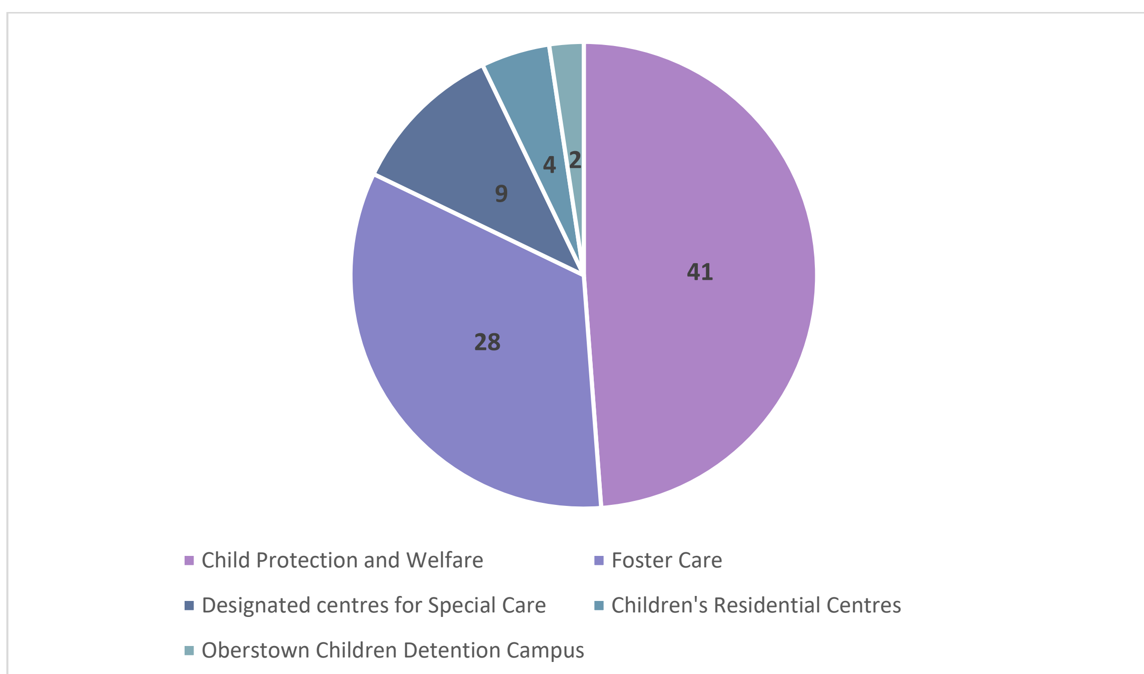
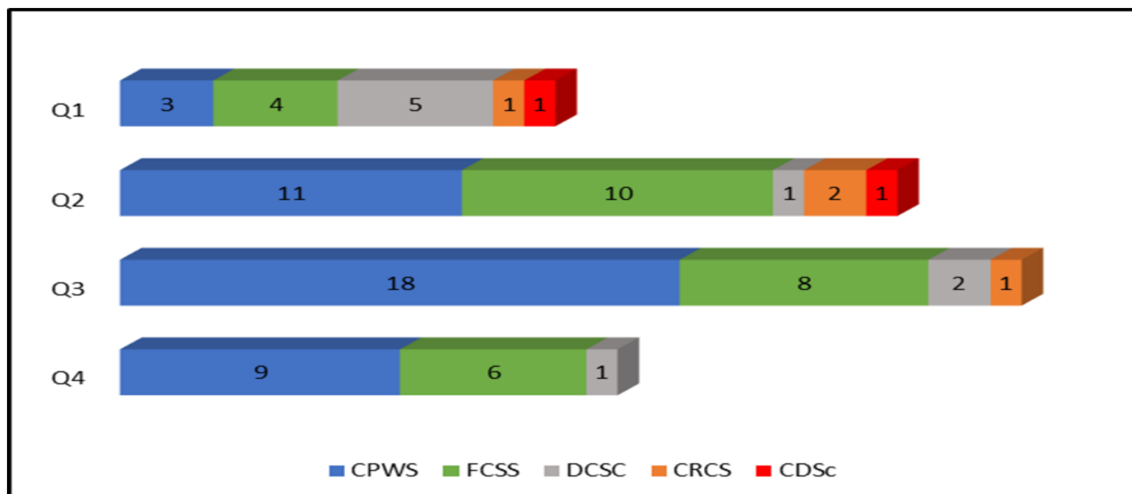


Figure 4 shows that we received the most feedback relating to child protection and welfare services in Q3 (18), with the fewest received in Q1 (3). We received the most feedback about foster care services in Q2 (10), and the fewest in Q1 (4). We received the most feedback about special care units in Q1 (5) and the fewest in Q4 (1). Children's residential care centres received the most feedback in Q2 (2) with no feedback received in Q4. One piece of feedback was received about Oberstown Children Detention Campus in Q1 and Q2.

Figure 4. Comparison of children's UROI per service in each quarter in 2022



Of the 17 Tusla service areas providing child protection and welfare and foster care services, we received feedback about 14 of these throughout 2022. This included Cork (10), Dublin South West Kildare West Wicklow (7), Kerry (6), Carlow Kilkenny South Tipperary (5), Louth Meath (5), Midlands (5) and Dublin South Central (5).

Contact person

The majority of people who contacted HIQA about children's services were relatives of children using these services (see Figure 5). Of the 84 pieces of information received, two (2%) were received from service users, 36 (43%) were from relatives and 12 (14%) were from employees. HIQA also received 34 (41%) pieces of information from 'others', including foster carers, legal representatives, health and social care professionals and members of the public.

Figure 5. Contact person for children's UROI in 2022

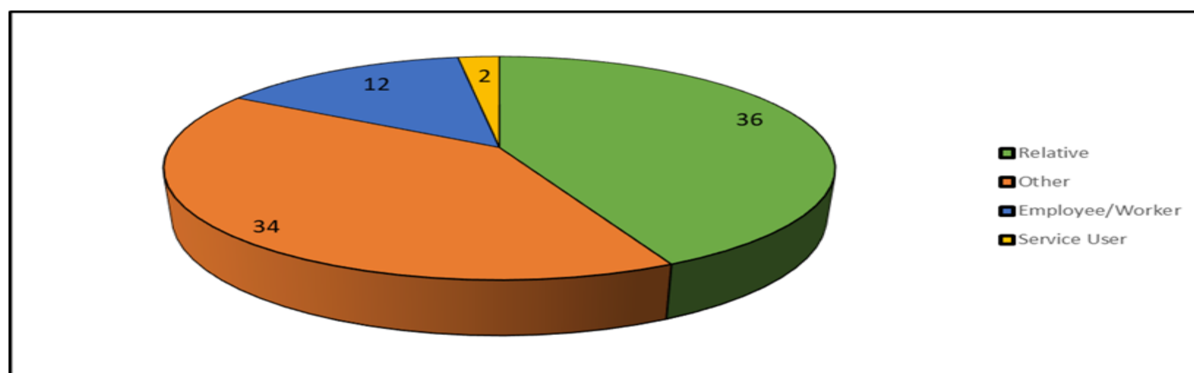
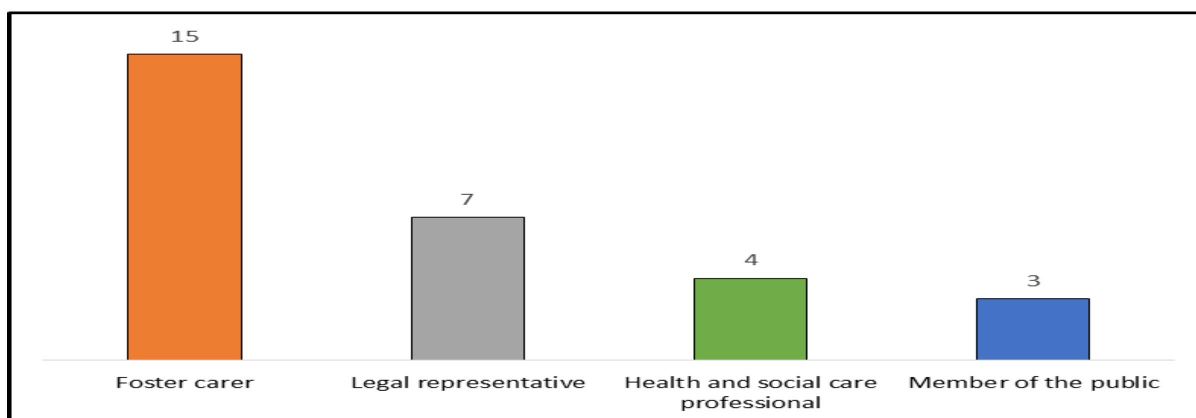


Figure 6 sets out a breakdown of the 'other' category, with 15 (44%) pieces of feedback received from foster carers, seven (20%) from legal representatives, four (12%) from health and social care professionals and three (9%) from members of the public. We also received one piece of feedback from each of the following: the Irish Refugee Council, a guardian ad litem[3] and an anonymous party.

Two pieces of feedback were generated from media articles and are discussed further in the qualitative review section.

Figure 6. Breakdown of most frequent 'other' category for children's UROI in 2022

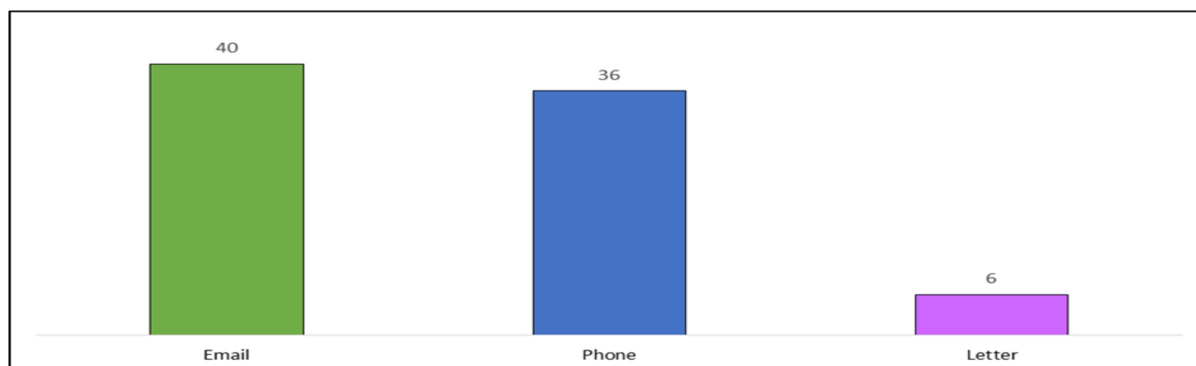


Contact method

Of the 84 pieces of information received, 40 (48%) were by email, 36 (43%) by phone and six (7%) were by letter (see Figure 7).

[3] A court-appointed advocate to independently establish the wishes, feelings and interests of the child and to present these to the court with recommendations.

Figure 7. Contact method for children's UROI in 2022



Information about potentially unregistered designated centres

In addition to the 84 pieces of information received for children's services, two additional pieces of information were brought to the attention of the Chief Inspector relating to two centres that may have been operating as unregistered special care units. An assessment of these centres was carried out and it was deemed that neither of the centres were operating in contravention to section 46 of the Health Act 2007 (as amended).

Qualitative review

Of the 84 pieces of feedback received in 2022, 73 contained information relating to the themes under the dimensions of quality and safety and capacity and capability, one contained themes relating to quality and safety only and a further eight contained only themes relayed to capacity and capability. The remaining two were media articles and are referenced below. No complimentary feedback was received during the year about children's services.

Due to the smaller volume of unsolicited receipt of information generated for children's services, they have been analysed against service type to identify any trends in that particular sector or area of children's social care services.

Child Protection and Welfare Services

There were 40 UROIs relating to 14 of the 17 child protection and welfare services and one national team. Two children contacted us about their experience with a child protection and welfare service. In addition, we heard from 22 relatives, 14 'others' and two employees. The 'others' included legal representatives (5), health and social care professionals (3), members of the public (2), a foster carer and an advocacy organisation.

Of the 40 pieces of information received, 35 contained themes under both dimensions and five contained themes related to capacity and capability only.

Under the quality and safety dimension, the themes[4] included safeguarding[5] (34), children's rights (29), the quality of care (22) and protection (4). Of the 22 quality of care themes, these included assessment and care planning, family contact and appropriate placements.

All unsolicited receipt of information included governance and management as a theme. Other themes included communication (21), staffing (7), complaints handling (6) and information governance (2).

Statutory Foster Care Services

There were 28 UROIs received in relation to 14 of the 17 foster care services. No children contacted us with feedback about foster care services. The feedback was received from 12 relatives and 16 'others'. The 'others' included foster carers (13), legal representatives (2) and a member of the public.

Of the 28 pieces of information, 25 contained themes under both dimensions, one contained quality and safety themes only and three contained capacity and capability themes only.

The quality and safety themes included safeguarding (19), the quality of care (19), children's rights (16) and protection and the management of allegations (5).

Under the capacity and capability dimension the themes included governance and management (26), communication (21), staffing (5), complaints handling (4) and information governance (4).

Special Care Units

There were nine UROIs raised about two of the three special care units and all included themes under both dimensions.

Under the quality and safety dimension the themes included safeguarding (8), protection (4), risk management (4), rights (3) and the quality of care (3). The quality of care issues included assessment and care planning and medicines management.

[4] Feedback can contain one or more themes.
[5] Safeguarding relates to the measures in place to uphold children's rights, to support their health and wellbeing, to reduce the risk of harm and to empower children to protect themselves.

The themes under the capacity and capability dimension included governance and management (9), staffing (4), communication (2) and information governance (2).

Children's Residential Centres

Four UROIs were received about four individual statutory children's residential centres and included themes under both dimensions.

Under the quality and safety dimension the themes included safeguarding (4), risk management (3), protection and the management of allegations (2) and the quality of care (care planning) (1).

The themes under the capacity and capability dimension included governance and management (4), communication (2), staffing (1) and complaints handling (1).

Oberstown Children Detention Campus

There was one piece of unsolicited receipt of information about this service which included themes under both dimensions. The feedback related to safeguarding and the use of single separation.

Media Articles

Two media articles were raised during the year as feedback. One related to the suspension of catering facilities within Oberstown Children Detention Campus due to rodent infestation, and the other related to Tusla's role in relation to unaccompanied minors that had arrived in Ireland from Ukraine.

Regulatory management of UROIs

All unsolicited information received is acknowledged, logged and examined by HIQA. The information is reviewed by an inspector to establish if the information received indicates a risk to the safety, effectiveness, and management of the service, and the day-to-day care children and their families receive. Unsolicited information allows HIQA to:

- ensure services continue to meet high standards of care for children and their families
- consider how well providers handle complaints and use them as opportunities to improve care for children and their families
- identify any trends or patterns that could indicate that something unacceptable is happening in a service
- make decisions when registering and or renewing the registration of

designated centres.

If HIQA considers that the service provider may not be compliant with the regulations and or national standards, we can respond by:

- asking the service provider to submit additional information on the issue
- requesting a plan from the service provider outlining how the issue will be investigated and addressed
- using the information on inspection
- carrying out an unannounced inspection to assess the quality and safety of the care being provided in the service.

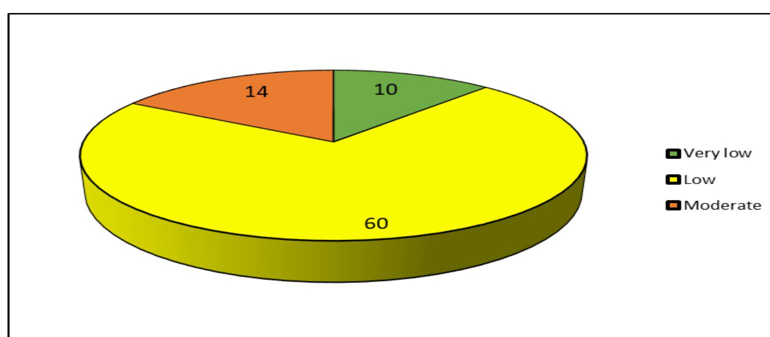
In addition, where the information indicates that people may be at immediate risk, HIQA will use its full legal powers and report the incident, where appropriate, to An Garda Síochána (Ireland's National Police Service), Tusla or the Health Service Executive (HSE's) Adult Safeguarding Team.

Assessment and risk rating

Of the 84 UROIs received, 10 (12%) were initially risk rated as a very low (green) regulatory risk, 60 (71%) were risk rated as a low (yellow) regulatory risk and 14 (17%) were risk rated as moderate (orange) risk (see Figure 8).

Seven of the moderate risk-rated pieces of information were reduced to being low regulatory risks, and two of the low regulatory risks were reduced to being very low regulatory risks by the inspector after completing the relevant regulatory reviews and actions (see section on regulatory action).

Figure 8. Initial regulatory risk rating of children's UROI received in 2022



Regulatory action

This section of the report explores the regulatory action taken on foot of the inspector's assessment and initial regulatory risk-rating of the information contained within the UROI.

In total, 63 of the 84 UROI were at the status of closed with no additional regulatory action required. In these cases, the information would be used as a line of enquiry for upcoming inspections. Of these, nine had a very low, 52 a low and two a moderate regulatory risk rating. Four of these UROI had been followed up as part of recent planned inspections and one that was closed specifically referenced that the information would be used as a line of enquiry for the next inspection.

Four additional pieces of information received were deemed by the inspectors to be similar to recent inspection findings of the relevant services and closed.

Sixteen UROI had regulatory action taken on foot of the information being received, and all were closed at the time of reporting. This included a phone call with the relevant manager to seek assurances, the issuing of a provider assurance report and or a triggered unannounced risk-based inspection.

In addition, three separate referrals were made to Tusla in line with the Children First Act 2015 on foot of the receipt of unsolicited information that contained unreported child safeguarding concerns.

Conclusion

The smallest volume of UROI received by the Chief Inspector were raised against children's social care services. Almost 50% (41) of this feedback related to Tusla's child protection and welfare services, with an additional 33% (28) relating to Tusla's foster care services. No complimentary feedback was received about children's social care services.

The majority of people who contact HIQA about these services were relatives (43%) followed by others (41%). Two children or young people contacted HIQA to provide feedback about child protection and welfare services.

Email was the most frequent contact method and accounted for 48% of the feedback received, followed by feedback received over the phone (43%). Six pieces of feedback were received by post.

Across all 84 UROI, which spanned the range of different children's social care services, the leading quality and safety themes were safeguarding, quality of care and children's rights. The leading capacity and capability themes were governance and management, communication and staffing.

Each piece of feedback were reviewed and assessed by the Chief Inspector, assigned a regulatory risk rating and used alongside the other information gathered about the centre or service to inform regulatory activities and or judgments.

3. Listening to the voices of children and young people

Children and young people have unique insights and information to offer, as they directly use the services that we regulate and monitor. Throughout 2022, HIQA continued to actively promote and reflect the voice of children and young people in its work. It is through this consultation process that we explored their experiences of care and support provided to them.

Our ultimate aim is to speak directly with children and young people accessing a wide range of services, such as child protection and welfare, foster care, residential and secure care.[6] Children and young people's views were sought through face-to-face conversations during inspections, phone conversations, online focus groups and service-specific child-friendly surveys. While the views of children and young people were invaluable in telling us about their experiences, these methods did not suit all children and young people as they differed in age and ability.

As part of the inspections completed in 2022, inspectors engaged with a total of 180 children and young people, comprising 24 receiving a Tusla child protection and welfare service, 47 in foster care, 65 in statutory children's residential centres, 16 in special care units[7] and 28 in Oberstown Children Detention Campus.[8] They participated in a number of ways that included speaking directly with an inspector during an inspection, over the phone or by completing and returning a survey.

The following section outlines the information we received from children and young people we spoke with and those who returned surveys.

[6] Secure care settings include Designated centres for Special Care (Children) and Oberstown Children Detention Campus.

[7] Special care units are secure (locked) units where children are placed by a court in response to the risk they may pose to themselves and or others.

[8] Oberstown Children Detention Campus provides safe and secure care and education to young people between 10 and 18 years who have been committed to custody after conviction for criminal offences or remanded to custody while awaiting trial or sentence.

3.1 What children said about their experience of services

Children and young people spoke positively about their experience of the social work services they received, such as the child protection and welfare service or where they were placed in either a residential or a foster care placement. The majority of children and young people understood why social work services were involved with them and their families and reported positive changes in their lives because of this involvement.

They also felt safe, well cared for and supported by staff and social workers. Children and young people were generally positive about the support they received from staff members and were happy about the level of contact they had with their families. Some of their comments included: "I'm happy here, staff are great", "they [staff] make you feel involved", "I feel very fortunate to be living with my foster family" and "Grand, happy because I am one of the family".

The majority of children and young people who were placed in secure care settings, such as special care units and Oberstown Children Detention Campus, also spoke positively about their care experiences. Some of their comments included: "I have grown a lot here", "the help has made me think of things in a different way" and I have been helped to work on reasons why I am here". When asked about their experience of living in a detention centre, one young person said "apart from the fact that you can't get out, the rules are okay". While those who met with inspectors during their placements in secure care were not always happy about having been placed there, the overwhelming majority talked about how safe they felt. One young person commented: "I don't like the place, it is a lock up, but I feel safe."

Overall, children and young people across the services said they were cared for, felt welcomed and involved in their placements. They described staff as supportive and kind, and they felt the care setting was a safe place which gave them stability. Although some felt that there were times when they could be listened to more, they

all said that they had staff they "can go to and feel safe and talk to". Other comments included:

"I can talk with the people here and they listen. They respect me for who I am. They all mean well, even if they don't always understand me, they try to help me".

Participation, consultation and inclusion were key elements for children and young people's care across all services. They understood why they were not living at home, or had a Tusla worker involved with them. They felt their individual needs were being met by staff and social workers involved in their care. They felt cared for and supported and had built good trusting relationships with staff members. Many children and young people spoke highly of the staff team or their foster carer, and said that if they were worried about anything, they would go and speak with them. Their individuality was respected and their rights were promoted and facilitated, and they were helped to develop skills for independent living and to take responsibility for decisions about their future.

"The food is nothing like home, but it's okay."

"This is a calm place for me to come to, it gives me a chance to do the things I like to do."

"It's like my second home."

Respite breaks in a residential centre

Residential respite breaks were availed of for children and young people either at home with involvement from the child protection and welfare service or placed in foster care. Of the four residential centres providing respite inspected in 2022, some of the children and young people were overwhelmingly positive about their experiences in these respite centres. They spoke about the staff being helpful,

supportive and easy to talk to. One child said that they could speak to staff if they were worried.

The staff were described by one child as "nice and they play football". Others described the centre as "class", liking everything about the house, "like the bedroom" and you can "bring toys" to the house. Another child said that they "get a break from home". Children spoke about how much they enjoyed the activities offered in one centre which included horse riding, surfing and go-karting. One child spoke of activities such as art, board games, football and cooking that they participated in and said they "like baking cakes".

3.2 Children's views on access to social workers

The majority of children and young people who gave their views to inspectors across the services said they had an allocated social worker that they liked and got on well with. They felt that they trusted their social worker and could confide in them about their worries and concerns. They said that there had been positive changes in their lives because social workers were involved with them and their families. Children and young people generally said that their social workers visited regularly and that they had opportunities to do things or go places with their social workers during these visits. Some spoke about relationship-building activities they did with their social worker, with one saying "she comes to visit, we go off for a walk and talk or for a coffee". Other comments included: "my social worker takes the things I say on board, and if things can't happen, they explain why" and "my social worker listens, does his best, and does what he can."

However, some children and young people described different experiences and challenges in working with their social workers. Some said they did not have any relationship with their social worker, while others did not regularly see their social worker or had very little contact with them. One child said that they did not know if their social worker had visited them or if they had made contact to speak with them. Another child described their social worker visits as "not that often, every few months, would rather more often." Frequent changes in social workers was a common frustration for some children and young people, "it gets repetitive and annoying when people keep asking and I have to explain myself over and over",

while others spoke about how they relied more on other professionals in their lives than their social workers, "more involved with aftercare worker now." Other comments included:

3.3 Rights of children

Rights of children – information

When asked about their knowledge of their rights, the majority of children and young people who spoke with inspectors said they were given appropriate information on their rights, and in some cases had exercised their rights. They said they were adequately supported to understand why a social worker and other relevant people were involved in their care, such as residential staff, foster carers and other professionals, including guardians ad litem. Children who had an allocated social worker reported that they were aware of their care plan and how to make a compliant, while some who were not allocated a social worker told inspectors that they did not feel they were involved in decisions regarding their care and were not aware of how to make a complaint. Some of these cohort of children and young people were able to identify their foster carer or another person they could talk to if they needed to. Children and young people in secure care spoke about how staff ensured that they understood their rights, including the right to make a complaint. They were generally happy with how their complaints were dealt with, and felt that staff followed up on any issues that they were unhappy with or concerned about.

Children and young people also told inspectors that they were involved in decision-making processes about their care, depending on their age and ability. They said they were aware of advocacy services that could further support them in upholding and promoting their rights. Some children had a court-appointed guardian ad litem, while other children used other advocacy services. While most were confident in making complaints or providing feedback to staff regarding the service, other comments included: "don't know who to contact" and "not told about when a new social worker was coming". One young person described making a complaint and said "it helped". The young person explained that they met with staff "discussed the situation and got it sorted". Another said that they had made a complaint recently and felt listened to. Most were confident enough to bring their views to the staff team or their social worker to address and were happy with the outcome.

"If I am upset I can go to any of the staff, they listen and understand."

"I've been very lucky, I've had a really good experience."

Rights of children - contact with family

Maintaining family links for children and young people was promoted and central to the work undertaken and care provided by staff and foster carers, especially for the children and young people who did not live at home. When asked about family contact, the majority of children and young people were happy with the arrangements in place, while some would like to see their families more often. Contact with families was part of the care and placement planning processes. Where appropriate, staff and foster carers facilitated children and young people to have regular visits and contact with their families and friends. Where families could visit them in their care placements, this was also facilitated. Some young people reported they took responsibility for organising contact and were appropriately supported by the staff team in doing so. Services also recognised the importance of friendship groups to children and also promoted keeping this contact.

"I get to see my family whenever I want and whenever I'm available... they [staff] drive me"

"Ya, I go home every weekend"

Rights of children - personal space

The right to privacy was important for children and young people in residential and secure care settings. They considered their bedrooms to be their private space. All children and young people spoke about how they had decorated their bedrooms in ways that appealed to them, by changing the layout, choosing colours they liked and adding decorations, photographs and other personal possessions that they had chosen. They reported decorating their bedrooms not just on admission but throughout their time in the centre. Some children and young people took pride in their personal space and wanted to show the inspectors their bedrooms during inspections. Young people's privacy was respected as staff knocked on doors and asked permission to enter their bedrooms. Young people could spend time alone in their bedrooms when they wanted to. Additionally, children and young people were generally involved in the creation of a homely environment in residential centres, as appropriate to their age and development.

For young people detained in the Oberstown Children Detention Campus, personal space was limited but each had their own en-suite bedroom. These young people told inspectors of changes implemented on foot of suggestions made by them to improve their living space. These included new curtains, bed linen and mattresses. The right to have access to fresh air, food, drinks, snacks and the use of multi-purpose[9] rooms were promoted and facilitated by staff during single separation[10] periods. These young people told inspectors that during periods of separation, their rights in relation to food, drinks and access to fresh air were in place and they could make phone contact with their families.

[9] Multi-purpose rooms: where young people can play video games, watch movies and take phone calls in private that are separate to the communal lounge area.

[10] Single separation: where a young person is removed from the group and kept apart from other young people when there are no other options available to manage their behaviour.

3.4 Participation by children in decision-making

For children and young people who are in care or receiving supports from child protection and welfare services, the right to participate in and be involved in decisions about any issues that had an impact on their lives was very important. The majority told inspectors that they felt listened to and contributed to decisions made about their care. Most said they were involved in the discussions about the plans for their care and aftercare, and they understood their care plan. They talked about their placement plans, safety plans and aftercare plans. Children and young people were invited to their review meetings and could chose to attend or not. Most were very positive about their experience, with one saying "I always attend the review meetings". One child spoke about the opportunities they had for training and employment that were written up in their care plan. Children and young people described regular meetings with the managers, staff and others living in the centre. They said they were able to make suggestions about day-to-day life in the centre, and they felt their views and wishes were listened to.

Children and young people told inspectors that their social workers met them prior to these meetings to discuss their views. Some young people said that that sometimes they chose not to go and this suited them. While most children and young people reported that they were happy with the decisions made in their care plan, some children expressed that they were not sure what their care plan was, and also said that they would like to receive feedback regarding the outcome of their review. Some of the responses given by children and young people would indicate that while they had the opportunity to be involved in care plans, their sense of fully participating was at times limited. For example: decisions were "not always" put into action and "I don't care anymore" and "Ya I do [attend], some decisions are out of my hands, some decisions lie with people higher up". Most children said they received a copy of the child protection safety plan or care plan from their social worker, while others said that it was just explained to them. One child said "I knew everything that was happening, the social worker wrote it all down, while another said "I'm just told about the decisions from it [care plan]."

A small number of children reported attending their child protection case conference[11] meetings for all or part of the meeting. The majority of children and young people said that social workers engaged with them and sought their views on their plans to keep them safe. One child said that they felt that their social worker

[11] A child protection case conference is an interagency and inter-professional meeting. The purpose is to share and evaluate information between professionals and parents, to determine if there is an ongoing risk of significant harm to the child and, consequently, to formulate a child protection plan.

made a difference in their life and had explained to them why the service was working with their family. The child felt listened to and said that their views were taken into account when their safety plan was developed.

From what inspectors viewed, heard and observed during inspections it was particularly challenging at times for children to be involved in the child protection case conference process or to attend their child protection case conference. This was due to a number of reasons, including the age of the child and the circumstances that they, and their families, were experiencing at that point in time. One child told inspectors that they did not want to attend the meeting, while another said that they were not invited. In preparation for the meetings, some children told inspectors that the social worker completed child-friendly tools with them to obtain their views, which they said they liked. Other children told inspectors that they had completed booklets which the social worker read out at the meeting and that the meeting had helped them and their families. Not all children chose to attend these meetings. While the majority of children and young people felt their participation in the child protection case conference was positive and made a difference, a number of children told inspectors that they had encountered some challenges including poor translation services, failure to follow through on decisions or agreed actions and limited interaction or engagement from social workers. Some of their comments included:

Attended the meeting "for a short while on the phone. I did get a chance to talk, I agreed with the worries."

"Translators are poor."

"They made me comfortable, made me feel at ease, helped a lot. I feel safe now."

"Never attended [Child Protection Case Conference], means nothing to me."

"The meetings were not fun… condescending, they spoke down to me."

"I find it very stressful".

Other comments about participation in review meetings and child protection case conference included:

Children and young people in care or receiving supports from child protection and welfare services also said that they enjoyed the opportunities they had to participate in a range of leisure and recreational activities of interest. Most children and young people had an educational and or training placement and some were actively involved in their education and life skills programme. The majority of the children and young people reported that they were consulted on their choice of activities and their particular interests and talents were encouraged and explored through discussions with them, such as cooking, music and trekking. They were supported to develop their life skills and described getting the bus into town and making their own medical appointments while being supported by staff when required. Some of their comments included: "Do stuff we've never experienced before…it's amazing", "staff take us on day trips to visit other cities and that is a lot of fun" and "I am going on holiday soon and it will be a big adventure".

3.5 Transitions to care, home or onward placements

Over the course of our inspections in 2022, children and young people told us about their experiences of coming into a care placement or moving on from care and feeling particularly vulnerable. Some young people approaching 18 years of age for whom planning was ongoing in relation to their future and independent living said they were satisfied with the service they were receiving. One young person commented about independent skills they had learned: "I do my washing, clean my room, cooking. That's good for me, 'cause I eventually want to live by myself". Another young person commented "I know what is happening until I'm 18". Young people who spoke with inspectors expressed mixed views about the arrangements for their transition from care and aftercare. While many spoke about having an aftercare worker allocated to them to prepare them for leaving care, some of the young people also expressed uncertainty and lack of information about planning for their aftercare. Some children and young people in secure care spoke about the difficulties they experienced in moving on from special care. This was primarily due to the lack of robust alternative placements available to the provider for young people to move on to, which resulted in increasingly lengthy stays in secure care. Two young people expressed their frustration about the lack of options for transitions out of secure care, and both said that this was something that they would like to see improved.

3.6 Children's experiences of secure care

Secure placements are required for some children and young people. The Chief Inspector inspects secure care settings that include Designated Centres for Special Care (Children) (or special care units) and Oberstown Children Detention Campus. Special care units provide placements for children and young people when it is determined that they need care and protection as their behaviour places them at risk. Oberstown Children Detention Campus provides care and education to children and young people who have been committed to custody following conviction for a criminal offence or who have been remanded in custody while awaiting trial or sentencing.

Children and young people in secure care settings were generally positive about their experiences living there. Their voices were heard and acted upon appropriately, and they felt included in all aspects of their care. Some comments from children and

young people in relation to how they were treated by the staff in secure units was overwhelmingly positive and included:

"I don't like the place, it is a lock up, but I feel safe. If I was worried I would tell one of the managers on the unit."

"Everyone made me feel welcome [here], I feel safe here."

"Staff are out straight, they all support you here."

"I don't like this place but I do like the staff."

Staff helped them "how to stay out of trouble."

"It's okay", "It's grand", "the place is great and the staff are great, they help me."

The majority of the children and young people in secure care told inspectors that they felt they could trust the staff as they felt they had their best interests at heart. They spoke positively about the staff who worked with them, especially their key workers. They told inspectors that they could speak openly around staff, were listened to and responded to in a meaningful way.

Children and young people could identify staff members that they could confide in and who they felt genuinely cared for them. One child described being able "to talk to staff about everything" and said that that they had made progress because of the trusting relationships they had developed with staff. However, other children and young people did not have a similar experience. One child did not feel safe in the centre due to their experience of alleged poor practice by a small cohort of staff. Another child felt that they were not provided with appropriate care, respect and understanding. In addition, not all children were satisfied about the consistency and familiarity of staff assigned to them on a day-to-day basis. Following the inspection of this particular special care unit, satisfactory assurances were received from the provider in respect of identified issues that impacted on children and young people's care experience.

Secure care - Special Care Units

While most children and young people shared a positive view of their care experience in secure settings, a number of children expressed some frustrations and concerns. These primarily related to what was described as a negative atmosphere within a unit as a result of another young person's challenging behaviour, the level of disrepair or physical condition of some of the secure units as well as concerns in relation to onward placements. One young person said "sometimes it [the vibe] is up and down in the unit, the vibe is not great". Another young person told inspectors that "it is not a nice life" and said that they felt "punished for the behaviour of others." Some comments regarding the physical condition of one of the secure care units included: "the place is a dump and it has to be fixed." This child talked about when they first arrived and that "it (the centre) was lovely, it was relaxing here but the property damage is too much". Other comments from young people included that "the place is a wreck", "half the doors are broken", and that "it should be painted different colours." The accommodation and premises was in a much better condition overall during the second inspection of this unit in October 2022 as the building had been repaired. The young people had been involved in choosing paint colours, new furniture had been purchased and efforts had been made to make certain areas within the unit more homely.

Secure care – Oberstown Children Detention Campus

Opportunities for young people in Oberstown Children Detention Campus to be consulted and contribute to decisions about their care took place through placement planning, student and campus council meetings[12] as well as unit meetings. Young people were generally positive about their involvement in their placement plans and felt involved in decisions that were made about them. Some had the opportunity to be part of the campus council and could bring issues that impacted the young people to these meetings for discussion. Young people gave examples of a number of changes that had happened as a result of decisions made at the campus council, for example, new curtains for bedrooms, changes to search procedures, as well as trialling new beds and mattresses and mealtimes. Another significant participation opportunity took the form of paintings created by young people in the campus which were shown to the public in the Irish Museum of Modern Art (IMMA) in April and May 2022. This was a collaborative project between the campus, IMMA and Gaisce – The President's Award.[13]

[12] Campus council: a safe space where young people can actively express their views on issues that affect them which are brought to management and team meetings for decision-making.

[13] Gaisce - The President's Award is a self-development programme for young people.

The range of recreation and leisure activities and opportunities available to young people in the campus was very good. They could participate in various activities in the evenings and at weekends which included: triathlon training, fitness instructor, boxing, barista training, horticulture, safe pass, first aid, manual handling, individual art work and unit-based art projects as shown by murals completed or in progress in the units. Skills and hobbies included textiles, art, cooking, wood burning, music, snooker and pool. The service also supported young people to work towards a Gaisce award, based on achievement in a range of activities over a period of time. One young person on the campus at the time of the inspection was working towards achieving a gold Gaisce award, and similar awards had been previously achieved by young people since the last inspection.

When asked about their experiences of how behaviours that challenge were managed, some young people spoke about their behavioural support plans: "yes, it is the plan to manage my behaviour when I lose it". Where young people had experiences of being in single separation, they told inspectors that "Yeah, it does happen but not a lot on this unit. If you stick to the rules, you are okay". Young people understood the reasons for single separation and said that staff members would complete problem solving exercises with them to try to help them learn from situations, so as to avoid repeating them. Other young people said that they "do not like being separated from the group".

Other comments included:

Overall, children and young people in secure care settings were supported to understand and take responsibility for their behaviours, and were provided with individualised skills, supports and understanding to build on their capacity and return to their communities.

3.7 Children's views on areas of improvement

Children and young people were also asked about what improvements they would like to see. While the majority of those who spoke with inspectors or shared their views in surveys expressed a positive experience of social work involvement with them and their families, some children and young people spoke about improvements that would enhance their experience and provide better outcomes for them. The areas for improvement identified by children and young people reflected findings of a number of non-compliances by HIQA and the Chief Inspector in those services inspected. The improvements identified by children and young people included:

- stability and consistency in social work allocation
- improved awareness and support to facilitate children and young people to celebrate their cultural heritage and practice their preferred religion
- strengthening of children and young people's awareness of how to make a complaint if they felt unhappy with any aspect of the service they were receiving
- improvement in aftercare planning for young people
- physical location of a residential setting and the physical condition of one secure setting
- onward placement planning especially for young people in secure care.

4. Listening to the parents and foster carers

What parents told us

In the course of our inspections in 2022, inspectors spoke with an overall total of 123 parents of children who were in care or were involved with a child protection and welfare service.

Child protection case conference process

Inspectors spoke with 48 parents and one other family member about their experiences of the child protection case conference process and whose children were, or had been, listed on the CPNS. The majority of the parents were satisfied with the service that they received. They said they were involved in all aspects of the process from assessments, to network groups[14] and the creation of safety plans. Parents described good communication with the various social work departments. They said they were given information about the child protection case conference service in advance of the meeting and that social workers explained the reason for their involvement with the family. Parents understood the social workers role and that the role and involvement of other agencies had also been explained to them.

Most parents said that their social worker understood the concerns and the problems that they faced in the home. They received additional help for themselves and their children. They felt they had been given all the information they needed including minutes of child protection meetings and safety plans. This helped them to understand what was required so as to ensure the care and welfare needs of their children. Parents described good partnership working and communication with professionals, in increasing safety and reducing risk for their child. Some parents described the child protection case conference process as challenging and expressed dissatisfaction with the service they received; they felt they were not respected or listened to.

[14] Involvement of everybody that has a natural connection with children as a means of leading to effective and lasting safety which includes kin, families, neighbours and professionals (teachers, family doctor, and so on).

"I don't feel panicked when I see my social worker, I feel comfortable around her."

" Tusla had a big impact in helping to make changes for me and my family. I feel the kids are happy now."

"Allowed to say what I wanted, felt intimidated by it all…. Nobody bothered with me for weeks while I was in the house with the kids on my own."

"Didn't get where [the service] were coming from."

"The social worker prepared me well for the child protection conference – they went through the form with me before the meeting to make sure I understood what would be said. It was not a shock, they made me feel comfortable – really lovely people."

"Not supported through it"… "liked to have my say more."

Participation by parents in the child protection conference

The majority of the parents felt that they were supported and encouraged to participate in the child protection case conference process. They spoke about social workers preparing them for meetings, explaining the process to them, informing them who would be there and what would be discussed. Most parents said that social workers met with them prior to the case conference to share their report.

In general, parents attended child protection case conferences and said they had opportunities to discuss their views. They said that they were enabled to bring a support person with them to the conference. The majority of parents said they felt respected and that their voice was heard. One parent said: "I spoke up the best way for my kids, they did listen". Another parent said they were given the opportunity to speak up, ask questions and state their views at the meetings, while another told inspectors that they got a chance to state their views and felt that the people at the meeting "actually listened". One parent noted that the positive actions that they had taken to address the risks were discussed at the conference.

Other comments from parents included:

"Given every chance to speak and have our point of view."

"The social work team were very open with us."

"They spent loads of time trying to explain the situation, trying to make us understand, trying their best to explain what was needed."

Parents generally had a clear understanding of plans and decisions from the case conference process. They spoke about support networks being clearly established and safety arrangements being reviewed. The majority of parents were aware of the child protection safety plan that was developed and the information it contained. However, a small number of parents said they had not received a copy of the safety plan.

Some comments from parents included: "They gave me written information and also told me about whatever was going on, I always knew what the plan was", "everything explained so well", "children were the priority", "there to protect children" and "sometimes the truth is hard to swallow".

Not all parents had positive experiences of participating in the child protection case conferences as some said they did not believe it was beneficial. One parent said it was "not a nice experience" as they felt the process "can make you feel like you are not adequate". Another commented that they "felt I was being chastised", while another parent said they felt intimidated by the process and they did not get a chance to speak, and they felt spoken down to. For some parents, the initial child protection case conference was a particularly difficult experience. One parent described the practical difficulties of attending the child protection case conference via teleconference as they "did not have enough credit "on their mobile phone. Another parent felt that they had not been given enough information about the legal processes that may follow if there was not enough improvement in the level of care they were able to provide for their children. Some of their comments included: "the first instance was very rough but once the children were on the register, it got better", "found it hard", "we were outnumbered" and the "language used…all very strange…not the language I use".

Other mixed views of parents included:

"Not supported through it and would have liked to have my say more."

"They offered to meet me beforehand but never did."

"They used everything against me, my feelings never came into consideration."

"While I was allowed to say what I wanted, I felt intimidated by it all, nobody bothered with me for weeks while I was in the house with the kids on my own."

Feedback to parents from the child protection case conference

The majority of parents were positive about the experience of the child protection case conference process. In addition to the views given by parents, inspectors reviewed feedback forms provided to parents after they attended a conference. The majority of parents told inspectors that they received written minutes from child protection case conferences and copies of the safety plans which promoted the safety and welfare of their children, and were clear about the plan and the desired outcome. Reports were also available and provided to some parents in different languages to meet their individual needs.

Most parents reported that the social worker called to check that the child protection safety plan was working and that everyone was doing what was agreed. Overall, parents spoke positively about how the professionals worked together in the best interests of the child. One parent explained "everyone had the children in the centre, it was all based around the kids". Another parent said that "not once did I feel unsupported, didn't feel put down by them". Where cases were closed, parents stated that case planning was undertaken and they were provided with information by the service as to the reason behind their decision-making. A closure letter was received by parents and additional support services were put in place where needed. Other comments from parents about their experience of feedback from the conference meeting included:

"They were very open in their communication with us."

"When the case was closed she gave me the reasons and sent a letter."

"Made sure I still had the family centre for support."

Impact of the intervention on parents and their children

The majority of parents agreed that working with the social work services had a positive impact on their children's lives. They described their experience of safety networks, the development of safety plans, and spoke positively about how the networks and professionals worked well together to help and support them. Parents also noted the various supports that had been put in place to support their families and the positive impact that it had on their children's lives. Activities and supports included outdoor pursuits, anger management and parenting classes.

Some children had been delisted from the CPNS as they were no longer assessed as at risk of serious ongoing risk of harm. The parents of these children said they were "delighted to be delisted", and that "it was great". One parent acknowledged that they would continue to work with the social worker and family support worker as there was "still a bit of work that needs to be done". Other comments that demonstrated a positive impact on parents and their children included:

"I have never seen them happier, wouldn't have happened without the social workers."

"There was a genuine problem that we need to address and we addressed them…it was beneficial for the kids."

"When first became involved I was not in a good place, reflecting on it now it was a good thing as they helped out."

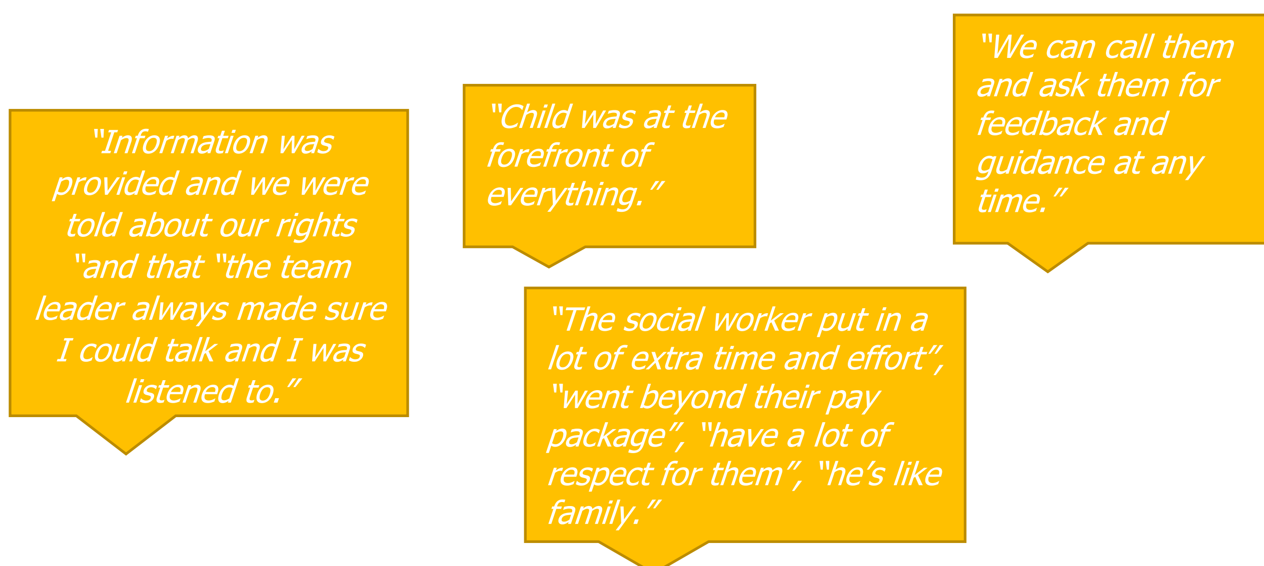
"At the beginning it was harsh, but then they were really good and they did everything they said they would."

"Tusla had a big impact in helping to make changes for me and my family. I feel the kids are happy now."

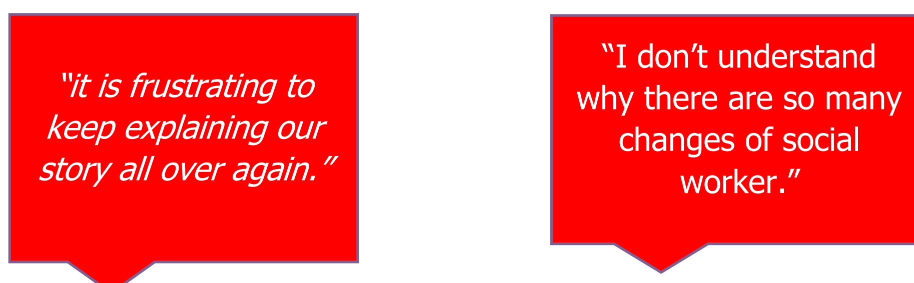
What parents told us about their experience of child protection and welfare services

Inspectors spoke with 22 parents in relation to their experience of the child protection services in one area where two risk-based inspections took place, and in another service area inspection. The majority of parents who spoke with inspectors in 2022 said that the child protection and welfare service promoted children's rights and their rights as parents. Most parents felt that they were treated with dignity and respect and were facilitated to participate in decisions about their children's care. They felt supported, listened to and that their views were sought by staff. Parents spoke about positive relationships with their social workers and said they visited them on a regular basis. Parents valued knowing when their social worker would be on leave and who to contact in their absence, they also said they were given social workers direct contact number.

Parents said they were provided with adequate information as to the reason for service involvement and information on support and advocacy groups. Where children had additional needs, parents told inspectors that the social worker took steps to tailor their approach to be more child-friendly and researched the child's additional needs so as to ensure better communication.



A number of parents expressed some dissatisfaction with the service they had received.

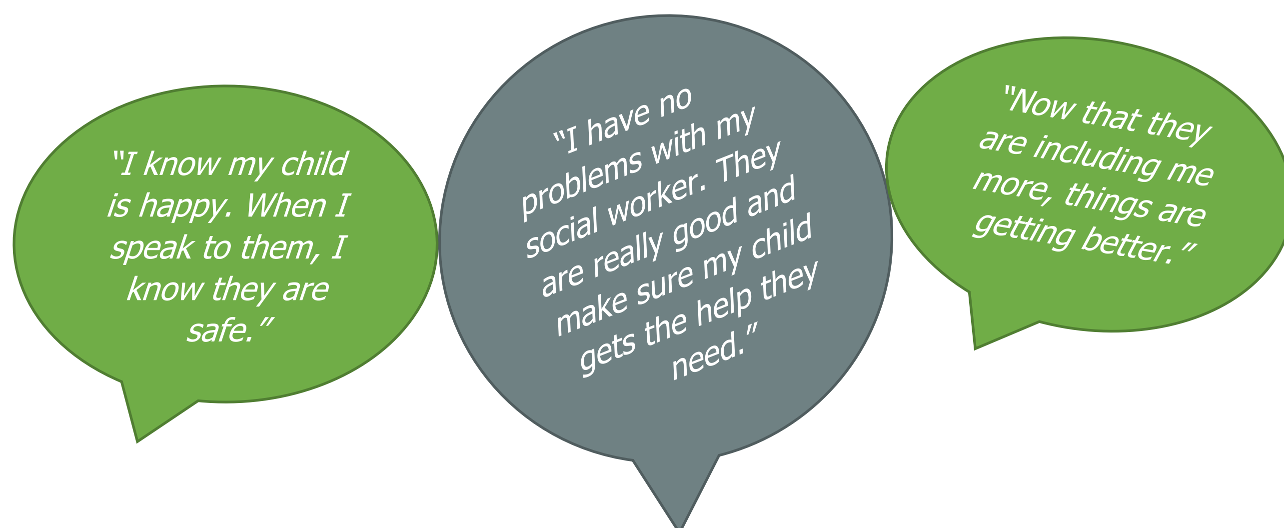


Parents identified a number of improvements, which included:

- stability and consistency in social work allocation
- social worker to visit or be in contact more
- more culturally responsive services
- more support for parents to prepare for and actively participate in meetings and assessments
- feedback about the service they received.

What parents told us about foster care services

Inspectors spoke with 20 parents in relation to their experience of foster care services. Overall, parents valued the care given to their children by foster carers. They felt involved in their children's lives, were listened to, felt supported by social workers and knew how to make a complaint. For the most part, parents felt their children were happy and that they had a good relationship with and contact from their child's social workers. Some of their positive comments included:



Other parents that spoke with inspectors did not have similar experiences as a number of parents were unhappy with the service they received from their child's social workers. Parents reported a range of concerns including poor communication and social workers not responding to their queries, reduced contact times with their children and concerns regarding the suitability of their child's foster care placement. One parent said that their views in relation to aspects of their child's personal care had been ignored despite discussing the concern with the social worker. Another parent said they felt let down by the system when they shared their concerns about the foster carer's ability to meet their child's needs.

Some of their comments included:

"Everything is going well but it can be difficult to get hold of a social worker."

"When I talk, everyone else jumps in."

What parents told us about children's residential care services

Inspectors spoke with 13 parents in relation to the care provided to their children in children's residential care settings. The majority of parents were happy with the care provided to their children and that information was shared with them on a regular basis. Contact and visits with their children were strongly promoted and facilitated by staff. Parents were generally included in all planning and decision-making in relation to the child's care plan. Parents were satisfied with how residential care staff engaged with their children and said that staff "listen to the kids" and also "listen to parents". Most parents spoke about the positive impact that the service had on their children and described the service as "feels like home". Other comments from parents included:

"We have seen great improvement. Everyone comes together to help our child."

"She is being looked after. Staff are friendly. I can ring anytime."

[The child is]"a lot happier there than in previous placements."

"I can sleep at night knowing [their child] is safe."

"From talking with my daughter she is safe and being looked after well."

What parents told us about special care services or Oberstown Detention Campus

Inspectors spoke with 17 parents in relation to the care provided to their children in secure care settings. They generally spoke quite positively about the impact that a secure care setting was having on their children. Some outlined that the staff talked to the child about their specific behaviours, and offered them the support that they needed. Most parents said that they were given information about the behavioural supports and practices that were used and received regular updates from the service. Parents said that staff were helpful and that they kept them informed of the progress their children were making. They had opportunities to have contact with the children and that their children were kept safe. One parent said that they "could call and talk to the managers if there were any concerns".

Some of their comments included:

"I am happy with everything they do for my boy and he is doing great."

"Saved my son, he was going down the wrong road….best decision."

"Haven't a bad word to say about them", "All staff are very nice."

While most parents or guardians spoke positively with inspectors about their experiences of secure care, others did not have the same view. Parents whose children were in the campus said that they were not happy with some aspects, such as communication with or from the staff, restrictive practices and staffing issues that impacted on visits.

What foster carers told us

Throughout the course of foster care inspections in 2022, inspectors met and spoke with 143 foster carers across nine statutory foster care inspections and 11 foster carers across two non-statutory foster care inspections. They said that the service promoted children's rights and children's cultural identity. They also said that care planning was effective as a means of ensuring the individual needs of children in their care were met in a comprehensive way. Inspectors were provided with a wide range of experiences and feedback from foster carers about the service. Some described very positive experiences, while a smaller cohort did not and identified areas for improvement.

The majority of foster carers felt very valued and listened to by their fostering link social workers and by the children's social workers. Some foster carers described their link workers as "outstanding" and "a great support". They described a supportive relationship and good communication with the service and benefited hugely from the training and supports provided to them. Some foster carers said that they had an opportunity to provide feedback on the delivery of the service through a variety of means, including child-in-care reviews, foster care reviews and individual consultations with social workers and their managers. They reported that their input and feedback was welcomed by staff. Foster carers spoke highly of the relationships they had with social workers and that they had access to supportive events and training.

"Social workers are very supportive and they are doing their best. They are very genuine and experienced."

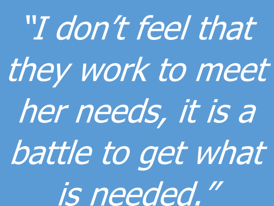
"Our link worker is very available to us…she is very responsive and I can't actually say enough good things about her."

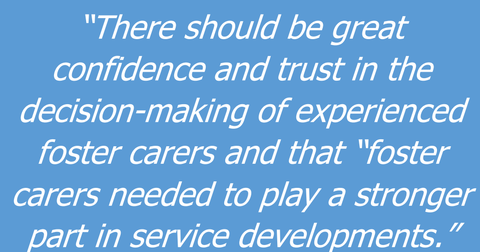
"Support from the fostering team is brilliant. They always ring me back and call to the house when needed"

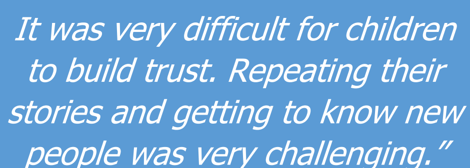
"We all work really well together and with the children's parents."

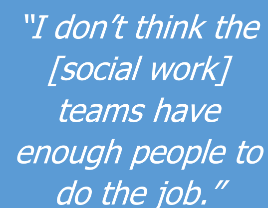
"They visited every three months and found her support invaluable."

While some foster carers experienced continuity in the support and interventions provided to them by social workers, other foster carers did not share this experience. A number of foster carers said there was a lack of continuity of social worker for them and for the children in their care. They highlighted that children were experiencing significant changes in social workers and this had a negative impact on children's care planning and access to services. There were mixed views among foster carers in relation to the support provided to children in their care who had additional or complex needs, and the difficulties in accessing specialist services and had experienced delays in access to respite care. Some of their comments included:









While the majority of foster carers had positive experiences of the foster care services, they were also asked about what improvements they would like to see. Examples of these included stability and consistency in social work allocation, improved access to support services and respite, greater levels of information sharing from the service and providing children with greater opportunities to say what they are feeling at meetings.

5. Child protection and welfare services

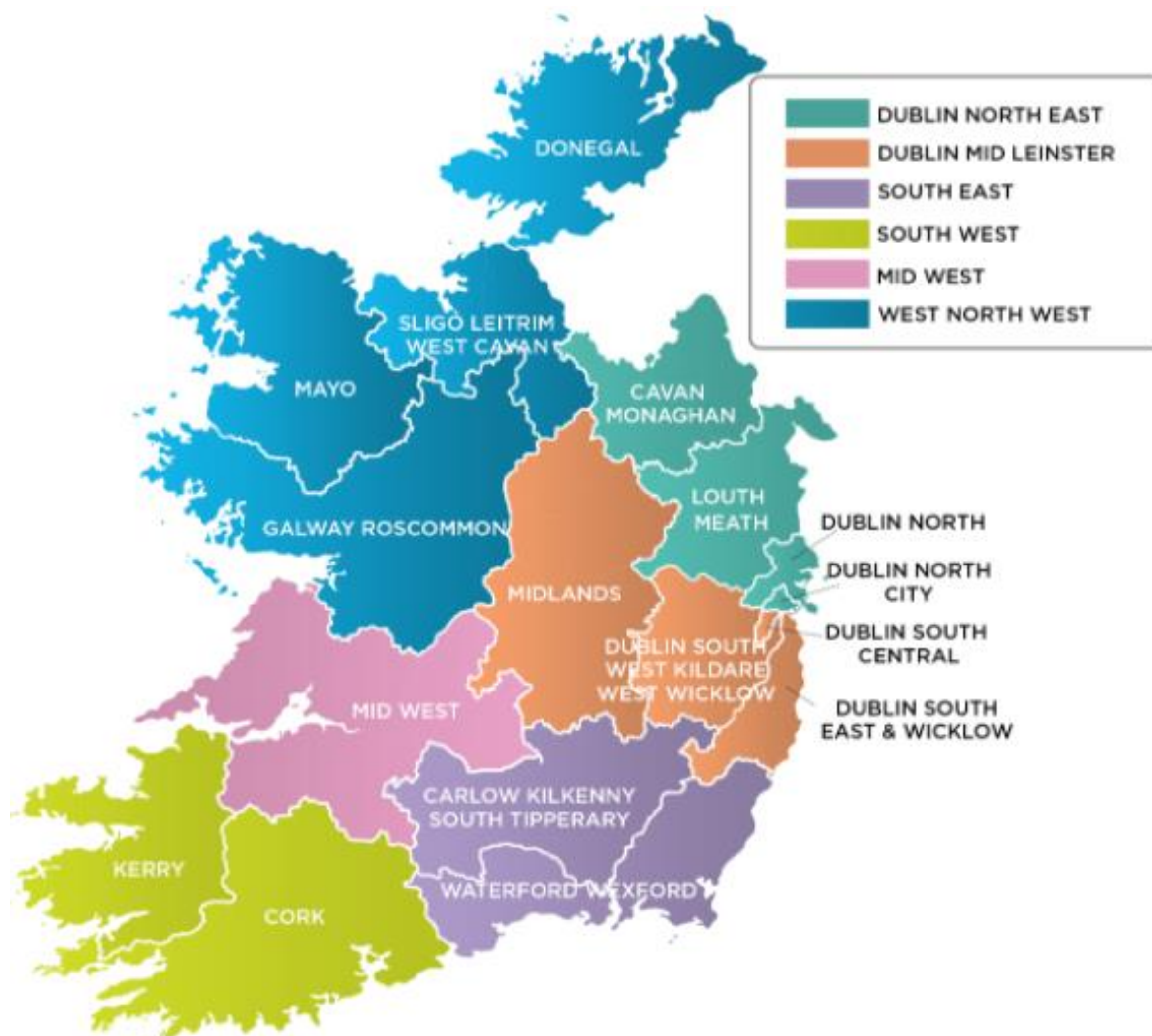
5.1 Introduction

HIQA monitors and inspects child protection and welfare services against the *National Standards for the Protection and Welfare of Children* (2012).

Role of Tusla

Tusla has statutory responsibility to protect children and promote their welfare under both the Child Care Act, 1991 and the Child and Family Act 2013. Child protection and welfare services are provided by Tusla in 17 service areas located within six regions across the country.

Figure 9. Tusla's service areas*



*Map source: Tusla website https://www.tusla.ie/.

Tusla received 82,855 referrals to its child protection and welfare service throughout 2022. This represented an additional 9,786 referrals when compared with 2021. At the end of 2022, the number of cases open to the child protection and welfare services was 22,033, which was an increase of 785 cases when compared to 2021. Open cases refers to the number of children about whom referrals were received by the service and which were identified as requiring a child protection social work assessment or intervention. In each of these open cases, children were receiving a social work service or were waiting for a service. Data available at the end of 2022 indicated that of all open cases, 15,920 (72%) had been allocated to a social worker, with 6,113 (28%) awaiting allocation, of which 391 (6%) had been identified as high priority. These figures illustrate an increase of 1,306 in unallocated cases, but there was a small decrease of 45 cases from the previous year of cases that were identified as high priority.

Data relating to children on the CPNS at the end of 2022 indicated that there were 845 children in total listed, all of whom had been allocated a social worker.[15] The number of children listed as 'active'[16] on the CPNS in the final three months of 2022 represented a decrease of 138 (14%) compared to the same period in 2021 (when there were 983 children listed).

Child Protection and welfare - monitoring and inspection activity

In 2022, HIQA conducted 11 inspections of child protection and welfare services in Tusla service areas. These inspections included:

- two risk-based inspections in one service area
- one service area risk-based inspection in one service area
- eight focused inspections of the CPNS.

This chapter provides an overview of the findings of the above inspections.

[15] End of 2022 data provided by Tusla Quality Assurance Directorate.
[16] Active means that there is a Child Protection Plan in place because it has been decided that the child is currently at risk of significant harm and needs support to be safe and well. Inactive means that the child was at risk of significant harm before and had a Child Protection Plan in the past. A child's name is removed completely from the list as soon as they reach 18 years of age.

5.2 Focused inspections of the Child Protection Notification System (CPNS)

In 2021, HIQA commenced a programme of focused inspections of the child protection and welfare service provided to children listed on the Child Protection Notification System (CPNS). Seven inspections were completed in 2021, a further eight service areas were inspected in 2022 and the remaining two service areas will be inspected in 2023. The CPNS is a national secure database containing the names of children who have been assessed by Tusla as being at ongoing risk of significant harm and for whom there are ongoing child protection concerns. The CPNS can be accessed by professionals with responsibility for making decisions about the safety of a child. These include members of An Garda Síochána, out-of-hours general practitioners (GPs), Tusla social workers and hospital staff. The decision to list a child on the CPNS is made as part of a child protection case conference. Parents, professionals and the child (where appropriate) can attend this meeting.

Every child who is listed on the CPNS is subject to a child protection plan which clearly sets out the steps to be taken to help reduce the risk of harm to the child, as well as identifying those responsible for each part of the plan. The children listed on the CPNS, their family circumstances, safety and progress of children subject to a child protection plan are closely monitored by social workers and other professionals. This plan is regularly reviewed for its effectiveness and, where progress is not evident or the child's safety and welfare could not be maintained, social workers then take action to ensure their safety, up to and included receiving the child into the care of Tusla.

Overall, there was a high level of compliance with national standards relating to children listed on the CPNS across seven out of eight service areas. Four service areas were deemed compliant or substantially compliant with all standards assessed. Three service areas were deemed non-compliant with one of the six standards assessed and one service area was deemed non-compliant with three of six standards assessed.

In the majority of service areas inspected, children who were identified at risk of harm and neglect had been referred to the CPNS service appropriately. Child protection case conferences were convened by an appropriately trained person who was not involved in the day-to-day management of the child protection case. Children on the CPNS had child protections plans which considered their long term and immediate needs to protect and promote their welfare. In the majority of areas, all children listed on the CPNS had an allocated social worker who held responsibility for overseeing the implementation of the child protection plan. All service areas were found to compliant and substantially compliant in ensuring that children's child

protection plans and interventions were reviewed to assess progress in line with requirements in *Children First: National Guidance for the Protection and Welfare of Children* (2017).

All eight service areas promoted meaningful participation of children and families in the child protection case conference process. This was achieved through children and families attendance at the meeting or through the social workers representation of their consultation with children and families at child protection case conferences. In addition, effective interagency participation at these conferences and collaboration supported and promoted the protection and welfare of children and improved outcomes for children.

Leadership governance and management arrangements were deemed effective in the majority of areas which ensured children listed on the CPNS received a consistent, good quality service. In these services, governance arrangements were strong with clearly defined roles and responsibilities identified across the team. As a result, overall accountability for the delivery of the service was clearly defined. There was also effective management systems including:

- Service Planning
- Quality assurance systems
- Systems for the monitoring of children's safety plans including visiting children
- Communication
- Risk management.

As a result of the above management systems, senior management could be assured that the service provided to children on the CPNS was safe and effective. Where risks or gaps in service provision were identified, there were systems in place to identify, address and escalate when required in timely manner.

Improvements required

While there was an overall good level of compliance across the majority of service areas, improvements were required in relation to some practices. As highlighted in our 2021 overview report, Tulsa's interim National Guidelines on Child Protection Case Conferencing and the Child Protection Notification System required review and updating. This guidance was not updated until July 2022 resulting in delays in updating guidance for staff, the consistency of the level of service provided to children varied nationally for part of 2022 as local areas had developed their own policies in order to guide managers and staff on their work.

Improvements were required by Tusla to ensure that there was consistent practice in relation to visiting children listed on the CPNS to ensure safety was maintained. This finding generally occurred in areas where social workers had significant workloads assigned to them due to vacant posts in service areas. Furthermore, monitoring and oversight of children's files required some improvement to be deemed compliant and to ensure these gaps were identified in a prompt manner and timely actions were in place to address deficits.

Additionally, in four out of eight services inspected, the quality and frequency of case supervision needed improvement in order to provide assurances to management that there were effective systems for ensuring safety arrangements for children as outlined in child protection safety plans were consistent and effective.

Risks Identified

While the majority of children on the CPNS were effectively monitored and were provided with a safe service in line with Children First (2017), there were some gaps identified in risk management and the absence of available placements and systems of monitoring. As a result, four service areas were found to be non-compliant with some standards.

In one service area, governance and management structures were not effective as they did not provide assurances as to the safety and quality of services provided to children. In particular, the monitoring and risk management systems were not effective to ensure all children were safe and that all risks were identified and assessed. Consequently, in this area, child protection plans were not monitored and not all children had been visited to ensure their safety and some child protection plans were not effective. Appropriate assurances were provided at the time of this inspection to assure HIQA that these children were appropriately safeguarded including being visited and met by a social worker.

The absence of available placements to meet the needs of children listed on the CPNS was also identified in two service areas. Improvements were also required in the effectiveness of the risk management systems in addressing the areas ability to meet those children's needs. In one area, the absence of placements posed a significant risk to the service. While this risk was appropriately escalated, the escalation of risk did not provide for provision of necessary alternative care to children. Despite supports being provided to those children to keep them safe at the time of the inspection, there remained a long-term risk to their development and safety. In another area, delays in access to suitable alternative care placements in the area had resulted in the needs of a child with complex needs not being met. This matter had also been escalated to senior management, however, progress had not been made at the time of the inspection. HIQA also requested and received

satisfactory assurances at that time in relation to the actions to be taken to ensure the individual child's needs were being appropriately addressed.

Overall, while the majority of children on the CPNS were provided with a safe service, it is of concern that a small number of children were delayed in coming into care due to the lack of appropriate alternative care placements. While these children were being closely monitored, it is essential that Tusla have the necessary resources to ensure that they are in a position to effectively discharge their statutory duty to take children into care when this is necessary.

5.3 Risk-based inspections

Key Findings of child protection and welfare risk-based inspections

Three risk-based inspections were completed in 2022. Two inspections of child protection and welfare services carried out in one service area focused on Tusla's management of child protection and welfare referrals from the point of receipt of a referral about a child to the completion of an initial assessment of the child's needs, including planning for their safety. The third inspection was a service area inspection which reviewed the progress made by the service in addressing key areas for improvement in both their child protection and welfare and foster care service that arose in previous inspections in 2020 and 2021. The effectiveness of the governance of the services were also reviewed.

In relation to the two inspections of one service area, the first inspection in April 2022 found that significant improvement was required in the monitoring and oversight of cases waiting for a service and the quality and oversight of safety planning. Measures taken to improve compliance with the standards were not timely at effecting change and the area was not in compliance with the time frames set out in Tusla's standard business process for the completion of preliminary enquiries and initial assessments. This meant that children and their families had to wait for long periods of time before the referral was processed and their needs were assessed. The management of waiting lists and how this was recorded required improvement as the review of waiting lists did not effectively ensure that risks to children while they waited for a service were identified and managed appropriately in all cases. There were potential risks to the safety, protection and welfare of these children while they waited for services. Staff vacancies and resourcing issues were the main challenge to the service in providing a timely service to children and their families. Assurances were sought in relation to the overall safety of the service, but due to an unsatisfactory response from the area, this was further escalated to Tusla's national office for further assurances.

Despite the risks present in the area, some good practice was identified during the initial risk-based inspection conducted in April 2022 in relation to the following:

- where there was immediate risk to children it was responded to appropriately and screening of new referrals was timely
- where preliminary enquiries had been completed, the majority included good analysis of the available information
- the quality of completed initial assessments was good
- when children had an allocated social worker, the work undertaken was child-centred and individualised to the needs of the child.

The follow-up inspection in November 2022 found that there were incremental improvements in the service area's delivery of the child protection and welfare service, but further improvement was required to bring the service into full compliance with the assessed standards. The area had made good progress in improving their compliance with the standards assessed:

- families were receiving a more timely service
- the system for managing unallocated cases had been strengthened
- the quality and timelines for completion of preliminary enquiries had improved
- the quality of completed initial assessments was good
- there were no high priority referrals awaiting a preliminary enquiry
- practice in relation to the quality and recording of safety planning was improving
- resources (including new staff) were being managed creatively to ensure that all resources were used to maximum effect.

Despite this progress, the service was still operating waiting lists (albeit in reduced numbers) so some children still had to wait to be seen by a social worker or social care worker. Areas of practice with regard to safety planning could be further improved so as to ensure all children were appropriately involved in the safety planning process and that the capacity of parents to safeguard children was assessed and clearly recorded. In addition, improvements were also required in relation to children's records so as to clearly reflect that safety plans were reviewed by management and updated as appropriate.

Filling vacant posts remained a challenge and this impacted on the area's ability to provide a timely response to new referrals including completing preliminary enquiries and initial assessments in the time frame set out by Tusla.

Specific risks

Risks relating to staffing and unallocated cases were noted on the area's risk register but the efforts made to address risks were not effective in the April inspection and these risks continued to be significant in the second inspection in November. The service area continued to make efforts to address these risks and had some improved capacity to implement identified controls to mitigate risks, however they had not yet been successful in eliminating them from the service.

Overall, the findings of the two risk-based child protection and welfare inspections conducted in 2022 illustrated that the service area was making progress in coming into compliance with the standards. Of the four standards assessed in November 2022, all four were found to be substantially compliant. This represented significant improvement in service delivery since the previous inspection in April 2022. A satisfactory compliance plan was in place to work towards full compliance in all of the standards inspected and HIQA will continue to monitor this service closely.

Key Findings of a service area child protection and foster care service risk-based inspection

A follow-up risk-based inspection of one service area across the child protection and foster care services was also completed in 2022. This inspection considered the progress the service area had made in addressing key areas for improvement that were highlighted in previous inspections in 2020 and 2021.

Overall, service leadership and systems of governance were developing well. The new senior management team was striving to embed a consistent approach across the entire service area and was working to deliver a comprehensive change programme to strengthen the quality and safety of its services. Management audits and risk registers were used to monitor progress made, but further work was required to strengthen management checks of the quality of practice and embed organisational learning.

While inspectors found evidence of some improvements, additional time and resources were required to address ongoing waiting lists and delays in responding to local need. Overall, the four social work departments within the service area, while having a shared direction, were at different stages in delivering improvements. One social work department indicated that 10 of its practitioners had unmanageable

caseloads due to the significant challenges it faced in recruiting staff, combined with high levels of turnover in the past year. Other departments had not formally flagged practitioner caseloads as unmanageable. However, two other departments continued to lack capacity to allocate all new referrals in a timely manner. These teams had a high number of cases which were designated as awaiting allocation, with some children waiting many months before any direct work was done with them and their families.

Other areas were further work was required in terms of:

- the availability of a suitable range of care placements especially for children with complex needs required improvement
- caseload management required improvement to ensure that all statutory requirements were met for children in foster care
- safety plans were not sufficiently developed or reviewed for some children in care referred to child protection and welfare service
- staff supervision and performance development of staff at all levels was required.

HIQA will continue to monitor this service area through their compliance plans, as well as further inspection activity in 2023.

6. Alternative care services

Alternative care refers to both residential care and foster care services provided by Tusla or non-statutory (private or voluntary sector) organisations for children and young people who are unable to live with their own families. HIQA monitors and inspects all 37 statutory children's residential centres provided by Tusla. It does not currently, however, have powers to inspect non-statutory residential care services, which continue to be registered and monitored by Tusla. HIQA also inspects both statutory and non-statutory foster care services.

Inspections of children's services, including residential and foster care services, during 2022 found that providers faced significant and increasing challenges in ensuring their service capacity was sufficient to maintain existing levels of provision and effectively plan for and meet the diverse needs of children entering care. Shortages of placements were clear in all regions and parts of the alternative care sector resulting in some children being placed a long distance away from their families and communities.

Inspectors found greater use by Tusla of unregulated 'special emergency accommodation', not only for unaccompanied children but also for older children with complex and additional needs. Increasing numbers of children referred to residential care were assessed as having emotional and behavioural difficulties linked to their earlier adverse childhood experiences. This required careful management in relation to matching considerations and the need for continual upskilling of the workforce. While inspectors found Tusla's new collective risk management approach (in use in its residential care centres) was largely effective in determining the suitability of placements, there was a need to strengthen learning and development programmes in response to the younger age profile and the complexity of needs of children being admitted to residential care.

A lack of specialist foster care provision had led to more children being placed in residential care given the limited number of viable alternatives. There were also few options to help younger children move out of residential care to a family setting prior to young people reaching the age of 18 and moving out of care. Such pressures and gaps in service provision meant that not all children in the care of the State were able to experience family life as a basic human right.

A small number of Tusla's residential care services were still provided in locations and buildings that were not homely or fit for purpose, and time frames for re-location had taken longer than had been anticipated. Although, overall, most inspections of children's residential centres were found to be adequately staffed, centre managers shared their growing concerns their increased use and reliance on agency staff.

HIQA's inspectors found overall that the majority of residential centre managers and their front-line teams provided a good standard of care that was tailored to the individual needs of children. Centre and regional managers maintained a strong focus on compliance with statutory regulations and the expected standards of practice as set out in the statements of purpose for each centre.

Tusla launched its Strategic Plan for Residential Care Services for Children and Young People 2022-2025 and Strategic Plan for Foster Care Services for Children and Young People 2022-2025 during 2022. These plans have the aim of creating a stronger service offering with a range of supports targeted at different levels of provision, such as in-home support, foster care, and mainstream and specialist residential care services. The achievement of its ambitions to transform service delivery was still at a relatively early stage of programme implementation at the time of writing this report.

6.1 Statutory children's residential centres

Quality of statutory arrangements for children in residential care

During 2022, HIQA conducted six announced inspections of the role and accountabilities of Tusla's social workers for children in residential care as set out in the Child Care (Placement of Children in Residential Care) Regulations, 1995. The inspections included a service area from each of the six Tulsa regions. The regulations describe the minimum requirements that need to be in place for children in residential care. This inspection process reviewed how children in both statutory and non-statutory residential placements were supported by their social worker. Inspectors found comparative levels of performance to the findings of a similar programme of inspection activity undertaken in 2018. However, recent inspections reflected the growing challenge regionally and nationally in recruiting and retaining designated children-in-care social workers. Despite such capacity challenges, most service areas prioritised social work activity in relation to the children they had placed in residential care.

Children placed in residential care often have complex needs and require a high level of individualised care and therapeutic support. Increasingly, children were placed in residential care at a much younger age, from five years of age and sometimes at a long distance from their homes and communities. Many children had already experienced foster care or previous residential care placement breakdowns. For these reasons, it was essential that all children had a named social worker that they saw regularly, who they could talk to about the things that mattered most to them, and who helped them to be actively involved in developing and reviewing their care plan.

The data submitted to HIQA provided key information about placement trends and indicated the need for Tusla to further review the way it commissions non-statutory residential care services. The six service areas together had a total of 152 children placed in residential care. Only 31 of these children were placed in Tusla's directly-managed provision. A total of 101 children were placed outside their service area, and 23 children were aged 12 years or younger. It was notable in one service area that 26 children were placed with non-statutory providers in 24 different service settings.

Tusla's Strategic Plan for Residential Care Services for Children and Young People 2022-2025 provides a clear direction in relation to their plans for expansion to help reduce its reliance on non-statutory providers, and focuses on areas where there is limited or no local provision to meet ongoing levels of demand. However, Tusla remains highly reliant on its use of non-statutory residential providers. It will also need to further strengthen links with fostering services and promptly implement its plans for a multidisciplinary approach to fostering to reduce the need for younger children to be placed in residential care and to expand opportunities for them to experience family life.

Care planning and child-in-care reviews

Overall, children's care plans were comprehensive and child centred and this led to the performance of all six service areas being rated as compliant in relation to care planning. Care plans provided a clear picture of children's individual strengths, challenges and the additional support they needed. They were generally responsive to children's age and stage of development, length of time in placement and their future care needs. Children and their families were encouraged to be involved in decisions about how best to promote and maintain their safety and welfare. The majority of care plans clearly documented the goals of the placement and what was expected of the service provider. Strong partnership working with other professionals and residential providers was evident in most cases. This meant children were able to benefit from shared expertise in assessing and meeting their individual needs.

Child-in-care reviews of children in residential care were generally well managed. Reviews routinely considered the suitability of the placement and longer-term planning for the child. They were generally held in a timely manner following the child's admission to a new care setting or where there was a risk of placement breakdown. Some service areas had separate independent review chairpersons which helped provide additional challenge and capacity, for example, in the appointment of a consistent person to oversee the reviews of children aged 12 years and under. This approach provided good oversight of the development and changing

needs of younger children. Three out of six service areas were rated as substantially compliant due to some reviews not being held within the time frames as are required by the regulations.

Efforts were made by social workers to encourage children to participate in their review meetings. While most children gave written feedback to inform their review, levels of attendance overall by children remained an area for further improvement. Inspectors found examples of good practice where parents were assisted by social care professionals to contribute to their child's care plan and review. This approach recognised their own needs and helped promote their ongoing relationship with their child.

Other professionals and partner agencies also contributed to and attended review meetings. This enabled shared exploration of changes required to the child's care plan or any additional support needed. Changes made to care plans were discussed with children, their families, the service provider, guardians' ad litem and other relevant professionals and agencies. Service areas had an agreed process in place to alert senior managers when additional resources were required or if the placement was no longer effective in meeting a child's specific needs.

Inspectors found that all service areas continued to strengthen their arrangements for monitoring social work practice and made good use of management trackers and performance reports to track compliance with statutory requirements. They had a range of policies, procedures and guidance to ensure the standard of professional practice was in line with the regulations. Good practice was seen in some service areas where there were self-audits, templates and checklists to aid social workers in quality assuring their own practice.

Supervision and visiting of children

Five out of six service areas were compliant or substantially compliant in ensuring children were regularly seen and that checks were made of their experience of residential care. Such visits aimed to inform social workers' ongoing monitoring as to whether the support provided was effective in meeting children's specific needs. The service area rated not compliant had eight children in residential care who did not have a social worker assigned to oversee and co-ordinate the delivery of their care, including undertaking visits to enable them to get to know them and their individual needs. Following the inspection, HIQA received assurances from this service area that all children in residential care without a social worker would be allocated one.

The three service areas that achieved full compliance ensured children in residential care were regularly visited and complied with the expected level of frequency set out in the regulations. Additional visits were made when required, including in response

to a child's request to see their social worker, ongoing direct work by the social worker, or in response to a concern or incident in relation to the safety or wellbeing of a child. Professionals meetings were held with the service provider and others to explore the best approaches to meeting children's current and future needs.

Most service areas maintained appropriate records of such visits including evidence of children's feedback and any concerns or complaints they had raised with their social worker. This helped to provide a clear picture of children's daily lives, their wishes, priority needs and any follow-up actions required.

Children's records

Improvements were required in maintaining children's records. Only two service areas were rated as compliant, and four others as substantially compliant in maintaining children's case records in line with the regulations. The regulations outline the information that is required to be recorded on a child's record. These include significant events, care plans, birth certificates, court orders, medical and school reports among others. Inspectors found that children's case records were securely stored. However, there were delays and gaps in uploading some records onto the National Childcare Information System (NCCIS).[17] This included management records of actions agreed in supervision with the child's social worker. Other issues related to lack of consistent use of naming conventions for specific records which meant they were not easy to find or follow over time. Service areas were strengthening their administration teams and provided additional training and protected time to caseworkers with heavy caseloads to enable them to get their records up to date.

Children's case records also included relevant correspondence and reports from partner agencies and reports from service providers. This included individual risk assessments and behaviour management strategies to safeguard children missing from care, those vulnerable to exploitation or at risk of harming themselves or others. Good practice was seen in the use of the significant events reporting process for recognising children's achievements and progress.

Overall, front-line staff and managers demonstrated good awareness of the complex needs and risks to the safety and welfare of children in their care.

[17] Tusla's integrated information system to manage child protection and welfare cases.

6.1.1 Children's residential centres - Inspection and monitoring findings

In 2022, HIQA completed 20 inspections of statutory children's residential services. The inspections were short-notice announced visits and covered the range of Tusla's service provision. This included short, medium and long-term placements, specific provision for children seeking international protection, and respite services for children aged five to 17 years. In addition to these inspections, inspectors continued with regular monthly check-in phone calls to centre managers to identify any ongoing issues in relation to the management of COVID-19 and risks associated with staffing capacity.

Overall, HIQA found that most residential services were well managed, with appropriate levels of support available to meet the specific needs of children placed there. The majority of residential centres had a publicly available statement of purpose that clearly and accurately described the services provided. A total of 19 centres were rated as compliant or substantially compliant. One centre was rated as not compliant where gaps identified in the previous inspection, in relation to management and staffing, had not been addressed. In this and another centre, bespoke temporary accommodation had been found in response to concerns in relation to poor peer dynamics and high levels of behaviours of concern. Tusla has since strengthened its approach to implementing individual and collective risk assessments pre-placement to enable earlier and stronger identification of matching risks.

The vast majority of residential services were found to have appropriate systems in place for planning, organising and managing the social care workforce. Centre managers and front-line staff teams were knowledgeable and experienced, with sufficient numbers of staff to care for the children placed there. This demonstrated improvements in comparison to 2021 when staffing resources had been identified as an area for improvement. However, two centres continued to experience significant challenges in filling vacancies and providing the levels of individual supervision required to prevent and reduce behavioural incidents. The compliance plans submitted to HIQA following these inspections provided assurances of actions being taken to appoint to vacant posts and ensure rotas were adequately covered in response to the management of risk and 'live' night cover.

Overall, the inspections found that the care and support provided recognised children's individual needs and sought to maximise children's wellbeing and personal development. A total of 11 centres were rated as compliant, eight as substantially compliant and one non-compliant against this standard. Good practice was seen in one centre supporting younger children where the nationally-agreed model of care was combined with a therapeutic parenting approach. This approach promoted improved recognition of the impact of childhood trauma on the presenting behaviours and development of younger children. One centre was assessed as not compliant as it did not use placement support plans in line with Tusla's policy. This meant there was not a clear and structured approach to helping children achieve their goals through effective implementation of Tusla's national therapeutic approach.

Centre staff also paid good attention to ensuring children were able to see and maintain contact with their family, friends and local communities in line with their wishes

The majority of children's residential centres were homely, with care taken to ensure the care environment promoted the safety and wellbeing of each child, but this was not the case for all centres. A total of 10 residential centres were assessed as compliant and five were rated as substantially complaint against this standard. It was of concern that some residential services continued to be provided in locations and buildings that were not fit for purpose or maintained to a high standard. Five centres were rated as not compliant against this standard, with actions required to urgently improve fire safety arrangements, address damage to buildings and locate the service closer to local communities. These gaps in the quality of the care environments were recognised within Tusla's regional service improvement plans, however, the identification of suitable alternatives was not progressing in a timely manner.

The inspections also considered the transition arrangements to help young people leaving care move to adulthood and found a high level of compliance in relation to helping young people prepare for adulthood. Tusla's Strategic Plan for Residential Care Services for Children and Young People 2022-2025 recognises the importance of expanding its capacity in relation to semi-independent aftercare provision. Good practice examples included where staff teams supporting young people seeking international protection, continued to offer outreach support for a period after they had moved out from the residential centres. However, inspections also highlighted the impact of wider gaps in Tusla's aftercare arrangements for young adults. This included late allocation of after care workers and lack of appropriate 'move on' accommodation to enable young people to achieve independence in a planned and timely manner. Delayed discharges from the service had led to increased anxiety for some young people about where they would be moving to. Overall, there was a high

level of compliance found in relation to care practices across the residential centres, there was a need to strengthen early joint planning with other agencies and expand the range of supported aftercare accommodation for young people to move on to.

The majority of residential services had appropriate systems and processes in place to ensure children and young people were safeguarded from abuse and neglect, and that their care and welfare was protected and promoted. Good practice was seen in some residential centres where regular multiagency professionals meetings were held to share learning and strengthen management of risk to young people who remained vulnerable to exploitation or exposed to harm, including when missing from care. Organisational gaps in practice included coverage of Children First (2017) training, awareness of policies and procedures for the management of safeguarding concerns and protected disclosures. HIQA received appropriate plans from provider to bring their centres into compliance.

Inspectors found that overall there was good practice in relation to children receiving high-quality care and support in response to incidents of challenging behaviour, including the promotion of positive behaviour support plans. A total of 13 centres were rated as compliant, four as substantially compliant and three as not compliant. Inspectors observed supportive and respectful relationships with children in all centres visited. Some gaps in practice related to delays in the timely identification, assessment and management of risks, including for children with self-harming behaviours. Work was required to ensure the least restrictive approach was taken for the shortest possible duration, and that restrictive practice logs were effectively maintained and reviewed. The engagement of children in shaping and reviewing their positive behaviour support plans required further practice development. In addition, the lack of suitable alternative provision also meant a few children remained in placements that were no longer appropriate in meeting their needs. These issues were escalated to Tusla and satisfactory responses were received.

The performance of residential services in meeting children's health and development was good with the majority of services compliant or substantially compliant with the standard. Areas for improvement included the management and oversight including the recording of medicines administered.

Given the increase in the number of younger children availing of statutory residential services, inspectors found that Tusla's current policies and procedures for its residential care services, issued in 2021, did not effectively support staff in addressing the developmental needs and behaviours of younger children availing of residential care including respite care. HIQA's inspections also indicated that Tusla, as the provider of residential services, needed to enhance workforce skills in response to the increasing diversity of its residential care provision.

In summary, HIQA's inspection reports of children's residential centres indicated good performance was seen and sustained in a number of areas, including the management of the social care workforce and helping children maintain contact with their family and friends. However, further work was required to ensure that all children consistently benefited from a safe and homely environment, that they received the levels of specialist support and review they required in managing their complex needs and behaviours and that there was good oversight of medication management processes. Tusla's Strategic Plan for Residential Care Services for Children and Young People 2022-2025 highlights plans to improve governance, accountabilities and integrated decision-making for residential care placements and to strengthen children's access to therapeutic support.

6.2 Foster care — statutory

6.2.1 Introduction to inspection of statutory foster care services

In Ireland, statutory foster care services are provided directly by Tusla on behalf of the State. In 2017, HIQA commenced a three-phase focused programme of inspection of these services across all 17 Tusla service areas.

Phase one was completed during 2017 and 2018 and focused on the recruitment, assessment, approval, supervision and review of foster carers, including the arrangements in place for safeguarding and child protection of children in foster care placements. Phase two was completed during 2019 and 2020 and focused on the arrangements in place for assessing children's needs, the care planning and review process, preparations for children leaving care, and safeguarding of children. In September 2021, HIQA published an overview report on the findings from this inspection programme across all 17 service areas.

HIQA began the third and final phase of its foster care programme in 2021, a thematic foster care programme which focused on assessing the efficacy of the governance arrangements across foster care services and the impact of these arrangements on children in foster care services. As this programme focused on service quality improvement, only those service areas deemed to have previously had a high level of compliance with standards were included in the inspection programme. Six inspections were completed in 2021 and a further seven service areas[18] were inspected in 2022. All other service areas were monitored and inspected in line with our risk-based monitoring approach.

[18] One further thematic inspection moved to a risk-based inspection once commenced and this is covered under section 6.3.

Inspections monitored the following eight standards:

- effective policies
- management and monitoring of foster care services
- training and qualifications
- recruitment and retention of an appropriate range of foster carers
- special foster care
- the foster care committee
- placement of children through non-statutory agencies
- representations and complaints.

Before the start of the thematic element of the programme, all service areas deemed eligible for the inspection programme were issued with self-assessment questionnaires, in order for them to self-assess their compliance with the above standards. These were submitted to HIQA and informed the scheduling of these inspections. Each area was required to develop a service improvement plan on foot of any deficiencies they identified in their self-assessments, in order to start their quality improvement initiatives.

6.2.2 Phase three inspection and monitoring findings

Good governance and management systems are important to ensuring the delivery of a safe and effective foster care service.

Overall, in respect to governance and management, all service areas had appropriate structures in place to ensure good quality and safe services were provided to children and foster carers. Although service areas had strong leadership and established governance structures in place, certain risk factors remained in some but not all of the service areas. Risk factors included shortfalls in staffing, children in care without an allocated social worker and a lack of sufficient and suitable placements to meet the needs of children.

Only one out of seven areas inspected in 2022 was compliant or substantially compliant with all of the standards assessed. The remaining six areas, while compliant and substantially compliant with some standards, also had between one and four standards deemed to be moderate non-compliant. One of these service areas was moderately non-compliant with one standard, three service areas were moderately non-compliant with three standards, and a further two service areas were moderately non-compliant with four standards.

Overall, the 2022 inspections found that there was appropriate governance arrangements in place for the delivery of services to children in foster care, however some areas governance arrangements were more effective than others, due to risks identified in these areas. Staffing and the recruitment of foster carers, despite the efforts of many service areas, remained a challenge. This highlighted the need for improvement in all seven areas with regards the capability and capacity of their services in order to provide a safe and effective service for children and foster carers. As this is a national issue, Tusla needs to ensure that adequate processes are in place to manage these risks, and ensure that improvement plans are robust, and that control measures put in place to mitigate the risks are achievable, and constantly monitored by Tusla in order to ensure that all children in foster care receive a good quality service.

In 2022, Tusla published their Strategic Plan for Foster Care Services for Children and Young People 2022-2025 which outlined their ambitions for the next three years. HIQA welcomes this plan as it addresses many of the areas of improvement identified by the thematic inspection programme. Firstly, Tusla's strategic plan committed to increasing their statutory foster care provision, to continue to place over 90% of children and young people in care in foster care and to develop services to better meet the needs of children and young people, foster carers, and staff, by 2025. In addition, the plan recommends that it with implement a consistent model of practice in foster care services, strengthen its organisations structures to better support its staff and to strengthen its support to parents whose children are in care.

Effective policies

Nationally-implemented policies, procedures and guidance leads to consistent practice. The 2022 inspections found that national policies, procedures and guidance were aligned to relevant legislation, regulations, policies and standards, but improvements were required in relation to adherence and implementation. In addition, several areas developed their own policies and procedures to manage situations whereby they felt there was a gap in national policy, which led to differing practice.

Three out of seven service areas were moderate non-compliant and the remaining four service areas were substantially compliant in respect to effective policies. There were areas of improvement and areas of good practice identified in each of the seven areas.

Throughout the seven service areas, inspectors found that they all had policies and management systems in place that ensured that policies, procedures and guidance were effective at guiding staff to implement a consistent practice with children and

foster carers. There was evidence of the provision of child-centred services, good partnership approach with children and foster carers, and joint working. However, there were levels of inconsistency and gaps in the implementation and adherence to some but not all of the policies.

A risk identified during 2022 was the number of unallocated children in care in some service areas. HIQA therefore looked at the policies and procedures in place to manage these risks. Three of the seven areas had introduced a local policy and procedure for responding to the needs of unallocated children in care. While this meant that service areas individually were putting measures in place to manage unallocated children in care, the lack of a national approach meant that practice differed throughout the country.

In some areas, the unallocated case procedures set out the expectation that social care workers or social care leaders who were managing unallocated cases in the absence of an allocated social worker, would receive monthly supervision of their caseload. Inspectors found that although supervision was mostly regular, it was not always in line with the expected frequency or standard as set out in Tusla's supervision policy. Given that they were undertaking the work usually assigned to a social worker, this oversight was critical to ensure the safety and quality of service provided to children in the care of Tusla.

While such systems ensured essential work was delivered in line with standards, there was growing pressure on the capacity of team leaders to balance case management responsibilities with their wider governance and service development priorities.

In one service area they operated a dual process for the recording of information on foster carer's files, which was not in line with Tusla policy. In addition, there was inconsistent practice in relation to tracking and recording of training for foster carers; therefore, in two service areas it was found that foster carers required updated training in Children First (2017).

There was appropriate planning and good oversight of children in care who transferred between service areas. The national transfer policy in relation to children being placed outside of their area was followed and there was evidence of good joint working between service areas.

Areas of good practice were identified on inspection, including where four service areas demonstrated that they promoted a partnership approach with children, foster

carers, and professionals. Other areas of good practice were specific to individual service area and examples included:

- having a well-defined strategy on child participation
- foster carers receiving information on policies from social work and business support teams
- regular support and supervision visits
- joint visits taking place with link social workers and children's social workers
- discussion with regards specific standards at monthly meetings to build on team skills, knowledge and expertise.

One service area implemented a new policy that addressed the issue of foster carers not receiving support and supervision in line with national standards and regulations. Inspectors found that there was effective governance and management systems in place to monitor adherence to policies in some but not all of the service areas, and one service area in particular had taken actions to respond to children's feedback.

Areas for improvement included:

- there was inconsistent implementation of some but not all policies, such as the complaints policy and supervision policy, and there was a lack of management oversight with regards the supervision of social care workers allocated to cases in the absence of a social worker
- local procedures for the management on unallocated cases were not effectively implemented or standardised across teams, and this related to two services areas in particular
- some service areas required improvements in adherence to policies regarding the maintenance of cases files and foster care records.

Management and monitoring of foster care services

All service areas had clearly-defined governance arrangements and structures in place. The management structures and reporting systems that were established allowed for clear accountability and effective reporting. However, some service areas struggled with staffing capacity and resources to be able to fully manage and monitor the service they provided. As a result, of the seven service areas inspected in 2022, six were moderate non-compliant and one area was substantially compliant in respect of management and monitoring of foster care services.

Service improvement plans were in place and it was noted that the service areas benefited from having strong, stable and experienced management teams. There was a clear focus on service improvement in all areas. However, inspectors found the pace of overall service improvement was compromised by persistent shortfalls in the capacity of some service areas to meet demands. In addition some service plans did not effectively identify and target some of the unique challenges and risks identified for foster care services in the previous 12 months.

The majority of areas had oversight and monitoring of certain aspects of service delivery by social work teams; however, areas of improvement included the management of child protection and welfare concerns (for children in foster care), the management of unallocated cases of children in care and foster carers, and the tracking and oversight of statutory visits to children in care and supervisory visits to foster carers.

Improvements were required to ensure managers had accurate, relevant data to provide oversight of these key aspects of the service. Three out of the seven areas inspected identified gaps in case management and information management systems.

Concerns were identified in three service areas, and further assurances were requested by HIQA. One service area was requested to provide assurances in relation to the control measures they had identified to manage unallocated children in care as they were not fully implemented nor were they possible to implement. In another area, it was noted that they still had work to do to prevent reoccurrence of 'dual unallocated' children and foster carers; this is where neither the child nor the foster carers had an allocated social worker to oversee the placement. Work was also required to ensure that all children placed in non-statutory foster care placements had a Tusla allocated social worker to oversee their care. In a third service area, individual children in care cases were escalated, due to the lack of management oversight of key statutory requirements such as visits to the children.

Some front-line practitioners had unmanageable workloads and were overstretched. One service areas in particular had a number of children who had experienced a very high level of social worker turnover. All service areas had unallocated children in care, and some children were unallocated for long periods of time. Inspectors' review of records indicated staffing pressures in some cases had impacted on the capacity of front-line staff and managers to maintain up-to-date case records or complete key projects within desired time frames. These findings indicate that a national approach for the oversight of unallocated children in care is urgently required, to ensure the monitoring of the quality and safety of the service provided to these children.

Quality assurance activity was not consistently leading to better practice at the time of these inspections due to pressures in capacity across the workforce. Some service areas had better developed quality assurance systems than others, and some service areas auditing activity was more advanced and effective than others. However, the lack of national oversight of quality assurance systems across all service areas was evident in the variance and inconsistent practices found. Some, but not all, service areas had a quality and risk service improvement officer.

Oversight and monitoring of some aspects of the service required strengthening in order to provide a high quality and safe fostering service. Supervision was not yet effective enough to ensure consistency of practice. Auditing of case records was an area for significant development. Consistent auditing was identified as an area of improvement in two service areas to ensure safe and effective service delivery. In three service areas staff vacancies impacted on the service area's capacity to be fully compliant with the standards.

One service area had approved the establishment of an additional team leader and social work posts and the reconfiguration of resources to enable the appointment of non-social work roles within front-line teams. New social work graduates had been attracted to work in some services areas. One service area had developed a joint approach with another service area to encourage better community awareness of fostering.

In one service area which was particularly challenged by high level of vacancies and significant numbers of unallocated children in care, leaders were seeking to achieve better value from local resources through partnership working and sharing of expertise. Inspectors found some examples of well-established relationships with community and voluntary sector organisations that promoted innovative practice, in order to support them in managing the risks.

Training and qualifications

All areas had systems and processes in place to ensure that staff were recruited in line with legislation, standards and policy. There was a high level of compliance across all service areas regarding this standard, with one service area being fully compliant, and six service areas substantially compliant.

All staff were suitably qualified, trained, and had the required registration or vetting completed. Improvements were required in relation to the storage of documentation on staff files. For example, in one area there was no evidence of CORU, Ireland's multi-profession health regulator, registration on file for five staff sampled, and in others references or qualifications were missing. This issue arose due to duplicate processes in place for storage of staff personnel files, some of which were still held by the HSE, while some records were held regionally by Tusla, and some were held nationally.

There were comprehensive induction programmes in place for new staff, which included a corporate induction, and local initiatives were also found, such as mentoring of new staff, and many service areas operated a reduced caseload for new staff, as well as increased supervision. Some improvements in the supervision process were required, such as ensuring the frequency was in line with Tusla policy, ensuing good records were maintained, and that actions and decisions were tracked from one session to another, to ensure there was no drift or delay.

Many areas struggled to recruit staff due to the general scarcity of social workers. As a result, service areas had put in place initiatives, such as wellbeing programmes, in order to improve the retention of staff in their areas. In addition, most areas had contingency plans in place in the event that the COVID-19 pandemic impacted on their staffing capacity. One service area had established a 'Celebrating Kindness, Service and Teamwork' initiative that encouraged a caring work culture through promotion of positive behaviours and best practice. In one service area staff said they met with Tusla's national management team to contribute their views and ideas in relation to staff retention and increased recruitment. Another service area had completed a staff survey, and established a staff retention subgroup to develop initiatives to increase staff retention in their area.

While some service areas had well developed training needs analyses to inform their workforce learning and development programmes, others did not have the same level of focus and professional development plans were not always in place. Tusla's 'Empowering Practitioners in Practice' (EPPI) forum was accessible to all practitioners and staff were encouraged and supported to engage with it for learning and further development.

Some service areas held joint training programmes with foster carers, with one area in particular holding six training events over the previous year. Another service area arranged external joint training, such as therapeutic approaches to parenting, and one area rolled out the 'Rupture and Repair' programme, which was an online training course involving both foster carers and social workers. However, one service area had not held any joint training sessions in the previous year due to other work pressures.

Recruitment and retention of an appropriate range of foster carers

Recruiting foster carers has been a significant challenge for Tusla in 2022 due to a number of factors, including COVID-19. While HIQA has found that, in general, service areas always tend to need more foster carers to meet the demand for services, in 2022 however, the lack of a sufficient range and number of foster carers was particularly evident. Four service areas were moderate non-compliant with this standard, while three areas were substantially compliant. Some areas had conducted exit interviews with foster carers in order to learn from them and address any reasons for leaving. However, it was often due to foster carers retiring, leaving on health grounds, or the children aging out of care, with some foster carers indicating communication difficulties, or lack of support.

The processes in place for the recruitment of foster carers varied across the service areas and regions. In the Dublin North East and Dublin Mid Leinster regions there was a specific team named the Regional Assessment Fostering Team (RAFT) who were responsible for the recruitment and assessment of carers in the service areas in these regions. In the other regions, the service areas themselves carried out this work.

Despite this, however, it was found that the regions who did have RAFT in place, did not have any better outcomes in relation to the recruitment of foster carers than the service areas who did not have this team. In fact, inspectors found that service areas themselves often were more successful in attracting, recruiting and assessing carers. In the seven areas inspected in 2022, four areas had RAFT, while three carried out their own recruitment programmes. In the 12 months prior to the inspections in the four areas where RAFT was in place a total of 19 foster carers were recruited across these areas, and four applicants were undergoing assessment. The three service areas with local recruitment initiatives recruited 31 foster carers in the 12 months prior to the inspections, and 31 assessments were ongoing. One of the service areas where RAFT undertook recruitment commented that this limited their ability to recruit locally, so they instead decided at the end of 2021 to develop and implement their own recruitment plan.

Responsiveness to enquiries to become foster carers was found to be good in all the areas inspected. The systems in place in some areas to ensure timely approval of relative carers required improvement, and gaps in staffing contributed to this delay.

The gaps in staffing capacity meant that all areas struggled to complete foster care assessments in a timely manner. The lack of staffing, therefore, had a direct impact on service areas ability to assess and approve more foster carers. The knock-on effect of this was that they continued not to have enough foster carers to meet the demand. While one service area had completed an evaluation of their recruitment drive, they were unable to make any progress as they lacked the staffing capacity to complete assessments.

In areas where RAFT was in place, there was a regional matching process, which meant that general foster carers assessed through RAFT were often matched with children from other service areas. This reduced the pool of available foster carers to the local service area.

There was mixed findings in relation to the evidence of the matching process, with some files containing good evidence of the matching process, while others had no evidence of the matching process on file. However, one area had completed an audit of the matching process and made recommendations on foot of the audit, such as the completion of written matching tools and placement request forms in a timely way.

Placing children within their own communities is considered best practice where possible, as they can generally remain attending the same school, and maintain links with family, friends and their community. Unfortunately, findings from these inspections found that, due to the lack of foster care placements, some children were not placed within their own communities.

All service areas prioritised placing children with relatives where this was possible and considered this as a first option. For example, one area had 63 of their 192 children (32%) placed with relatives, while other areas had between 26% and 30% of children in care placed with relatives. This sometimes meant that these children were placed outside of their service area, however this was a better option from the perspective of keeping children within their extended family of origin.

Due to not having enough foster carers to meet demand, some children were placed in non-statutory foster placements or were waiting for a suitable match. Some children were placed with carers who already had too many other children placed with them. This was not in line with the regulations, which state that no more than two unrelated children should be placed at any one time. One area, for example, had 14 foster placements where the number of children placed exceeded what is recommended (two unrelated children), 21 children were placed in non-statutory

placements and 13 children were waiting for a suitable placement. Another area had 47 children placed in non-statutory placements.

The lack of placements to meet demand had an impact on the ability of service areas to match children appropriately.

Good practice was found in all of the service areas inspected in relation to the practice of offering exit interviews to foster carers who had left the panel, to inform service improvements. All areas offered exit interviews, and for those who volunteered to participate in them, they were arranged in a timely manner. In some areas, the foster care committee analysed the exit interviews for learnings, and this was an example of good practice. In some service areas where the take up of exit interviews was low, alternative ways of capturing feedback, outside of the exit interview process, were being considered.

Special foster care

There is no national policy in relation to the provision of special foster care, as required by the standard. However, in six of the seven service areas inspected, inspectors found that while these areas did not recruit foster carers to become 'special foster carers', additional supports for foster carers who were caring for children with complex needs was provided. These supports varied from additional payments to cover medical costs, or additional support in the form of respite, training, and access to therapeutic services. Six service areas were substantially compliant with this standard, and only one area was non-compliant moderate.

In the service area that was deemed non-compliant, the process for accessing additional funding and additional supports was complex and not timely and, as a result, children and their foster carers were often waiting excessively long periods of time to access these additional supports in comparison to other service areas.

Some areas had developed their own policies for the provision of additional services, in the absence of a national policy. However, while this was found to be effective in these service areas, it led to regional and inter-area inequities arising. For example, a child in one service area that had clear processes and policies in place was able to access more supports and do so faster than a similar child in a neighbouring service area.

Some areas had very well developed systems for accessing ancillary services. For example, through regular liaison meetings with the HSE, and in one area there was a 'therapies committee'. However, this was not consistent across all service areas inspected, and therefore children received a different response depending on the service area in which they were living.

HIQA highlighted the inconsistent approach to Tusla who indicated that they were seeking to promote consistency in their approach to the provision of foster care to children with complex needs, and the provision of services to better support their foster carers.

Tulsa demonstrated some progress toward the latter part of 2022, through piloting their own multidisciplinary teams. During the inspection in the Midlands region in late August 2022, the service area advised that they had been selected as a pilot site for the development of an 'integrated therapy team' and the process had begun to recruit a psychologist, occupational therapist and a physiotherapist to work with children in care in the area. This was a positive initiative to improve access to services for children in care. This pilot reflected Tusla's Strategic Plan for Foster Care Services for Children and Young People 2022-2025. It also advises that every service area has an appropriate trauma-informed therapeutic service for all children in care and young people.

The foster care committee

The findings in relation to this standard were varied across the service areas inspected, with only one area in full compliance with the standard. Four service areas were substantially compliant and two service areas were moderate non-compliant with this standard.

The *National Standards for Foster Care* (2003) require that Tusla have foster care committees in place in order to:

- consider assessment reports and make recommendations and appropriate approvals regarding foster carers
- approve long-term placements of over six months duration
- review the approval status of foster carers after Foster Care Reviews
- contribute to the development of policies, procedures and practice.

All service areas had a foster care committee that was made up of members in line with Tusla's Foster Care Committee Policy. They were all chaired by an experienced independent chairperson, with the exception of one area. Due to the continued absence of the existing chairperson, this service area had to put alternative arrangements in place. However, the alternative was not independent of the service, as required by the policy. In this area, other non-compliances were also found as a result of the challenges faced by the service area in the previous 12 months. There was a backlog of reviews being heard by the foster care committee, and disruption reports were not being presented to the committee. This foster care committee had also approved foster carers without evidence of the required training in Children First

(2017). This was escalated to the service area at the time of inspection, as it is a legal requirement under the Children First Act 2015.

In the main, all members of the foster care committees were appropriately vetted, their references had been sought, and their qualifications were on file. There were some improvements required relating to the filling of foster care committee members' records, as the way in which they were filed differed between areas. One area had an excellent system for the storage of these files, while in another service area, they did not hold files on committee members. Therefore, key records were not always easily accessible or retrievable, and the practice differed from that of the other service areas. In the latter part of the year, Tusla encountered an issue with the timely Garda Síochána (police vetting) of committee members, however they had appropriately escalated this issue to An Garda Síochána.

Foster care committees operated in line with the policy for the most part, with a few exceptions as already noted, and all had access to relevant expertise, such as medical advice, when required. Minutes of meetings were detailed, and recommendations and decisions were well documented. There was good reporting arrangements in place between foster care committee chairpersons and the service area, either to the area manager or their equivalent.

Overall, the main areas for improvements were addressing the backlog of foster carer reviews to be heard, presenting disruption reports in a timely manner, ensuring foster care committee members personal files were of good quality, ensuring that the chairperson was at all times independent, and ensuring foster carers were trained in Children First (2017) prior to their approval.

Placement of children through non-statutory agencies

Service level agreements are now in place with all non-statutory foster care agencies in Ireland. At the start of 2022, a new protocol for the governance of non-statutory foster care agencies was implemented by Tusla. The role of governance and oversight of service provision by the non-statutory foster care agencies was delegated by Tulsa to two national managers, and the protocol set out Tusla's governance arrangements for all non-statutory agencies. A Tusla national manager met with the non-statutory agencies every quarter and reported to the regional chief officer in relation to this. Only one area was non-compliant moderate with this standard. Four areas were substantially compliant and two areas were compliant.

For the most part, all areas ensured that children in non-statutory placements were allocated and that all statutory visits were completed in line with regulations, and that care plans and child-in-care reviews were up to date. There were some individual examples where this was not the case. For example, in one service area

one child was unallocated, and in another service area there were delays in statutory visits and undertaking child-in-care reviews.

One service area had put in a tracking system to ensure that statutory work for all children placed in non-statutory agencies was undertaken, which was an example of good oversight.

Improvements were required in one service area in particular in order to bring it into full compliance. In this service area, one of the children placed in non-statutory foster care did not have an allocated social worker for the three months prior to and also at the time of the inspection, which while not in line with the national standards. This also meant that Tusla had no direct oversight of this child. In addition, this service area did not have a service level agreement in place for a non-statutory foster care provider outside of the State, and finally, the names of non-statutory foster carers living in their area were not on their local foster care panel, which was not in line with statutory requirements.

Representations and complaints

There was good level of compliance found in relation to this standard with one area fully compliant, and five of the seven areas substantially compliant with this standard. One area was assessed as moderate non-compliant.

The service area which was assessed as non-compliant had a significant number of unallocated children in care. This meant that children did not have a known, trusted, social worker with whom to raise their complaints. While the template in this service area for the recording of statutory visits to children included a prompt in relation to informing the child of how to make a complaint, and to check their knowledge of the process, the lack of an allocated social worker for a significant number of children in this service area meant that this was not done.

This service area also did not produce quarterly or annual complaints reports, and issues in relation to complaints were not routinely raised or recorded within area management meetings. These gaps in reporting detracted from organisational learning about complex issues. There was limited evidence of tracking to ensure improvement actions had been effectively completed.

Overall, the service area's capacity to manage complaints in line with the expected time frames required further review. Tusla's national monthly report for April 2022 indicated that the service area had three complaints (all related to services) that were open for more than 12 months, five were for longer than nine months, and eight longer than six months. Letters had been sent to the complainants, in line with Tusla's procedures, advising them of the need to seek further extensions of time. Issues raised in complaints about foster care services included matters in relation to

permanency planning for children, communication and access, and children not having a social worker.

The other six areas had mostly good systems and processes in place to ensure that children and foster carers knew how to make a complaint, and were supported, if necessary to do so. Areas of good practice were found in that some areas provided children with an information pack when they came into care, which included information on how to make a complaint. In addition, some areas had also gone a step further by engaging with children so that they could provide feedback on their experience of the service for further learning and improvement.

The majority of the service areas also had systems in place to ensure that both children and foster carers were aware of the national advocacy organisations that were in place, and how to contact them if they required independent advocacy.

Where service areas tracked both compliments and complaints, this information was used to further develop the service provided and to learn from the feedback. This was also discussed at senior management meetings, thereby ensuring senior managers also had knowledge of feedback from children and foster carers.

Some minor improvements were required in relation to the recording of complaints. These related to ensuring consistency in how each area tracked and recorded complaints, including their outcomes, whether the complainant was satisfied or not, and if not whether they had been informed of the appeals process.

6.3 Key Findings of statutory foster care risk-based inspections

During 2022, HIQA conducted two risk-based inspections of foster care services in two service areas. One inspection was a follow-up foster care inspection to measure progress with respect to agreed actions to address risks to children. This was in response to previous inspections and significant risk issues identified within the service in 2020 and 2021. In the second service area, HIQA commenced an announced foster care thematic inspection. However, due to the risks identified regarding a lack of statutory visits to children in care and supervision and support visits to foster carers, it changed to a risk-based inspection.

Findings from the follow-up foster care inspection in 2022 of one service area demonstrated that significant difficulties had been experienced by the service that impacted their ability to meet the standards and regulations. The high turnover of social workers continued to negatively impact on the quality of support provided to children in care. Despite this, the service area had reduced the risks, had actioned their compliance plans from previous inspections and while not achieving compliance in all standards assessed, had moved to improved levels of compliance.

Good practice was identified in relation to the following:

- statutory visits, where social workers met the child in the foster care home and also met the child at other locations and undertook activities with them
- social workers spent time with children during statutory visits to provide a safe space to speak about their wishes and feelings about significant issues
- foster carers were provided with a platform to express their views, concerns and recommendations for service improvement
- a support group for foster carers had been set up and also a mentor and an outside agency had started to provide training to foster carers
- the area was also at the early stages of establishing a support group for biological children of foster carers.

While managerial oversight had improved, the instability of the workforce capacity due to vacancies remained a significant factor that influenced the service's ability to progress and maintain improvements in the quality of service provision. Children in care continued to face changes to their allocated social worker more frequently. Not all children in care were supported to express their views, wishes and feelings to inform the planning of their care and further work was required to address these challenges and improve practice. Children's case records and frequency of statutory visits to children required further improvement as gaps were identified.

In the second service area, an announced foster care thematic inspection escalated to a risk-based inspection due to the risks identified during the inspection regarding a lack of statutory visits to children in care and supervision and support visits to foster carers.

Governance and management systems had not ensured that children were visited in line with the legal requirements set out in the Child Care (Placement of Children in Foster Care) Regulations, 1995. For example, one child was seen outside of their placement nine months prior to the inspection, but had not been visited in their foster care placement by a social worker for over three years. In addition, while the majority of supervision and support visits to foster carers were of a good quality, systems to oversee visits to foster carers required improvement to ensure more frequent visits to foster carers occurred. Given the risks identified, an urgent compliance plan was issued to the area manager after the inspection, specifically in relation to the oversight of visits to children in care and foster carers. The initial

response was satisfactory in all but two areas. The subsequent response provided adequate assurances that these issues would be addressed in an effective and timely manner. HIQA will continue to closely monitor the area.

Similar to the findings of the follow-up inspection, this area had significant staff vacancies which contributed to the areas risks which were unallocated children in care, unmanageable caseloads for staff. Other risks identified were high staff turnover and the high number of emergency or unapproved foster carers.

Positively, the majority of the serious concerns and allegations were managed in line with Children First (2017) and the interim protocol for managing allegations and serious concerns against foster carers. However, further improvements were required to ensure all serious concerns and allegations were appropriately managed.

Overall, both of these areas submitted comprehensive compliance plans and one has reverted to routine monitoring. The other area continues to be closely monitored.

7. Foster care — non-statutory

Children's foster care services are also provided by non-statutory foster care agencies under agreements with Tusla. However, Tusla retains its statutory responsibilities to children placed with these services. Tusla also approves the foster carers recruited by these agencies through its foster care committees.[19] Non-statutory foster care agencies are required to adhere to the relevant national standards and regulations when providing a service on behalf of Tusla.

HIQA conducted inspections of two non-statutory (private) foster care service providers in 2022. The standards which were included in both inspections were:

- Standard 10: Safeguarding and child protection
- Standard 14a: Assessment and approval of non-relative foster carers
- Standard 15: Supervision and support
- Standard 16: Training
- Standard 19: Management and monitoring of foster care services
- Standard 20: Training and qualifications.

Additionally, two other specific standards were considered, one for each of the service providers due to previous findings or the length of time since the service was last inspected. These standards related to:

[19] A prescribed group that meet to make recommendations regarding foster care applications and to approve long-term placements.

- Standard 17: Foster care reviews
- Standard 18: Effective policies.

Overall, the non-statutory service providers achieved good levels of compliance. One service provider was compliant with all the standards, and in the other, four standards were found to be complaint and three substantially compliant.

Both providers were rated as compliant in their safeguarding of children arrangements. They took timely action to ensure children placed with foster carers were protected from harm and neglect, including implementing safe care plans where required. All staff and foster carers were up to date with their Children First (2017) training. Foster carers who spoke with inspectors were aware of how to make a child protection report and their responsibilities as mandated persons under the Children First Act 2015. Concerns, complaints and allegations against foster carers had generally been responded to and managed appropriately.

Assessments of prospective foster carers were comprehensive and generally undertaken in a timely manner. All relevant checks were made to determine applicants' suitability. Service providers had effective arrangements in place for approval of new foster carers by the relevant service area's foster care committees.

Foster carers were provided with appropriate supervision and support by both providers. All foster carers were allocated to a professionally-qualified link social worker. Visits and contact with foster carers was regular, and staff were responsive and available to foster carers when required, including outside of office hours. Supervision and support visits were at the heart of providers' approaches to developing foster carers' confidence and skills. Foster care records demonstrated good discussion on all aspects of fostering, including their ongoing training needs.

Both providers were rated as compliant in their provision of training to foster carers. Foster carers were provided with a range of training opportunities to ensure they had the levels of skill and knowledge needed to effectively care for the children placed with them.

Reviews of foster carers was assessed within the inspection of one service provider and were found to be comprehensive. However, not all initial foster carer reviews, one year post-approval, had been carried out within the required time frame. Foster carers reported positively about their experience of engagement in the review process, welcomed their opportunity to contribute their views and reported that recommendations made by the foster care committee had been promptly followed up.

One service provider's policies were reviewed and their suite of policies and procedures was of good quality and sought to promote safe and appropriate care.

However, inspectors found there was a need to improve scrutiny of the implementation of policies and checks of their effectiveness.

Both service providers had appropriate structures in place for the management and monitoring of service operations and ensured their staff understood their roles and accountabilities for the delivery of a quality foster care service. The governance and performance management systems in one service was more advanced. This service provider had clear and effective marketing and recruitment strategies in place to meet its growth aspirations.

Service providers had effective recruitment practices, including induction and probation arrangements in place in line with legislation and best practice. There was a good open culture within the service which allowed for reflection and supported continual professional development. Staff received appropriate support and supervision to ensure they performed their role to the best of their ability.

HIQA's inspection schedule for 2023 includes inspections of all non-statutory foster care agencies.

8. Regulation of special care units

8.1 Monitoring and inspection findings

There are three special care units in Ireland. These units are secure (locked) residential centres for children aged 11 to 17 years. Children and young people are placed in special care by a court when it has been determined that they require care and protection, as their behaviour places them at risk. Children and young people who are placed in special care receive therapeutic and educational supports in each unit.

Special care units are registered and regulated by the Chief Inspector within HIQA. All three special care units were first registered by the Chief Inspector in November 2018 and their registration was renewed in 2021. Within each three-year registration cycle, special care units are regulated[20] by the Chief Inspector to ensure ongoing compliance with the regulations and standards.

Each of the three special care units were inspected in 2022. Two special care units were inspected twice, as inspectors had concerns in relation to specific risks in both units, and the third unit was inspected once. All five inspections were unannounced inspections to monitor ongoing compliance with the regulations and to further assess

[20] Where the Chief Inspector refers to 'regulating' in this section of this overview report, it includes inspections, review of information submitted by the special care unit, information held about the unit and ongoing review of information. This is all taken into account when the Chief Inspector is assessing compliance with regulations and standards.

risks reported to the Chief Inspector. While there was progress made throughout 2022 to address identified risks, there were substantial issues which were required to be addressed. The regulations where most work was required across the three units for the provider to achieve compliance were reported under capacity and capability and related to governance and management, staffing and notification of incidents. The regulations under quality and safety related to positive behavioural support, risk management. The regulations in relation to education, individual needs, religion, ethnicity, culture and language required improvements in two of the units.

In our 2021 overview report, it was noted that improvements were required to enable children to move out of special care units when they were ready to do so. Tusla had committed to address this gap in service provision for children and confirmed during 2022 that they had identified premises to establish step-down facilities. At the time of writing this report, HIQA was aware of two such premises being secured. Despite this, delays continued in children's discharge from special care units.

Throughout 2022, where required, the provider provided assurances in relation to high-risk non-compliances identified through the ongoing monitoring of special care units as well as inspection activity. All three units inspected against the regulations were required to submit compliance plans following the inspections carried out in 2022. The provider submitted plans outlining how it intended to come into full compliance with the regulations, as required by their conditions of registration.

One of the two unannounced risk-based inspections was particularly concerning to the Chief Inspector. It took place in response to information received by the Chief Inspector that the provider intended to move two of the four children detained in the unit to an alternative, non-registered Tusla centre, to allow building work to the special care unit. All eight of the regulations assessed were not compliant and there were significant gaps identified in the effective management and oversight of the unit.

Inspectors escalated specific urgent risks to the provider on the day of the inspection regarding fire safety precautions and the capacity of the unit and the provider took immediate steps to address these, including applying to vary the centre's capacity from four to two children. The provider gave assurances in relation to the high-risk non-compliances relating to governance and management, risk management and the notification of incidents to the Chief Inspector.

There was a further unannounced inspection of this special care unit in October 2022 to assess whether satisfactory progress had been made to comply with regulations. While there had been some positive changes since the last inspection, the provider, with the agreement of the Chief Inspector was granted additional time

to comply fully with all regulations where there had been significant risks identified in the previous inspection.

Two unannounced inspections of another special care unit were carried out in February and September 2022. These inspections found that the children were well cared for and their safety, wellbeing and protection was prioritised. Good professional partnership working with other relevant agencies and services ensured children's needs were being met and they were provided with a safe service. An unannounced inspection of a third special care unit took place in October 2022. Children were supported and encouraged to make decisions regarding their care, and their views were actively and regularly sought by staff. Further work was required in relation to safeguarding and adherence to children's plans and risk assessments.

In order to achieve full and sustained compliance with the regulations, the governance and management of all three units required strengthening. The provider needed to ensure that the Chief Inspector was notified in a timely manner of all required notifications such as allegations of abuse or serious incident as two of the designated centres had failed to make all necessary notifications and the third had been delays in some notifications. All necessary notifications were subsequently provided.

All three special care units had staffing vacancies to varying degrees. This impacted on the level of service provided and on the number of beds available for children requiring special care. There was some progress with offering new staff a more formal induction to support them when they began in their roles.

Restrictive practices were implemented in response to risk and safety, and children were afforded as much freedom of movement as was possible within a secure environment. Inspectors saw that these measures were individual to each child, based on their specific needs and risk. When inspectors noted any concern during and following inspections, management responded appropriately.

Overall, while the provision of care to children was mainly positive, improvements are required in the overall governance of the service to ensure full compliance with the regulations. The provider of all the special care units was responsive to findings

of inspections, however, improved governance would ensure that the provider identifies their own shortcomings and are proactive in taking appropriate action.

9. Oberstown Children Detention Campus

Oberstown Children Detention Campus is a national service that provides safe and secure care and education to young people aged between 10 and 18 years old. These young people have been committed to custody after conviction for criminal offences or remanded to custody while awaiting trial or sentence. The principal objective of the campus is to provide appropriate care, education, training and other programmes to young people The overall aim of the campus is to support young people to improve their decision-making capacity, to move away from offending behaviour and prepare them to return to their communities and society following their release from detention.

Oberstown is funded by the Department of Children, Equality, Disability, Integration and Youth. It operates under a single board of management, which is appointed by the Minister for Children, Equality, Disability, Integration and Youth. HIQA inspects Oberstown Children Detention Campus annually under Section 185 and Section 186 of the Children Act 2001 (as amended).

HIQA inspected this service against the Oberstown Children's Rights Policy Framework which consists of 12 rules, implemented since 2020 following the consent of the Minister for Children, Equality, Disability, Integration and Youth. The framework sets out a high-level statement or standard by which the performance of the campus will be measured. The inspection in 2022 focused on six rules in relation to young people's participation, care, positive behaviour, restrictive practices, safeguarding and staffing, management and governance. Of the six rules assessed, five were substantially compliant and one was compliant. This was a marked improvement from previous inspections of the service which had found a number of non-compliances in relation to staffing, management and governance, and the use of restrictive practice.

This inspection found that the young people were well cared for and were provided with individualised supports and opportunities to participate in meaningful activities and programmes. While the rules in relation to health, offending behaviour and preparation for leave were not assessed, young people had access to a range of medical and multidisciplinary staff and were provided with educational, vocational and recreational programmes appropriate to their needs

The campus manager and his team ensured that young people's rights were promoted as there were good systems in place to give young people a voice about their care, and also about the running of the campus. Young people had good established links with the campus advocacy officer as well as access to other

advocacy services. External independent advocates were welcomed to the campus to engage directly with young people and hear their stories. Young people were provided with opportunities to be part of a campus council. This was a safe space where young people could actively express their own views as well as those of the other young people detained in the campus on issues that affected them individually and collectively. The inspection found that some issues raised by young people had either brought about a number of changes or were being trialled to assess their impact. Young people had also been consulted about the Oberstown Strategy 2022-2026 which sought to strengthen the voice and participation of young people, their families and stakeholders. The strategy outlined Oberstown's commitment to listening to the views of the young people in their care and valuing their input. The young people were encouraged and facilitated to develop their own version of the strategy, to adapt the language used so as to make it their own and to express what it means for them in practical terms. This was ongoing at the time of the inspection. While young people were supported to participate in decisions about their care, improvements were required to ensure consistent recording of their participation in all aspects of their lives on campus.

Systems to provide assurances and oversight to the board, director and managers on practices across the campus were in place and had been further developed since the last inspection. These included improvements in the quality of recording on the service's electronic case management system, as well as targeted audits to ensure appropriate and effective decision-making and practice.

Although lines of accountability were clear, the system in place to hold staff and managers to account through the provision of staff supervision required improvement. The inconsistent delivery of staff supervision has been a recurring finding over the past four years. However, steps had been taken by the campus director and a new supervision model had been sourced. Training for staff was due to commence shortly after the inspection.

There were good governance structures in place. The campus was well led and managed by a highly motivated senior management team that supported the delivery of a good service to young people with a focus on continuous improvement. There was evidence of a collaborative and child-centred approach to discussions and decision-making across the campus. There were effective communication systems for information sharing in relation to progress, risk and challenges.

An organisational capability review was being undertaken by an external agency at the time of the inspection. This was a three-phased review to look at the structure of the organisation, to assess staffing requirements at all levels across the campus in line with the new strategic plan and the needs of the young people detained.

Staff were skilled in recognising and responding to individual needs and vulnerabilities of young people. Where risks related to practice were identified they were managed appropriately. However, improvements were required to ensure that appropriate contingencies were in place in the absence of the designated liaison person to ensure staff fulfilled their mandated duties.

There was an improvement in the management of challenging behaviour and a reduction in the necessity for the use of restrictive practices used within the campus. The finding in relation to this rule had moved from non-compliant moderate in 2021 to substantially compliant in this inspection. There were also some improvements in the quality of the records maintained regarding the use of restrictive practices.

While good quality work was being carried out by staff with young people, improvements were required to ensure consistent and accurate recording of all interventions so as to support managerial oversight and monitoring of direction and decision-making on individual cases.

In summary, the 2022 inspection found that young people received good quality care that promoted their development, wellbeing and potential. Positive and respectful interactions between young people and staff were observed during the inspection, as well as staff supporting young people to deal with any individual difficulties or concerns. An individualised approach was taken to responding to young people in line with their individual plan.

Overall governance of the campus was strong, proactive and responsive to the needs and rights of the young people. While progress was evident in many aspects of service delivery, areas of practice that required further improvements in this inspection related to ensuring consistent high quality recording of records on the electronic case management system, the consistent provision of staff supervision and ensuring appropriate contingencies were in place for the management of safeguarding and child protection concerns. The findings of this report will inform the inspection of this service in 2023.

10. Stakeholder engagement

During 2022, the Children's Team continued to meet with children, their parents and or guardians, professionals, external agencies services and service providers in person and remotely. Reflecting the views of children, their parents and carers on their services of services is central to the work of the team.

10.1 Children and their families.

In total, across the services, inspectors consulted with 180 children either directly, over the phone or by way of a survey. Of the 180 children, 65 were children in residential care, 47 children in foster care, 24 children who were supported by child protection services, 28 children in detention and 16 in special care. Inspectors also spoke with a sample of parents and or guardians, foster carers and other professionals such as guardians ad litem as part of our inspection activity.

Listening to children's voices during inspections enables us to capture children's experience of their care, and understand better the impact of the governance of these services on these experiences. A particular focus of participation of children and young people in our work is to capture how they are involved in decision-making on issues that affect them. Such decision-making is enshrined in the Irish Constitution and Article 12 of the United Nations Convention on the Rights of the Child (UN, 1989), ratified by Ireland in 1992.

One hundred and twenty-three parents also told inspectors about their experiences of services in 2022. These parents ranged from parents receiving support in the community from child protection and welfare services, to parents whose child were in foster care or residential care or special care or Oberstown Children Detention Campus. As highlighted in the report, while many parents were satisfied with the level of support they received, others were not. They also highlighted the importance of receiving regular communication from services and there were mixed views from parents in relation to the quality of communication from services.

10.2 Department of Children, Equality, Disability, Integration and Youth.

HIQA continued to engage with the Department of Children, Equality, Disability, Integration and Youth (the Department) during 2022, to inform our regulatory and monitoring remit.

The Chief Inspector and HIQA's Head of Programme (Children's Services) met with Department officials and exchanged relevant updates and information on good practices as well as actual or potential risks across the sector.

HIQA also participated on public consultations in relation to the draft codes of practice (Assisted Decision-Making Capacity Act 2015).

10.3 The Child and Family Agency (Tusla)

Throughout 2022, we held regular meetings with the CEO of Tusla and members of Tusla's senior management team to share information such as on regulatory developments, risks, practice issues and service delivery.

Stakeholder meetings were held with staff from special care units, foster care (statutory), child protection and welfare services during quarter 4 2022. HIQA's focus on a children's rights approach to monitoring and inspection was presented, along with our key findings from inspections and our plans for 2023.

10.4 Oberstown Children Detention Campus.

The Chair of the Oberstown Board and the Campus Director met with the Chief Inspector and managers from the Children's Team during 2022 and discussed regulatory developments, children's rights and future plans.

10.5 The Department of Education

HIQA and the Department of Education updated their memorandum of understanding in 2022.

10.6 Other stakeholders

Other stakeholders we engaged with in 2022 included:

- Non-statutory foster care providers
- the CEO of EPIC
- the CEO of Irish Foster Carers Association (IFCA)
- Children's Ombudsman's Office

- Alliance of Birth mothers
- Providers of non-statutory foster care services
- Persons in charge and persons participating in management of special care units
- Social Work students from Universidad de Vic, Barcelona.

11. Conclusion

Over the last three years, there have been unprecedented challenges in children's services – from a global pandemic, to the statutory provider being impacted by a cyber-attack, and the impact of increased numbers of Ukrainian refugees in 2022. The majority of inspections of children's services published in 2022 illustrate incremental improvements despite services being under significant pressure. Therefore, providers of services in general are endeavouring to continuously improve their services through their own quality improvement initiatives and this is not only driven locally but also by organisation's business plans and strategies.

Within the context of these challenges, staff and managers within services have endeavoured to continue to improve their services and, our regulatory approach in the main highlighted that:

- Children who are allocated to a social worker generally receives a good service
- Children and young people want to be involved in decisions about their lives – some want to be consulted, while others want to be consulted and to attend meetings which are relevant to them
- Strong leadership and governance enables a culture of service improvement and learning which leads to incremental improvements in the provision of good quality services to children and in service's adherence with national standards and rules
- There is a need to build additional capacity within children's alternative care services in order to ensure that there is a range of appropriate regulated placements types available to meet children's specific needs. Despite the implementation of significant staff recruitment and retention initiatives by the statutory provider of child protection, foster care and residential services, children's quality of services continue to be impacted by staff vacancies
- Finally, a collaborative national strategic approach is required to

examine and respond to the workforce challenges to enable children to receive the right service at the right time.

The increase in the number of referrals to Tusla is significant for an organisation who in essence need to do more work (due to an increased number of referrals) with less resources due to staff vacancies. This situation is having a significant impact on children and young people's receiving the right service at the right time.

11.1 Moving Forward

HIQA and the Chief Inspector will continue to promote ongoing improvements in children's services by focusing on the regulations, standards and rules around children's rights, leadership, governance and management of services. In 2023, we will ask children in statutory residential care and Oberstown Children Detention Campus about what feedback they want after inspections and by the end of 2023 we will incorporate this into how we provide feedback on our inspections to children.

Secondly, our quality improvement inspections will continue with the final inspections of the management of cases on Tusla's CPNS will be completed. An overview report of our findings from our thematic inspections of the governance of foster care services will be completed. All inspections of children's services will incorporate a review of how children's rights are promoted within the various settings from foster care, to child protection to children's residential centres, detention and special care. This will provide an insight into how children are supported in exercising their rights and their participation in decision-making around their support and or care.

HIQA will also commence a programme of inspection during the second half of 2023 which will monitor Tusla's implementation of their Child Abuse Substantiation Procedure[21] by reviewing the management of the assessment of child abuse including retrospective allegations of abuse. During 2023, a child protection and welfare inspection of the separated children seeking international protection team will also be completed.

Over the last six years, it has been proposed that the remit of the Chief Inspector be expanded to include the regulation of all children's statutory and non-statutory residential centres. This proposal remains outstanding and it is essential that this is progressed so that all children placed in residential care are subjected to the same regulatory processes. HIQA and the Chief Inspector will continue to liaise with the

[21] Tusla (2022) Child Abuse Substantiation Procedure (CASP) Version 1.2, June 2022.

Department of Children, Equality, Disability, Integration and Youth to transfer the inspection function for all children's residential centres to the Chief Inspector.

Finally, HIQA and the Chief Inspector wish to acknowledge the participation and cooperation of children, young people, their families, foster carers, advocates, providers and staff during our inspection. We are committed to listening to the experiences of children, young people and all those who support them to improve the way we work, in order to enable providers to further improve the quality of children's services.

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