Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

**Foster Care Inspection**

Health Information and Quality Authority Regulation Directorate monitoring inspection on the progress of the service area's implementation of their foster care services actions.

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| Name of service area: | Kerry |
| Name of provider: | Child and Family Agency Tusla |
| Fieldwork ID: | MON-0037669 |
| Type of inspection: | Follow up Risk-based Foster Care Inspection |
| Date of inspection: | 12 – 15 September 2022 |
| Lead inspectors: | Hazel Hanrahan |
| Support inspector(s): | Susan Geary<br>Sue Talbot |

## About this inspection

HIQA is authorised by the Minister for Children, Equality, Disability, Integration and Youth under Section 69 of the Child Care Act, 1991 as amended by Section 26 of the Child Care (Amendment) Act 2011 to inspect foster care services provided by the Child and Family Agency (Tusla) and to report on its findings to the Minister for Children, Equality, Disability, Integration and Youth.

This inspection of Kerry Service Area was a follow-up inspection due to the on-going risks within the children in care and fostering services in the area. A risk based service area inspection of the child protection and welfare service and the foster care service in October 2021 identified non-compliances and risks to children in care in the area.

This inspection was a foster care inspection aimed at assessing the progress within the area with respect to agreed actions by the area manager identified to address risks to children, in response to previous inspections and significant risk issues identified within the area in 2020 and 2021. In the context of this inspection, the areas inspected related to identified risks and therefore the entire standard was not assessed in all cases.

## How we inspect

As part of the inspection, inspectors sampled children and foster carer records along with staff records to assess the quality of care practices and systems in place for identifying and managing risk.
Furthermore, inspectors spoke with frontline staff and managers, and interviewed relevant senior managers in the service area and region. Inspectors spoke with children and young people, their families and foster carers and reviewed a range of documents related to service improvement and management reports.

The key activities of this inspection involved:

- the analysis of data submitted by the area
- interviews with
  - the area manager
  - principal social workers
  - independent reviewing officer
- speaking with foster carers, parents and children
- focus groups with
  - social workers
  - fostering link social workers

    - aftercare manager
    - team leaders
- observations of:
    - child-in-care review meeting
- questionnaire sent to sample of children in care in the area
- the review of
    - local policies and procedures
    - minutes of various meetings
    - nine frontline staff and management staff supervision files
    - management trackers and audits
    - service plans
    - sampled the relevant sections of 28 children's case files pertaining to the inspection
    - sample of 12 foster carer case files and the relevant sections pertaining to the inspection and
    - other reports and documents as required.

The inspection team issued a request for documentation and data to the service area in relation to each standard of the inspection. The inspection team evaluated progress within the area in the management of identified risks and engaged with the social work teams and management with respect to the systems and governance issues which were acknowledged by the area following the previous inspections of the service.

Where an inspector identified a specific issue or systems risk that may present an immediate and or potential serious risk to the health or welfare of child/ren, then, in line with HIQA policy, these risks were escalated to the relevant local Tusla manager during the inspection fieldwork and or following completion of the inspection fieldwork to the Tusla area manager, regional service director and or Tusla's director of services and integration.

**Acknowledgements**

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

# Profile of the service area

## The Child and Family Agency

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

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

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

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

## Service area

Kerry is one of the 17 areas that forms part of Tusla's Child and Family Agency. In 2016 the Census recorded the population in Kerry was 147,707. This saw an increase in child population (0-17yrs) of 1.76% from the period of 2016 to 2011. In 2016 the child population (0-17yrs) was recorded as representing 23.4% of the areas total population with a child population (0-17 years) of 34,527. This represented 23.4% of the Area's total population.

According to Pobal HP Relative Deprivation Index score for Kerry in 2016, 12.5% of small areas in Kerry were classed as disadvantaged or very disadvantaged. Within this 28.5% of the population living in disadvantaged or very disadvantaged areas was aged less than 24years.

The area was under the direction of the Director of Services and Integration and was managed by the area manager. The area manager oversees a number of functions in relation to the governance, commissioning, service delivery and partnership working in the service. These included the direct management of the following post holders:

- principal social worker - duty/ intake team
- principal social worker - child protection and welfare team
- principal social worker - children in care team
- principal social worker - fostering resource unit, aftercare team/supported lodgings
- manager – aftercare
- principal social workers - child protection case conference chairperson and independent chair for the foster care committee
- manager - prevention, partnership and family support
- manager - family centre
- business support manager.

The area had engaged in a process of restructuring the service since the previous inspection in October 2021. This restructuring was implemented to ensure robust governance procedures were in place with defined teams for each pillar of the service. This included the duty and intake team, child protection and welfare team, children in care and aftercare, fostering, and supporting lodgings, prevention partnerships and family support, and an area support team, which was an extension of and a support to the area manager's office. Additional posts had been created at principal social worker, social work team leader, social worker and business support level to ensure that newly developed structures underpinning practice were implemented, resourced and supported within the teams.

Since the previous inspection in October 2021 the area had been met with challenges in staffing and had carried and was continuing to carry a number of vacant positions. The area had one children in care team who provided a social work service to all children in care. The area carried a vacant principal social worker post on the children in care team for a number of months in 2022 which was subsequently filled in August 2022. There had also been four social work vacancies on the team which were filled at the time of inspection. During this period the principal social workers from the duty and intake team and fostering resource unit provided oversight and support to the children in care team from Q1 to Q2 of 2022. At the time of inspection, the children in care team was managed by three social work team leaders who reported to the principal social worker. The three team leaders managed a team of social workers and a child care leader. There was also 1.5 admin support workers assigned to the fostering resource unit.

Kerry foster care service was comprised of one fostering resource unit who were line managed by one team leader, who reported to the Principal Social Worker. The

fostering resource unit had carried three social worker vacancies and one team leader vacancy for most of 2022. At the time of the inspection two social worker positions had been recruited. This reduced the number of vacancies on the fostering resource unit to one social worker and one team leader. The area had also experienced a period of six months where there was no independent chair to conduct child-in-care reviews. This position was filled in February 2022.

## Children in Care and Foster Carers

According to data provided by the area there were 94 foster care households operating in the area. This consisted of 72 general foster care households and 22 relative foster care households. Four of these were classed as special foster care households.

The area had 134 children in foster care at the time of the inspection. This included 96 placed in general foster care and 38 children placed in relative foster care placements. Of this, 122 were placed within the area and 12 were placed outside of the area with 11 of these being in private foster care placements. Ten children who were at the time placed in foster care placements were waiting for long-term placement matching.

## Kerry Service Area monitoring and inspection activity

Below is a brief overview of inspection activity and engagement with the Kerry service area relevant to this follow-up inspection of foster care, including the risks identified since the last foster care inspection in 2019, the risk-based service area inspection in January and October 2021:

## March 2019: Foster care inspection

The key findings were largely related to poor governance. Two standards were non-compliant moderate, two were substantially compliant and two were compliant. The key risks were:

- no system in place to track allegations and child protection concerns
- inadequate management and classification of complaints
- the area had not appropriately informed the Foster Care Committee (FCC) of relevant issues about placements and child protection concerns against foster carers
- lack of documentation about case management and safety planning
- an absence of managerial oversight of care plans and quality of records the validity of the data provided by the area to Tusla national office and HIQA; given that there were differences in what was reported and what inspectors found.

## January 2021 – Risk Based inspection

A service area risk based inspection which included the child protection and welfare service and the foster care service was carried out. The focus of the inspection was to assess progress in relation to the implementation of measures to enhance the capability and capacity of the service. Progress had been required to ensure the delivery of safe and effective child protection and welfare and foster care services in Kerry. The inspection also focussed on the extent to which these measures had addressed the non-compliances found during monitoring inspections in 2019, as well as the concerns throughout 2020. In relation to the three foster care standards which were inspected in January, two of the standards were non-compliant major and one standard was non-compliant moderate. The overall findings were:

- Not all children had an allocated worker
- Statutory visits to children in care were not carried out at the frequency required and the quality of the visits were mixed
- Some children experienced multiple changes in social workers and not all children had a consistent professional involved in their care.
- The recording on children's files and case supervision required improvement
- Not all child protection allegations of abuse or neglect were categorised correctly and dealt with in a timely manner under child protection procedures that comply with Children First (2017)
- Intake and initial assessment records required by standard business processes were not consistently completed in a timely manner
- Notifications to the foster care committee in relation to allegations and serious concerns were not routinely made in a timely manner
- Governance in relation to case management and oversight in relation to allegations and serious concerns required further improvement
- The Area's capacity to respond to staff remaining on extended leave was a significant factor influencing the service's ability to progress improvements and the quality of service provision
- Actions agreed to address non-compliances identified during the previous inspection of the service in March 2019 had not all been effective in ensuring statutory requirements were met.

## October 2021 – Risk Based inspection

A further service area risk based inspection which included the child protection and welfare service and the foster care service was carried out in October 2021. The focus of the inspection was to assess progress in relation to the implementation of

measures to enhance the capability and capacity of the service. Progress had been required to ensure the delivery of safe and effective child protection and welfare and foster care services in Kerry. The inspection also focussed on the extent to which these measures had addressed the non-compliances found during monitoring inspections in 2021. The overall findings were:

| **Standard 5**<br><br>**The Child and Family Social Worker** | **Judgment:**<br><br>**Compliant** |
|---|---|
| ▪ Each child in care had a dedicated social worker who promoted their safety and wellbeing.<br>▪ In the majority of cases social workers carried out Tusla's statutory duties in order to co-ordinate the care of each child.<br>▪ The majority of social work practice met statutory requirements and there were examples of practice that exceeded the frequency required by the regulations.<br>▪ Effective recording of key aspects of a statutory visit to a child in care were found. | |
| **Standard 7**<br><br>Care planning and review | **Judgment**<br><br>**Substantially Compliant** |
| ▪ There were 17 child-in-care reviews overdue, which the area had not identified and practice used that scheduled child in care reviews was not in compliance with the regulations, nor did it promote child-centred best practice.<br>▪ The independent reviewing officer position was vacant and the principal social workers and team leaders were rotating chairing child-in-care reviews.<br>▪ There remained an element of drift and delay in progressing some actions from child in care reviews.<br>▪ Not all care plans were up to date | |
| **Standard 10**<br><br>**Safeguarding and child protection** | **Judgment**<br><br>**Substantially Compliant** |
| ▪ The management of concerns, allegations of abuse and neglect against Foster Carers were not always timely.<br>▪ Local resolution complaints were not logged as complaints, and are therefore not tracked. | |

- Case files were missing the care risk assessments for children missing from care. This was not in line with Tusla's Missing from Care Protocol.

| **Standard 15**<br><br>**Supervision and support** | **Judgment**<br><br>**Non-Compliant Major** |
|---|---|

- Not all foster carers were supervised by a professorially qualified social work
- Not all foster carers had had supervisory visits completed in 2021
- There were gaps in the effective and timely sharing of information relating to the child's care; and additional supports for foster carers were not consistently identified and addressed in a timely manner.
- The fostering department "check-in" system through their duty system that provided on-call service to foster carers was found to be ineffective
- Foster carers' supervision records did not routinely include regular health and safety checks.
- There remained gaps around the quality of support provided to foster carers.
- The quality of record keeping and case notes required improvement.

| **Standard 19**<br><br>Management and monitoring of foster care services | **Judgment**<br><br>**Non-Compliant Moderate** |
|---|---|

- The governance and oversight of services provided to foster carers remained inadequate.
- The area could not be assured that foster carers were consistently provided with the necessary information, advice and professional support necessary to enable them to provide high quality care.
- Vacant posts and movement of staff continued to impact the delivery of services to children and families.

## Compliance classifications

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

| **Compliant** | **Substantially compliant** | **Non-compliant Moderate** | **Non-compliant Major** |
|---|---|---|---|
| The service is meeting or exceeding the standard and is delivering a high-quality service which is responsive to the needs of children. | The service is mostly compliant with the standard but some additional action is required to be fully compliant. However, the service is one that protects children. | The service is not compliant with the standard. Where the non-compliance (moderate) does not pose a significant risk to the safety, health and welfare to children using the service, the provider must take action *within a reasonable time frame* to come into compliance. | The service is not compliant with the standard. Where the non-compliance poses a significant risk (major non-compliance) to the safety, health and welfare of children using the service the provider responds to these risks in a timely and comprehensive manner. |

**This inspection was carried out during the following times:**

| Date | Times of inspection | Inspector | Role |
|---|---|---|---|
| 12/09/2022 | 09:00 – 17:00 | Hazel Hanrahan<br>Susan Geary<br>Sue Talbot<br>Lorraine O Reilly<br>Sabine Buschmann | Lead inspector<br>Support Inspector<br>Support Inspector<br>Remote Inspector<br>Remote Inspector |
| 13/09/2022 | 09:00 – 17:00 | Hazel Hanrahan<br>Susan Geary<br>Sue Talbot<br>Sabine Buschmann | Lead inspector<br>Inspector<br>Support Inspector<br>Remote Inspector |
| 14/09/2022 | 09:00 – 17:00 | Hazel Hanrahan<br>Susan Geary<br>Sue Talbot<br>Sabine Buschmann | Lead inspector<br>Support Inspector<br>Support Inspector<br>Remote Inspector |
| 15/09/2022 | 09:00 – 16:00 | Hazel Hanrahan<br>Susan Geary<br>Sue Talbot | Lead inspector<br>Support Inspector<br>Support Inspector |

## Views of people who use the service

As part of the inspection, inspectors spoke with one parent and twelve foster carers and listened to their experiences of the service. These foster carers and parent had experience of the foster care service in the area.

Hearing the voice of children is very important in understanding how the service worked to meet their needs and improve outcomes in their lives. For this inspection, children were consulted with to ask whether they wished to speak with inspectors about their experiences. Children were provided with the freedom to choose to participate or not. The majority of children selected choose not to speak with inspectors however, the inspectors did speak with two children.

Children told inspectors that their experience of the fostering service was;

- *'really good' and*
- *'grand, happy because I am one of the family'.*

Children also described to inspectors that their time at their foster care placement provided a safe environment for them and that they were treated the same as everyone else. Children said that if they had any worries that they would talk to their parents and foster carers. A child said that they would ask the social worker questions about things in their life. Children used the following statements to express the impact of foster care in their lives:

- *'very happy'*
- *'very nice'*
- *'loved everything' about it and*
- *'play lots of games'.*
- *'meet friends'*
- *'go to the cinema'*
- *'do cooking and baking and get to eat everything afterwards'.*

When talking about their social worker children described them as;

- 'answers any questions I have' and said that they had;
- 'a few different social workers' and
- that 'all of them were nice' and
- they could 'contact them if I need it'
- 'listens to me'

- 'I can just ring her anytime and she would come over if I need her'
- *'don't care'*
- *'don't know who to contact'*
- *'not told about when a new social worker was coming'.*

The social worker was described by a child to help them with school and medical appointments. Children talked about meetings that affected them and said that they got invited to them but made the choice not to go. Children said that they filled out forms about their views to be read out at the meetings but they didn't like this as it was too long. When talking to children about care plans they were not sure what this was with one asking 'what is it?' Children said they did not know how to make a complaint and were not given information about it.

Inspectors spoke with one parent who provided mixed feedback on their experience of the service. The parent said to inspectors that although they felt that their child was 'absolutely safe', that they understand the roles of each worker in place for their child but that there was 'a lot of chopping and changing of social workers and social care workers'. The parent felt that they were not listened to and that when at child-in-care reviews, they were provided with an opportunity to speak but that access visits to their child did not improve. The parent was aware of how to make a complaint and highlighted that they could speak with the area manager.

The majority of foster carers spoke positively about the service describing it as;

- 'never had a problem' with social workers
- they 'are excellent', 'absolutely brilliant'
- 'they would do anything they could for you'
- 'will do everything they can'
- 'visits are great'
- 'can't speak highly enough about my link worker'
- 'always well supported'
- 'absolutely amazing'
- 'fantastic' and 'acted really fast'
- 'she is very supportive. Constantly rings me and encourages contact - very helpful'.

There were a number of foster carers who told inspectors they had experienced challenges in the turnover of social workers and fostering link worker assigned to them. Some of the comments from foster carers were:

- 'constantly getting used to new social workers is frustrating'
- 'good overall, but large turnover'
- 'on our third link worker this year - not easy, when they keep moving'
- 'the constant changing of social worker is not good'

- 'the biggest thing is that she is not getting the services she needs - it is desperate seeing her trying to get the words out'
- child 'now refused to engage when a social worker visits'
- 'things don't progress when there's no social worker'.

All foster carers had attended child-in-care reviews and spoke positively about their experience saying that social workers 'will do everything they can'. As reported by a foster carer child-in-care reviews provided a space where;

- 'We are all clear about what is going on for the child and what we want to happen going forward - all one team'.

The challenges met by foster carers at these meetings was when 'things are out of their (social workers) control, that's where there are issues'. Foster carers told inspectors that children's attendance at child-in-care review meetings depended on 'a bond with the social worker'. Two areas that were highlighted by foster carers as needing improvement were the children's child–in-care review form as children refused to fill it out due to the way it is worded and a need for stronger joint working between Tusla and the HSE.

When talking about training foster carers spoke positively about it and that the training focused on trauma and sibling relationships and that there was *'plenty of training'* available. However, foster carers said that consultation with them to identify training needs did not recommence after COVID-19 restrictions were lifted.

All foster carers reported they had a fostering link social worker at the time of this inspection, but there was one foster carer who was not certain. Foster carers spoke of the positive group experiences that the area had organised for foster carers, foster children and birth children and how the area provided opportunities for foster carers to facilitate training.

- 'The area had a coffee morning the first Friday of every month'
- 'Two outings for children this year, inclusive of birth children. One trip to Fota Island and one to Killarney'
- 'Two foster carers presented to other foster carers in training'.

## Summary of inspection findings

The Child and Family Agency (Tusla) has the legal responsibility to promote the welfare of children and protect those who are deemed to be at risk of harm. Children in foster care require a safe and stable service that is well supported by social workers. Foster carers must be able to provide children with warm and nurturing relationships in order for them to achieve positive outcomes. Services must be well governed in order to produce these outcomes consistently.

This report reflects the findings of the follow-up risk-based inspection, which looked at five standards:

- Standard 5: The role of the social worker,
- Standard 7: Care planning and statutory reviews,
- Standard 10: Safeguarding and child protection,
- Standard 15: Supervision and support of foster carers, and
- Standard 19: The management of the foster care service.

In this inspection, HIQA found that, of the five national standards assessed:

- four standards were substantially compliant
- one standard was non-compliant moderate.

This inspection found that the service area had worked hard through a difficult period of staff instability to prioritise competing priorities to meet the needs of children in care. The area had put new measures in place to address the risks found on the previous inspections and had also strengthened existing processes. These measures included:

- quarterly audits,
- departmental days to enhance learning from practice and through training,
- enhanced supervision practice through the implementation of a new template,
- enhanced oversight of monitoring statutory and supervisory visits through revised templates and trackers,
- embedding priority action meetings,
- embedding new national approach to Child Abuse Substantiation Procedure (CASP) 2022,
- support groups for foster carers and biological children of foster carers,
- the introduction of a new independent reviewing officer for the child-in-care reviews,
- the development of a tracker and check list for child-in-care reviews,
- the restructuring of the child-in-care team that provided three additional team leaders for oversight and support.

The service area had reduced the risks and while not achieving compliance in all standards assessed, had moved to improved levels of compliance. However, the inspection identified challenges related to the role of the child and family social worker. The inspection found that not all children in care had an allocated social worker and that there was a significant increase since the beginning of the year. The inspection also found that although the service had improved the frequency of statutory visits taking place, there were areas for further development. It was also found that case records required improvement as gaps were identified and some case records were missing. Further improvement was needed in the implementation of priority actions from a child's care plan. The inspection found that not all children

in care were supported to express their views, wishes and feelings to inform the planning of their care.

The service was operating with a vacant position of independent reviewing officer to chair the child-in-care review for six months. It was found that the interim measures put in place were inadequate in delivering an effective service. This was due to 50 child-in-care reviews becoming outstanding during this period. This had a knock on effect on children's care plans becoming out of date.

The service had embedded a new national procedure, Child Abuse Substantiation Procedure (CASP) 2022, however, had no CASP social worker in place for a period of one month to oversee this key area of casework. Due to this there was no effective oversight and designated person responsible for undertaking a substantiation assessment that determined whether the person subject to abuse allegations (PSAA) posed a risk to children.

The service had improved in the number of foster carers allocated to a fostering link social worker. And at the time of the inspection, only two foster carers were unallocated. The service had experienced instability in its capacity to assign fostering link social workers to foster carers since the previous inspection, with foster carers reporting high staff turnover and the impact of this on them. Staff vacancies impacted on some statutory obligations not being met by the service. It was found that the majority of supervisory visits to foster carer's were in line with the frequency set out in the service areas policy. However, where foster carers required further supervisory visits if issues and difficulties occurred they had not always received this in line with the policy.

The inspection found that managerial oversight had improved and a restructure to the child-in-care team provided greater oversight and support. However, 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. As new measures and practices introduced in 2022 were still at the initial stages of being embedded into practice, determining their effectiveness was ongoing.

This report reflects the findings of the inspection, which are set out below. The provider is required to address a number of recommendations in a compliance plan which is published separately to this report.

## Findings and judgments

**Standard 5: The child and family social worker**

There is a designated social worker for each child and young person in foster care.

### Summary of inspection findings under Standard 5

Data provided to inspectors prior to the inspection showed that not all children in care had an allocated social worker. At the time the data was returned there were 31 out of 134 children in care unallocated, and by the time of the inspection this had risen to 37 unallocated children in care.

These 37 children were prioritised as follows:

- 10 were high priority,
- 10 were medium priority and
- 17 were low priority.

The service area had seen a sharp increase in the number of children not allocated to a social worker from the beginning of 2022, where in January the number reported was only five children. From the inspection, it was evident through documentation and interviews held, that the area had experienced a number of social worker vacancies on the child-in-care team for much of 2022. The area also had staff out on leave for long durations which had an impact on senior roles becoming vacant intermittently in 2022. From January 2022 to April the role of child-in-care principal social worker had been shared by three principal social workers, from the fostering resource unit, duty and intake team, and child protection and welfare team, who took on additional duties to support the child-in-care team. The area manager informed inspectors that a recruitment process was undertaken to fill the social work vacancies. The area were successful in recruiting two social workers and an acting principal social worker. The acting principal social worker subsequently became the permanent principal social worker to the child-in-care team before the inspection.

The risk to the delivery of service that was impacted by the numerous vacant positions, was placed on the areas risk register by the area manager in December 2020 and remained on the risk register in June 2022. The area manager had identified the direct impact on children in care 'receiving an appropriate service in an acceptable timeframe'.

Inspectors spoke with the newly appointed principal social worker on the subject of unallocated cases. The principal social worker said that a large number of the unallocated cases amounted to one caseload. The cases were previously assigned to a named social worker, with a defined intervention plan, but due to the lack of capacity as a result of staff vacancies, not all cases were reassigned to a new social worker. The principal social worker said that a team leader had been assigned to work and manage the unallocated cases whilst awaiting assignment to a social worker. This responsibility included prioritising children who had the greatest potential needs for support, undertaking statutory visits, and attending child-in-care reviews. The principal social worker said that she would and had undertaken statutory visits to any children who remained unallocated. The area sent a letter to the family and foster carers, when a case became unallocated. This letter included confirmation that the child was unallocated and details regarding how to contact the team in the event of any issues arising. Inspectors found evidence on case files that this process was being implemented. The principal social worker had oversight of the unallocated cases through monthly meetings with the team leader, where they assessed and considered factors that may have increased risk. Documentation showed that these meetings happened and were in line with their standard operating procedure. Inspectors found areas of good practice in the prioritisation of unallocated cases and saw examples where it was recognised that the risk was higher than originally assessed and required a higher priority for allocation.

Additionally, where cases were prioritised as low inspectors found that these children were in long-term stable placements, were safe and whose needs were being met. However, inspectors found one case where the area had not prioritised the child's case correctly, although this case was already risk assessed and subject to regular review by managers. This child was deemed by the area to be medium priority, and remained unallocated, despite the child presenting with additional needs and being placed outside of the area in a private placement. Therefore, no Tulsa social worker was visiting them, and records showed that the child had not been seen for a substantial period of time. Inspectors found that their current circumstances and safety of the child were unknown to the service. Assurances were sought on this case at the time of the inspection and the child was assigned a social worker in the days following the inspection.

Inspectors spoke with a child who said that they were aware that they did not have a social worker and hadn't had one for a few months. The impact on the child was that they did not know who to contact if they needed to, and that they did not know when a new social worker was going to be assigned. Some foster carers expressed concern when children were not assigned to a social worker, that the impact was that actions did not progress and that the child disengaged from social workers. The negative impact on a child's life of not being allocated to a social worker was evident in a case of a child nearing the age of leaving care. Inspectors found that there was

poor engagement with the child and delay in the completion of priority actions from their care plan, although these were being tracked. Subsequently, inspectors found that priority actions were closed, as management reviewed and recorded inaccurately that the child had turned 18 years of age. The lack of oversight of the unallocated case had a direct impact on the child that resulted in the child falling through the gaps, where issues were not noticed or dealt with.

Inspectors reviewed 25 children's case files for the purpose of reviewing the timeframes of statutory visits over twelve months prior to the inspection. From the data submitted prior to the inspection, the area had identified 13 children who had not been visited by a social worker in line with regulations.

Of the 25 children's files sampled by inspectors, it was found that 10 of these children in care were being visited in line with national standards. However, for 15 children the frequency of statutory visits was not in line with foster care regulations. Out of these 15 children, six children were not allocated to a social worker and two of these children were placed outside of the area. Three of the six children not allocated to a social worker had a disability and or additional needs and one child was subject to the *'Report on the Look Back Review into Child and Adolescent Mental Health Services'* (Look Back Review) where they had suffered significant harm. For three children there were significant gaps between visits that ranged from eight, nine and 10 months.

Inspectors found that statutory visits to see children in care were carried out by a social worker and that while there were gaps as noted above, there were improvements in the frequency of statutory visits taking place. There was good practice noted where the child, where possible, was seen alone. In circumstances where this was not possible the reasons for this was recorded. Social workers did not always confine their statutory visits with the child to the foster care home but met the child at other locations and undertook activities. Good practice was identified by inspectors where a social worker spent an extended amount of time with a child during statutory visits to provide a space for the child to speak about their wishes and feelings about significant issues. Through this, the social worker was able to capture clearly, through the child, what was happening in relation to their foster care placement. This allowed for ongoing tracking of the child's well-being with guidance provided from the social worker to the foster carers. For children who were not of sufficient age there was good understanding of the child's lived experiences and the impact on them of any failure to properly meet their needs. Additionally, inspectors found good use of child-centred language to promote understanding of a child's experience in other case files.

Social workers recorded good quality observational opportunities to collect information on what was occurring during the statutory visits. Case notes documented what social workers saw offering a brief interpretation that identified

and supported the child's strengths, needs, interests and development. Statutory visit records also assessed the suitability of the placement and the overall circumstances of the child's living environment, including how the child responded to foster carers, play, child's appearance and the home environment. The area had introduced a new statutory visit form to improve recording and inspectors found it was used by social workers. However, inspectors found two cases of children who had a disability who were not able to verbalise their feelings, that their statutory visit did not provide an adequate picture of their development and progress. It was not clear whether the child had an understanding of what was happening in their life from their statutory visit. There was also evidence where an older child's voice was not always heard and actions progressed from their wishes and feelings about the suitability of their placement. Upon speaking with the area manager she said that the voice of the child had been identified as not being fully incorporated into practice by the service and that further work was required to address the challenges and improve practice.

Concerns remained regarding the absence of case records as evidence that statutory visits had occurred. Inspectors found that there was inconsistency in the quality of recording statutory visits across the different teams of social workers. There were examples found where the case record did not clearly and succinctly outline the voice of the child, or identify actions and what had happened to and for the child. Inspectors also came across statutory visit records that were missing from the case management system, NCCIS. For some statutory visits, inspectors found the content and language was similar overtime resulting in repetition. Other weaknesses identified by inspectors were that statutory visit records were not always up to date and did not always influence the next steps in the child's care planning. Inspectors found a statutory visit to a child with a disability did not have any actions identified yet a significant amount of work was required to address the child's future health needs and progression for aftercare planning. Without accurate and timely information to inform risk assessments and decision-making from statutory visits, social workers may not always be able to make the right decisions, for the right children, at the right time.

Staff said to inspectors that they were provided with dedicated administration time per week to complete administration tasks. The area manager confirmed this to inspectors but that it was not always effective against a backdrop of staffing capacity issues.

Inspectors found that children in care continued to face changes in their social worker more frequently since the previous inspection and that foster carers said there was a large turnover of staff experienced. In one case the child's social worker had changed five times over a five year period whilst in another case, a child was on their seventh social worker. Frequent changes in social workers are associated with a lack of trust among children in care.

Social workers coordinated the care of children with the input of other professionals when this was required for care planning. The majority of foster carers spoke positively about their experiences of working with social workers for the child placed in their care. Inspectors found good examples of social workers supporting foster carers to access respite services.

Social workers maintained good links with families and foster carers. They also encouraged and facilitated sibling access visits to ensure ties remained strong and intact where possible. There was also good use made of professionals meetings to plan family access and determine the need for long-term care, and cases were brought to the complex case forum for further support and direction. Inspectors identified from file review and interviews that foster carers experienced financial challenges in the caring for children with disabilities and or additional needs. For example, financial assistance not being available at the time when medical devices were required. There was evidence that enhanced payments had been made available to the foster carers however, there was one occasion where an outstanding matter regarding enhanced payment application was not addressed. This meant that foster carers were left with uncertainty of the payments continuing due to the review process.

The priority action meetings were a forum to track and monitor actions agreed at the child-in-care review meetings. From speaking with the principal social workers and reviewing the priority action meeting minutes, the service was tracking and reviewing on a monthly basis, all new and outstanding therapeutic services and supports for children in care. It was evident that where actions could be addressed in a timely manner these were, such as life story work, orthopaedic appointments, orthodontics. However, inspectors found that children who were unallocated or whose social worker was out on leave from work were impacted more negatively as no updates were provided and actions were transferred over to the next monthly meeting. Delays impacted access to external services due to demand and availability of some services nationally. This resulted in children in care being placed on a waiting list. Where the area could facilitate privately funding children in care to access services this was done on a case-by-case basis. It was clear that the priority action meetings were essential in tracking and progressing access to services but the impact of staffing capacity on the effectiveness of the meetings was highlighted. In April 2022, 11 cases were presented to the meeting, this significantly increased to 60 cases in July 2022. The area manager acknowledged to inspectors that the priority action meeting list was significant and a review of the effectiveness of the meetings would be undertaken.

Inspectors found that the *'Joint Protocol for interagency collaboration between the Health Service Executive and TUSLA to promote the best interests of children and families',* was in operation. Inspectors found from document review and interviews

that the interagency and regional meetings with the HSE had taken place and acted as a referral pathway. It wasn't always clear if cases escalated at interagency meeting had been addressed at regional level. For example in July 2022 six cases were escalated to the regional level, however, inspectors could not find evidence that these cases were discussed or if not a record of decision-making that outlined this. From case file review inspectors found that there was not always timely and consistent access to assessments and specialist interventions for children with disabilities. It was identified that one child was waiting four years for a feeding assessment to be conducted. In another case, the records provided an overview of a child's additional needs and current services, but there was no clear direction evident in terms of how the child's needs would be followed up. Shortfalls in accessing services would become one of the factors for placements becoming at risk of breakdown. Inspectors found that two cases were at risk of placement breakdown at the time of inspection. Inspectors found that more progress was needed in supporting and implementing the needs of children in care living with moderate to severe disabilities. The area manager said they were aware that further progress was needed, to make the protocol meaningful to children in care and foster carers, in fulfilling not only a pathway but access to supports services.

The inspection found that significant difficulties had been experienced by the service since the previous inspection that impacted the services ability to meet standards and regulations. The high turnover of social workers continued to negatively impact on the quality of support provided to children in care, with statutory visits not always undertaken in line with regulations. Not all children in care were allocated a social worker, and while improvements were noted as regards the systems of oversight of unallocated children in care, further work was required to ensure that those that required allocation were prioritised. Where visits were taking place, the quality had improved. The majority of children's records contained some gaps and key case notes and activities were not recorded on the case management system. While the needs of children in care were generally adequately identified; processes in place to ensure timely and comprehensive assessment of their needs and access to relevant support services overall needed further improvement. For these reasons the area was judged to be moderately non-compliant.

**Judgment: Non-Compliant Moderate**

**Standard 7: Care planning and review**
Each child and young person in foster care has a written care plan. The child or young person and his or her family participate in the preparation of the care plan.

## Summary of inspection findings under Standard 7

Data provided by the area in advance of the inspection indicated that the area was operating a service, from July 2021 to February 2022, with a vacant position of independent reviewing officer to chair child-in-care reviews for children in care. Responsibility for chairing the child-in-care reviews was reassigned to principal social workers who were rotating this on top of their normal duties. In addition, the area manager had assigned a principal social worker from the child protection team to monitor the completion of actions from care plans.

It was found that the independent reviewing officer vacancy resulted in a drift in child-in-care reviews. In February 2022, the area identified that 50 child-in-care reviews remained outstanding from 2021. Inspectors found that at that time child-in-care reviews was not well managed, were not always within the required timeframes and were largely overdue by a significant period of time. The impact of this resulted in a recognised gap in care plans not being up to date and not based on an informed assessment of children's current needs or any significant or proposed changes in their lives. Without oversight from an independent reviewing officer, notification of any significant changes in a child's circumstances or placement provision were not adequately monitored or appropriate consideration given as to whether child-in-care reviews should be held earlier than the scheduled date. During this time, the measures in place were inadequate for effective service delivery, with respect to care planning and the statutory reviews of children in care.

The service made substantial improvements in February 2022, when a team leader was recruited to the role of the independent reviewing officer. Furthermore, the area manager assigned an additional team leader to support work on the outstanding child-in-care reviews. This team leader was in place for a period of one month. In July 2022, with the commitment of the independent reviewing officer, the principal social worker and the additional support from the team leader, the outstanding child-in-care reviews were completed. The data submitted supported the perseverance of the service to bring itself in line with regulations and standards as it had conducted 132 child-in-care reviews from November 2021 to August 2022. This data also highlighted that six child-in-care reviews were outstanding, but this had been reduced to two by the time of the inspection.

The independent reviewing officer was responsible for scheduling, chairing and minute taking of child-in-care reviews along with the development of the care plan.

She was an experienced social work team leader who operated independently of the social work teams and reported directly to a principal social worker on the child protection team. On speaking with the independent reviewing officer she described to inspectors the process of organising reviews. A new child-in-care initiation form was developed to ensure all necessary information was provided to the chairperson and to streamline the process. Once this form was initiated by the social worker, the administration team scheduled the reviews with the chairperson and invitations would be issued to key people such as the child, parents, foster carers, social workers, fostering link social workers and other professionals, such as guardians-ad-litem, teachers, and juvenile liaison officers, who were involved in the child's care. The independent reviewing officer spoke of meeting with children and parents prior to and after meetings. Additionally, social workers met with children prior to the reviews taking place to gather their views either verbally or in writing.

As part of the review process social workers and other professionals submitted written reports. Inspectors observed these reports on file. The independent chairperson had incorporated a new statutory review checklist as part of the child-in-care review process. This was to improve the quality and to meet national standards. Part of this checklist was completed by the social worker prior to the review, where a further section was discussed at the start of the review. The checklist looked at gathering a number of key pieces of information including medical, priority actions, HSE services and statutory visits. It also looked at whether the child-in-care reviews was being held in line with regulations and if not the reasons documented. Inspectors who attended a child-in-care review observed this to be in use and utilised comprehensively. Child-in-care reviews were typically held during office or school hours. However, where children were placed outside of the area, the independent reviewing officer had held and was flexible in scheduling the reviews at the child's location to meet their needs. The independent reviewing officer said that their focus of reviews was around the child. In instances where the child voiced their views not to be present at a review, consideration was given as to what was in the best interests of the child and if required, the review was held in two separate parts for children to attend and be heard.

Inspectors found after reviewing 20 children's files around their care planning and review that eight cases were in line with statutory requirements. Inspectors found that for 12 children's cases, their child-in-care reviews were not up to date. Three out of the 12 cases had delays of two, seven and 18 months. In addition, for one case the initial child-in-care review was two months overdue after the child's placement into foster care.

Upon reviewing case files inspectors found that child-in-care reviews provided opportunities for parents, foster carers, other professionals and children to contribute and express their views at the meeting and that this was well documented. The new

structure provided for good quality meetings and discussion where foster carers spoke positively about the quality of the child-in-care reviews. Inspectors found that not all children choose to attend their reviews and the reason was documented. The service was seen to promote the child's preferred means of communication and this resulted in positive engagement. In one case, a child attended their review, completed the review form and conveyed their wishes and feelings at the meeting. In another case, a child's preferred communication method was through virtual means and this was facilitated. Where children did not attend child-in-care reviews, inspectors found that the child-in-care review booklet was completed with the child, their views documented and captured as part of the review process.

Inspectors found that the areas practice for eliciting the voices of children with communication, speech and language needs to gain insights into their experiences was limited. Inspectors found that not all children with disabilities and or additional needs attended their review. Further work was needed in this area, to ensure that the views and feelings of children with complex needs were heard, to actively shape the support available to them. For example, a case reviewed indicated that a child with communication needs had capacity to participate with support but this did not happen. The child was not supported by an independent advocate who had the appropriate expertise of the child's communication needs.

Inspectors observed a child-in-care review that was attended by the parents, foster carer, fostering link worker, guardian-ad-litem and the social worker. The child did not attend the review but completed the review form to be read out at the meeting. The child's written views were read out exactly as the child had written them and it was given due weight throughout the review. The discussion at the review was in-depth and focused on a number of areas of the child's life that included health, education, family access and emotional wellbeing. The review also looked at the suitability of the placement and the long-term stability for the child and the parents were included in this discussion.

When the new independent reviewing officer was in position and conducting reviews, inspectors found that they were well structured, and detailed discussions were documented about the child's life and the statutory responsibilities of the area and if these were being met. Inspectors found good follow up discussions to monitor if decisions made at the last review were successfully implemented and if not the reasons recorded. Inspectors found there was good discussion and focus on permanency planning that looked at which option was most likely to meet the needs of the individual child, taking account of his or her wishes and feelings. Additionally, there was good evidence of forward planning and discussion around a child's pathway plan on leaving care. This was well documented in the review and the child's care plan and captured the actions identified and assigned to the responsible person in order for the child to make a successful transition from care.

From the last inspection, there remained an element of drift and delay in progressing some actions agreed at the review. In particular, these actions related to a delay in referrals being made to services, barriers to accessing occupational therapy and other therapeutic services. The priority action meetings were used by the independent reviewing officer to track and monitor the completion of all new and outstanding therapeutic services and supports for children in care. These monthly meetings had been met with challenges around their effectiveness. Inspectors found that children with disabilities and or additional needs were more effected by these challenges. For example, one child had a delay of 18 months for a review to take place, was not allocated to a social worker and was waiting on access to services, and these actions were still outstanding at the time of inspection. Gaps in reviews had led to uncertainty in relation to the future co-ordination of services for children in care, particularly regarding the levels of specialist support they required.

Data provided by the area indicated that a small number (11) of children in care did not have an up-to-date care plan. Inspectors reviewed the care plans of seven children and found that all their care plans were up to date. The child's feedback was effectively captured in their care plan. The decision-making was clear and they recorded who was responsible for actions and the timescales agreed for completion. Inspectors found that care plans had oversight from a team leader albeit some delays were identified in the signing off of care plans

A new tracker was established by the independent reviewing officer as a tool to have oversight in monitoring the schedule of child-in-care reviews. Inspectors reviewed this tracker and found it was in use and detailed. The independent reviewing officer told inspectors that as an additional safeguard she also checked the child-in-care database on a regular basis. She also spoke with social workers and team leaders in order to ensure that she had accurate information of each child's journey, whether that was in relation to change in placement provision, circumstances, legal status or a child admitted into care.

According to the areas standard operating process the independent reviewing officer was responsible for maintaining a database tracking children's participation in the statutory review process. This report was to be provided quarterly to the principal social worker for children in care. At the time of inspection, on speaking to the area manager, this had not yet commenced. Part of the independent reviewing officer role was to also review the actions agreed from the child-in-care review and their progress as part of review meetings for the child. The independent reviewing officer at first instance alerted the accountable manager to any failure to implement decisions. Additionally, actions new and outstanding were recorded on the priority action sheet and submitted to the priority action meeting. Inspectors found that this practice was being implemented but there were cases where actions were not being

progressed in a timely manner but rolling over from month to month. The priority action list had accumulated a significant number in the year. These meetings were designed to track and progress access to services deemed necessary for the child's health development and welfare. However, it was found that these actions were not always acquired in a timely manner and the needs of the child were not always met appropriately.

The service had made substantial improvements since the previous inspection in the recruitment of an independent chairperson, an improved structure and improvements to the quality of child-in-care reviews. The new independent chairperson had introduced a new tracking system along with other mechanisms for oversight. However, the independent reviewing officer position remained vacant for six months, and the interim measures put in place were ineffective resulting in 50 outstanding child-in-care-reviews. Additionally, the priority action meetings were not always effective in progressing actions from child-in-care reviews. Further work was needed in eliciting the voices of children in care and their participation at child-in-care reviews. For these reasons the area is judged to be substantially compliant with this standard.

**Judgment: Substantially Compliant**

**Standard 10: Safeguarding and child protection**
Children and young people in foster care are protected from abuse and neglect.

## Summary of inspection findings under Standard 10

Inspectors found that the area had continued to make significant improvements to embed good practice in the management of complaints, concerns, and allegations against foster carers and other allegations made by children. Inspectors found that the services approach to assessment and investigation was in line with *Children First: National Guidance for the Protection and Welfare of Children, and of the Children First Act 2015* (Children's First).

Data submitted by the area prior to the inspection indicated that it had received 52 referrals of child protection and welfare concerns pertaining to children in foster care since 01/11/2021, of which 20 referrals were still open. Additionally there were four allegations made against foster carers, and three of these remained opened. The data also showed that since November 2021 the area had conducted two foster carer reviews following an allegation. In addition, there were also five serious concerns made against foster carers, all of which had been concluded at the time of the inspection.

The data indicated that there were no dual unallocated cases, that is, there were no families where both the child and the foster carer did not have an allocated social worker. Inspectors did not find any cases of dual unallocation during the inspection.

Since the previous inspection the area were working with a new national procedure, Child Abuse Substantiation Procedure (CASP) 2022, after it was introduced and came into effect from the 27th June 2022. This procedure provided new guidance in the assessment of allegations of child abuse. At the time of the inspection the area had no CASP social worker in place for a period of one month. As a result, the area had no designated social worker who had oversight and responsibility for undertaking a substantiation assessment that determined whether the person subject to abuse allegations (PSAA) posed a risk to a child. The vacant position was placed on the areas risk register by the manager as the area were unable to meet its obligations under the CASP procedure. The manager informed inspectors that steps were taken prior to the previous CASP workers leave from work. A review of all CASP cases was undertaken and priority for allocation determined. Additionally, the manager had requested for the vacant position to be filled to facilitate the ongoing implementation of CASP. At the time of the inspection, the manager was at the final stages of selecting a candidate for the vacant position.

Inspectors reviewed three cases where allegations were made against foster carers and one case where a serious concern was made. These allegations were managed

in line with *Children First* and the new national procedure (CASP) 2022. Inspectors found that on all cases reviewed, that the allegations and serious concern were screened appropriately by the duty social work team for immediate serious risk of harm to the child, and that the details of the report were given due consideration in determining decision-making and classification. Inspectors found evidence of classification meetings held along with numerous strategy meetings and complex case forums. Where necessary, An Garda Síochana were in attendance to plan any joint actions that were to be taken as a result. Although all reports were responded to appropriately, not all cases were responded to in a timely manner thus prolonging the process. In one case, there was a delay of six weeks from the point of the allegation being disclosed by the child, to the referral being made to CASP. In another case, it took the social work team two months to progress a decision for a referral to be made to the family centre to conduct an assessment of the allegations made by the child. Inspectors found that further work was needed to improve the areas approach to make the process more child centred, as children were not always seen as part of the initial assessment process or provided with information by social workers in a timely manner.

Inspectors found that the standard of quality from the classification and professional meeting records varied from hand writing not being legible, to no outcome documented on file.

Staff told inspectors that the new national approach to the handling and investigation of allegations against foster carers and or third parties of child abuse had been implemented in the service area. Staff who spoke with inspectors were clear on the new processes in place that outlined the steps to be taken when investigating allegations of abuse. Staff told inspectors that social workers from the child-in-care team and the fostering resource unit worked closely together around allegations and other areas of their work for children in care. Staff gave examples of allegations made against foster carers and how these were assessed and the protective measures taken in regards to safety plans and or the removal of the child from the placement. Managers told inspectors that they were confident in their social workers ability to identify safeguarding issues and that departmental days were an ongoing feature to support the embedding of the new national approach to the handling and investigation of allegations.

Inspectors found that there was good practice in the sharing of information with An Garda Síochana where a concern that a person may harm a child or put a child at risk of harm. Additionally, the voice and responses of the foster carers to the concerns and or allegations raised were clearly documented. Inspectors found good practice of social workers putting in place support services for the foster carers that were subject to an allegation made against them. This included psychologists. There was also evidence on file that, where feasible, parents were informed of the

concerns and or allegations disclosed. From review of senior management meetings, the manager had allocated training to be made available to foster carers about the new national procedure (CASP).

Three out of the four cases reviewed had a written record that included the outcome of discussions or formal investigations on file. There was good evidence of the duty team or child-in-care team taking immediate action where required, and assessing risk of harm posed to other children in the same placement of the alleged allegation. A safety plan was put in place that had clear actions such as weekly visits to the foster carer home and timeframes set out to review the safety plan. Safety planning remained an ongoing feature as a safeguarding measure for children where the assessment was ongoing.

Data provided by the area indicated that three children had gone missing from care since the previous inspection. Inspectors reviewed one case where a child had instances of absconding from their foster placement. The case file evidenced that the social worker had informed the child about the risks to their safety from absconding and the process in place for responding and reporting these instances. The foster carers responded appropriately and contacted An Garda Síochána in a timely manner and also the social worker. There was good evidence that placement at risk meetings had occurred and good case management of the child's needs and assessment of the suitability of the placement.

The two principal social workers, who managed the child-in-care team and fostering resource unit, maintained trackers to assist in the oversight and management of allegations and concerns received. The principal social workers told inspectors that they worked closely together on cases that included allegations and serious concerns across their teams. Inspectors reviewed these trackers and found that classification meetings were held, discussions were had regarding thresholds, fostering link social workers met with the foster carers regarding the allegation and supports were offered. The tracker was updated by the principal social, with new information on each case and was of good quality. However, inspectors found that only allegations or serious concerns made against Tusla foster carers were placed on the tracker and that private foster carers was not recorded or tracked by the area. Concerns remained over the areas level of oversight of any allegations and serious concerns made against private foster carers who had children in care placed with them.

Inspectors also reviewed the tracker that was in place to log complaints made. Complaints were notified to and investigated by the complaints officer. From review of senior management meetings, complaints were featured as an agenda item and discussed at these forums. Inspectors reviewed a child's file, where a complaint was made and sought further assurances from the principal social worker, the complaints

process was followed and the child was spoken to by a social worker and steps taken to improve outcomes for the child.

Since the previous inspection in October 2021, the dataset provided showed that the area had submitted nine 'Need to Know' notifications between the regional and national office. Three of these were related to the fostering resource unit and six were related to the 'Look Back Review'. The 'Need to Know' reporting procedure is Tusla's national incident management system and is used to notify Tusla's national office of serious incidents and adverse events in relation to children in care. Inspectors reviewed the area's 'Need to Know' log and found that the area had identified a number of risks, had detailed recording of these risks, and the impact and actions outlined in response to such risks. Inspectors found the 'Need to Know' log to be detailed and effective. This inspection reviewed two 'Need to Knows' that examined the effectiveness. One was related to Garda Vetting of foster carers and the second was the breakdown of a placement following an allegation. Inspectors found that the actions outlined in response were detailed, with some having been completed and others remained outstanding.

Inspectors were not able to fully review all areas in the assessment of allegations of child abuse in the service, as there was no CASP social worker in place, and therefore the cases that were referred to CASP were on a waiting list. In addition, the CASP records were maintained on an alternative system, and were not saved on NCCIS. As a result, this hindered the inspector's ability to fully assess the areas compliance with national standards as only elements of the national procedure could be measured. Of the areas inspected it was found that the service had made great strides in the face of adversity in implementing a new national approach to the management of allegations and serious concerns. The area had appointed a CASP social worker from the onset however, the position became vacant within a matter of months. As a result, there were cases waiting for an assessment to be conducted. There was also no oversight of the timeliness in the management of allegations and serious concerns. Further improvements were required in the areas approach to make the process more child centred as children were not always seen as part of the initial assessment process or provided with information by social workers in a timely manner. Concerns remained over the areas level of oversight of any allegations and serious concerns made against foster carers in relation to the timeliness and children in care placed in the private sector. For these reasons the area is judged to be substantially compliant with this standard.

**Judgment: Substantially Compliant**

**Standard 15: Supervision and support**
Approved foster carers are supervised by a professionally qualified social worker. This person, known as the link worker, ensures that foster carers have access to the information, advice and professional support necessary to enable them to provide high-quality care.

## Summary of inspection findings under Standard 15

Data provided to inspectors prior to the inspection showed that all foster carers had an allocated fostering link social worker assigned to them. This amounted to all of the 72 general fosters carers and 22 relative foster carers. This showed a vast improvement in this area from the previous inspection, where 28% of foster carers did not have an allocated foster link social worker.

Upon reviewing documents, inspectors found that the service had gone through periods where foster carers were unallocated to a fostering link social worker in 2022. In February, the team had no foster carers awaiting allocation however, this saw a significant increase in May where there was 20 unallocated foster carer households. In August 2022, it was documented in a senior management meeting that some statutory obligations were not completed due to staffing capacity and that it had sought support from another service, for social care workers and social care leaders to help complete tasks.

The area had experienced four vacancies on the fostering resource unit from January 2022. One of the vacancies was the team leader position which had been vacant since February 2022. The area manager informed inspectors that a recruitment process had been put in place to fill the social work vacancies. The area were successful in recruiting two social workers to the team in August just prior to the inspection. However, the team leader position remained vacant along with one social worker position. A document of an analysis into the service's vacant posts, for the period from 1st January to the 31st August 2022, showed that the overall hours lost to the team was 952.2 for the team leader position and 2,593.4 in social work positions. The area manager talked through the analysis with inspectors, the impact lost hours had on teams and in delivering a service to children in care.

Inspectors reviewed eight foster carer files and found that they all had an allocated fostering link social worker at the time of the inspection. Of the eight foster carer files reviewed, four foster carers had children with a disability and or additional needs in their care. Some foster carers experienced a high turnover of fostering link social workers in the past 12 months. The impact of this was actions were not progressed.

The data submitted by the area prior to the inspection highlighted that all foster carers had a supervisory visit undertaken within the past six months. When inspectors reviewed the eight foster carer files, it was found that the majority of foster carers were visited in line with the frequency set out in the service areas policy. This policy stated that the requirement was, a minimum of two supervisory visits were to take place per year and four visits recommended, or more, if foster carers had experienced any issues, difficulties, illness or bereavement. Inspectors found that there were some foster carers who experienced periods of unallocation, and a high turnover of fostering link social workers. Foster carers who required additional supervisory visits due to a child's additional needs or issues arising, had not received this in line with the policy. The impact of this was that visits were not always completed at the frequency required, and therefore the monitoring of the child's placement with the foster carer(s) and the support required for foster carer(s) struggling in their role, through regular visits to the foster home, was inadequate.

Where supervisory visits occurred inspectors found that the new supervisory visit form was used by fostering link social workers. This form was used to monitor key areas, for example, if mandatory training and regular health and safety checks were completed. Inspectors found that Children First mandatory training was up to date and that health and safety checks due were documented. Inspectors found good practice in the recording of supervisory visits and that the case notes were clear, detailed and provided comprehensive recording and checks of ongoing suitability of the placement. Also, there was evidence that foster carer views and concerns were clearly captured, with effective tracking of actions between supervisory visits.

Foster carers were given opportunities to express their views, concerns and recommendations for service improvement. For example, foster carers were asked for their feedback of the service in January 2022. The feedback looked at, what was working well, complicating factors, recommendations for change and the supports foster carers found useful. Inspectors examined the results and approximately 15% of foster carers provided feedback to the service. It was clear from speaking with foster carers and reviewing case files that the majority of fostering link social workers developed good communication and relationships with foster carers through regular telephone calls and supervisory visits.

In order to provide a minimum level of oversight and support to unallocated foster carers, the fostering resource unit had set up a system through their duty social worker team. Fostering link social workers, when providing on-call duty, would also contact unallocated foster carers to monitor their foster placements. However, the area had identified in its service improvement plan that this measure was ineffective. This was due to the demand placed on the duty team to source available foster carers as soon as requests for a placement were received. This risk was escalated to the area manager and the responsibility of unallocated cases reverted back to the

principal social worker. On speaking with the principal social worker she had good oversight of any unallocated cases through supervision, audits and the use of a tracker. Additionally, the principal social worker communicated on a regular basis with the child-in-care team principal social worker to ensure no dual unallocated cases occurred. Where concerns of dual unallocation arose, this was clearly communicated between the teams and priority given to the child being assigned a social worker.

The area was seen to take steps to help support foster carers to meet the needs of children placed with them. This included the setup of a support group for foster carers and also a mentor. The area encouraged participation through communication with foster carers. The fostering resource unit also provided a support group to the biological children of foster carers, who played an important part in supporting children in placement. Additionally, an outside agency had started to provide training to foster carers. At the time of the inspection, the area manager said that the support group for foster carers had commenced and that further worked was needed to increase attendance and embed the practice. In regards to support for biological children this too needed further work. It was found that foster carers were supported to attend ongoing training and to develop the skills required of them. Foster carers said to inspectors that they were provided with a calendar of foster carer training events that focused on skills and knowledge to support a child in their care. This training ranged from trauma training, support for contact with birth children, support for sibling relationships and bereavement and loss. Some foster carers felt that the training was repetitive in nature. Foster carers were also given the opportunity to present knowledge and skills to other foster carers as part of the training programme.

An area that presented as a challenge and barrier to foster carers was the access to therapeutic and specialist services for children in care. Foster carers said to inspectors that the fostering link social workers were great at their role but that the high turnover of staff did not create an environment that was easy to navigate. Inspectors found cases where children were in receipt of speech and language therapy and respite care, however concerns remained on the barriers and ongoing gaps for children with complex needs who required intensive support services and the impact of this on foster carers and placement stability.

From a document review, interviews with the principal social worker and the area manager, it was found that the system in place for ensuring Garda vetting of foster carers had encountered problems in 2022. It was identified through the Garda Vetting Bureau, three months after the documents were submitted, that the forms were not completed correctly. After the correct documents were submitted, a further delay was encountered as the consent was also out of date. It took 10 months for

the matter to be fully resolved. This resulted in a significant impact in that 15 foster carers Garda vetting becoming out of date. Once the service was alerted to the error and impact, immediate action was taken. A full audit of Garda vetting of fosters carers was undertaken, a 'Need to know' was submitted and the incident was listed on the areas risk register. Further safeguards were put in place, as an interim measure foster carers were contacted to sign a declaration form. At the time of the inspection, the Garda vetting for foster carers was still outstanding. This was partly due to the demand on the Garda vetting bureau in processing applications.

The service had worked hard to improve their performance since the last inspection. Inspectors found that there were no unallocated foster carers. However, fosters carers had experienced periods of unallocation and a high turnover of fostering link social workers. This had impacted on the support provided to foster carers in meeting the needs of the child. Additionally, foster carers who required additional supervisory visits due to additional needs or issues arising had not received this in line with the services policy. In addition, the system in place for ensuring the Garda vetting of foster carers was ineffective and had resulted in inaccuracies and time delays. The oversight of Garda Vetting checks was ineffective. For these reasons the area is judged to be substantially compliant with this standard.

**Judgment: Substantially Compliant**

**Standard 19: Management and monitoring of foster care services**

Health boards have effective structures in place for the management and monitoring of foster care services.

## Summary of inspection findings under Standard 19

The service areas governance and management structures to oversee the quality of its foster care services, had changed since the previous inspection in order to secure the future sustainability of the service. The area manager had identified the need for greater oversight of the child-in-care team. A new structure was established that made up three separate child–in-care teams that were each overseen by a dedicated team leader. All team leaders reported to a principal social worker. The service had experienced significant changes in staffing capacity across the child-in-care team and the fostering resource unit throughout much of 2022. This had impacted on the service areas ability to consistently deliver an appropriate and effective service to children, and also to ensure foster carers received regular and stable supervision and support. Due to the staffing challenges experienced, the area had introduced a range of methods to improve its governance and oversight. Some of these were at the early stages of implementation at the time of inspection and a business case to expand the staffing levels of the child-in-care review team was at the submittal stage. The governance and oversight of services provided to children and foster carers remained at times inadequate throughout much of 2022 but had seen critical improvements by the time of the inspection.

Senior managers provided strong leadership during what had been an extremely challenging period for the service. They had focused their attention on delivering vital organisational priorities which saw three principal social workers take on extra responsibilities to support the vacant principal social worker position on the child-in-care team. Senior managers worked steadily to build workforce capacity and capability but the impact on staff vacancies was noticeable. The regional chief officer had good oversight of the performance of the service area through quarterly regional risk management meetings and their supervision with the area manager.

The service was managed by an experienced area manager who was in position since 2019 and was striving to develop a culture of high aspirations and expectations for staff to transform and improve the lives of children in care. During interview, the area manager described that the service was in a 'process of change' and that staffing capacity was a challenge since the previous inspection. The area manager emphasised the importance for the service in having a report of every child in care, to capture a pen picture of where they were in their life and in terms of service

delivery. This report was completed and reviewed by inspectors. The area manager was visible and accessible to staff on the ground and also to foster carers, with a focus on ensuring children received the best possible care. The area manager had a good understanding of the services strengths and areas for development. For example, the service were looking at plans to further develop and increase the participation of children to contribute to the planning of their care and the development of the service. The area manager was also appraised of the risks that the service faced and was honest to inspectors about the hurdles that were being experienced. Although staff turnover was high, and the area was not well resourced at intervals in 2022, this was not indicative of one factor but a number of factors at play, such as staff out on leave, retirements and promotions. Therefore, inspectors were assured that the area manager's development of the service would in time improve service delivery for children in care.

Inspectors reviewed the minutes of senior management team meetings that had occurred on four occasions since the previous inspection. The senior management team meetings comprised of a number of professionals, the area manager, and principal social workers from the chid-in-care team, fostering resource unit, child protection and welfare and duty intake team, along with Prevention Partnership & Family Support (PPFS) Service manager, business support manager, aftercare manager and the family centre manager. Inspectors found that written pillar reports had been introduced as part of these meetings, and that they provided written updates from each department. These pillar reports were very detailed and captured cases awaiting allocation, vacancies, 'Need to Knows', emerging issues, interagency meetings, feedback from audits, and statutory and supervisory visits. The reports provided further oversight to the area manager of each pillar and strengthened the lines of accountability.

Inspectors found that the priority action meetings that were implemented in 2021 were embedded by the time of the inspection and occurred on a monthly basis. However, the effectiveness of the forum in providing oversight was not always managed appropriately resulting in actions from statutory child-in-care reviews not being processed in a timely manner. The impact of staffing capacity on the effectiveness of the meetings was identified as one factor. There was a majority consensus from principal social workers and the area manager, that the priority action meeting list was significantly high and a review of the effectiveness of these meetings would be undertaken.

Inspectors found that the area manager had oversight of the Joint protocol arrangements with the HSE and was kept briefed of any shortcomings of the interagency and regional meetings. The area manager was aware that further progress was needed to make access to therapeutic and specialist support services a reality for children in care and not only a pathway.

Furthermore, three principal social workers had taken on extra responsibilities to support the child-in-care team. This included the fostering resource unit principal social worker, but inspectors found that their professional capacity was stretched at a time when the team leader position was vacant and they had taken on additional duties. Inspectors found these complicating factors had placed pressure on the principal social workers role where they were managing too many competing priorities. The vacant team leader position left the team without a dedicated manager that oversaw, guided and supported their work.

The service had in use a number of trackers on both the child-in-care team and the fostering resource unit. The independent reviewing officer had also introduced a tracker in 2022 that established and ensured accountability that statutory child-in-care reviews happened within the required timeframes. The inspectors reviewed the live tracker with the independent reviewing officer, and found that it was detailed, with the scheduled dates for child-in-care reviews logged. Also the allegations and serious concerns tracker was reviewed and found to be detailed and of good quality. However, further improvements were required as oversight of allegations made against private foster carers was not part of the tracker. The principal social workers continued to implement trackers to oversee that staff were meeting statutory requirements, such as: supervisory visits to foster carers; and statutory visits to children in care.

Principal social workers told inspectors that the trackers established accountability amongst the teams because it provided feedback on the progress of tasks. The area manager had oversight of these trackers, and also utilised their own trackers as an additional safeguard in the identification of what was working well, performance issues and risks that may prevent the completion of tasks and how to address them. The area manager said that the use of trackers supported the measurement of progress in teams to deliver positive outcomes for children in care and foster carers. Inspectors found the trackers to be implemented effectively and supported the service to improve their practice in meeting its statutory requirements.

Inspectors saw evidence of quarterly audits undertaken by the child–in-care team and the fostering resource unit. The audits consisted of both quantitative and qualitative investigations that ensured the necessary documents were on case files, timescales met, provided a detailed analysis of files, and judgments on overall quality and content. Inspectors found that the audits were detailed with recommendations made and followed up by the principal social workers, team leaders and social workers. A review of an audit showed that where social work practice required improvement, additional resources were provided in mentoring and training and monitored through supervision. Inspectors were told by staff that the results from audits were reported back to each team to improve practice and the quality of the

service provided. Departmental days were also organised with teams with the intention of improving outcomes for children and young people through a process of continuous learning from audits. Clear lines of communication allowed information to be shared efficiently and effectively. This was confirmed by staff members, and they said that they felt supported and were kept up to date by managers. Inspectors found the audits to be beneficial and effective to the service.

Inspectors found that managers had embraced learning since the last inspection. Managers took assertive action when practice fell below standard and learning was embraced and disseminated through regular team meetings that informed future planning. Inspectors found that management oversight of cases was at times not timely on case records. Inspectors found that managers scrutinised decisions related to the appropriate application of thresholds. However, for children placed outside of the area, further improvements in their oversight were required.

Staff worked in a supportive and reflective environment. They had opportunities that explored their training needs in areas of interest that enhanced their practice. Inspectors found that not all staff had regular supervision and that this was impacted by staff vacancies throughout 2022. The quality of the supervision varied across teams in terms of agenda items discussed and the recording of the meeting. It was not always clear what was needed to progress planning for children. Inspectors found that the new supervision template was being implemented and there was a marked improvement in the standard of quality in recording and accountability. Inspectors found that there had been a noticeable shift in the supervision structure that helped inform staff practice and monitored the care provided to children. This provided oversight in decision-making and progression of tasks that ensured that progress was regularly monitored and understood by all, and decisions were not made in isolation.

Inspectors reviewed the area's risk register that had three new items relating to the remit of the inspection. These were;

- Garda vetting of foster carers that were outstanding,
- Unable to meet obligations under the CASP procedure due to vacancy
- Access to assessment and therapeutic service for children in care.

The risk register had long standing items that related to staffing issues and the inability to recruit social workers since 2020, and also to the inability of the fostering resource unit to provide a service that was adequate and compliant with national standards due to staff vacancies since 2021. For each risk identified, additional control measures were put in place, apart from one. The measures put in place were an audit undertaken of foster carer files, a tracker was devised for Garda vetting of foster carers and a review was undertaken of all CASP cases, with the plan for the vacancy to be filled. In relation to the risk of access to assessment and therapeutic

services for children in care, no control measure was documented, and the risk was rated medium.

Overall, this inspection found that managerial oversight had improved since the previous inspection. However, vacant posts remained a significant factor that influenced the service's ability to progress and maintain improvements in the quality of service provision. Additionally, where additional responsibilities were placed on senior staff this had stretched their professional capacities in delivery of their work effectively. Systems put in place for oversight of new processes were at the early stages of becoming embedded. For these reasons the area is judged to be substantially compliant with this standard.

**Judgment: Substantially compliant**

# Compliance Plan

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

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|---|---|
| **Provider's response to Inspection Report No:** | MON_0037669 |
| **Name of Service Area:** | Kerry |
| **Date of inspection:** | 12 – 15 September 2022 |
| **Date of response:** | 16th November 2022 |

These requirements set out the actions that should be taken to meet the *National Standards for Foster care* (2003).

**Standard 5**
**Non-Compliant Moderate**

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

1. Not all children in care had an allocated social worker.

2. Not all statutory visits to children in care were in line with the requirements of the standard.

3. The prioritisation of unallocated children in care cases required improvement.

4. The consistency and quality of record keeping, and case notes required improvement.

5. Further improvement required in the monitoring and completion of priority actions from care plans.

6. Platforms that supported all children in care to express their views, wishes and feelings required improvement.

7. Timely and consistent access to assessments and specialist interventions for children with disabilities and or additional needs required improvement.

**Action required:**
Under **Standard 5** you are required to ensure that:

There is a designated social worker for each child in foster care and they are visited in line with regulations. That the child's case file is kept up to date and that decisions from care plans are implemented along with ensuring access to specialist services. Social workers co-ordinate the care of the children

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

1. Tusla Kerry recognises that recruitment challenges and long-term sick leave has created vacant posts in the area. In response to this issue, the Senior Management Team has dedicated a Social Work Team Leader to oversee and manage all unallocated cases. These cases are reviewed every 6 weeks in conjunction with the Principal Social Worker. An additional Social Worker is due to commence post in the Children in Care Team in December 2022 and this will significantly reduce the current unallocated case list. The Area Manager is ensuring that the Children in Care pillar are prioritised for staffing, to ensure statutory compliance to all Children in Care.

**Proposed timescale: On-going**
**Person responsible: Area Manager**

2. The Principal Social Worker for the Child in Care Team has oversight of the required statutory visits via the statutory visit tracker. This tracker is also forwarded to the Social Work Team Leaders on a monthly basis to alert Social Workers to complete their statutory visits. The current unallocated cases that require a statutory visit are being completed by the Social Work Team Leader, who is assigned to manage the unallocated cases. As noted above, the unallocated cases are reviewed every 6 weeks with the Social Work Team Leader & Principal Social Worker regarding governance and oversight of the statutory responsibilities and tasks.

**Proposed timescale: On-going**
**Person responsible: Area Manager**

3. The Area developed a practice guidance which was disseminated to the Children in Care Social Work Team Leaders on the 7th of July 2022, regarding the prioritisation of unallocated cases. The prioritisation criteria for cases to be unallocated was:
    - No dual unallocated cases between Children in Care pillar and Fostering Resource Unit
    - Children with a moderate or severe disability
    - Reception into care less than 6-month period
    - Placement disruption

The unallocated cases are reviewed every six weeks by a dedicated Social Work Team Leader & Principal Social Worker of Children in Care to ensure governance, oversight and review of the prioritisation of the cases. The Principal Social Worker of Children in Care will be assured of the correct prioritisation of the cases in the quarterly audits. These audits will ensure further governance and oversight regarding unallocated cases.

**Proposed timescale: On-going**
**Person responsible: Area Manager**

4. The Quality Assurance Officer will conduct training with the Social Work Department regarding the principles and importance of quality recordings. Quality of recordings will be a theme for the Children in Care pillar, Service Improvement Plan for 2023.The Quality Assurance Officer will complete a workshop with the team regarding the importance of quality of recordings. In tandem with ensuring quality recordings the Area Manager has mandated all staff of all grades, to complete a commissioned one-day workshop on record keeping and a one-day workshop on minute-taking to ensure good principles of recording.

**Proposed timescale: Q1 2023**
**Person responsible: Area Manager**

5. Whilst recognising that a staffing deficit led to incomplete actions from care planning to be completed in a timely manner, the area has assigned a Social Care Leader to support the Social Worker to complete the actions from the Child's Care Plan. To minimise a repeat of unfilled actions in the future, the Area has assigned Social Care Leader staff to the Children

in Care pillar, with the core component of their role to complete actions from the Child's Care Plan.

**Proposed timescale: December 2022**
**Person responsible: Area Manager**

6. In recognition of the additional challenges of children in care with additional needs, the Senior Manager Team will implement a local practice direction that a Social Care Leader from the Children in Care team will meet with children with communication challenges such as speech and language, for direct work sessions prior to the Child's Child in Care Review. This will ensure every effort is made to elicit the child's view prior to the Review meeting. The Quality Assurance Officer will engage with the Disability Service regarding consultation on how best to communicate with children with disabilities. A training session will be organised to up-skill staff regarding quality engagement with Children in Care who have disabilities, to elicit their views.

**Proposed timescale: Q2 2023**
**Person responsible: Area Manager**

7. The Senior Management Team is committed to ensuring that every child in care with additional needs are prioritised for the required assessments and interventions. In the first instance Tusla Kerry will advocate to the Health Service Executive to provide the required assessment and or intervention. If the Health Service Executive are unable or unwilling to provide the identified Service, then the Senior Management Team will continue to fund these services to ensure the best interest of the child is met within a timely manner. Tusla national are currently developing a therapeutic team per Area, to focus on meeting the therapeutic needs for Children in Care.

**Proposed timescale: Q2 2023**
**Person responsible: Area Manager**

| **Proposed timescale:**<br><br>**Timeframe: Q2 2023** | **Person responsible: Area Manager** |
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**Standard 7**
**Substantially Compliant**

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

1. Not all child-in-care reviews had taken place in line with regulations.

2. Not all children in care had up-to-date care plans.

3. Eliciting the voices of children with communication, speech and language needs at reviews required further improvement.

4. Participation of children at care at child-in-care reviews required improvement.

**Action required:**
Under **Standard 7** you are required to ensure that:

Child-in-care reviews take place within legally defined time limits. That child-in-care reviews are convened and conducted in a manner that facilitates children, their families and foster carers. Prepare a care plan for the care and upbringing of the child and that the child is consulted.

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

1. As noted in the HIQA report the Child in Care Review post was vacant for a substantial period in 2021, which impacted on service delivery for Child in Care Reviews in 2022. A dedicated Social Work Team Leader is now assigned to the role of chairing Child in Care Reviews. To support the Chairperson, there is tracker in place to monitor and record all Child in Care Reviews regarding timeframes. This tracker is updated on a weekly basis by a dedicated administrator and is forwarded to the Children in Care Principal for review on a monthly basis.

**Proposed timescale: On-going**
**Person responsible: Area Manager**

2. The dedicated Chairperson now in post will ensure that the Child in Care Reviews and care plans are occurring in an appropriate timeframe. The monthly statistics regarding Children in Care Reviews are recorded in the monthly pillar report for the Child in Care Team to be reviewed by the Area Manager at the Senior Management Team meeting.

**Proposed timescale: Q4 2022**
**Person responsible: Area Manager**

3. The Senior Management Team will assign a Social Care Leader from the Children in Care team to meet with children with communication, speech and language needs for a direct work session: prior to a child in care review. This will ensure every effort is made to elicit

the child's view prior to the Review meeting. The Quality Assurance Officer will engage with the Disability Service regarding consultation on how best to communicate with children with disabilities. A training session will be organised to up skill staff regarding quality engagement with Children in Care who have disabilities to elicit their views.

**Proposed timescale: Q2 2023**
**Person responsible: Area Manager**

4. The Senior Management Team are allocating Social Care Leaders to the Children in Care pillar to prioritise relationship building with children in care. This is to support the child/young person in participating in their Child in Care review. The Quality Assurance Officer & the Principal Social Worker for Children in Care will arrange a focus group with young people who are in care, to illicit their views on what would assist them to participate in their Child in Care Reviews.

**Proposed timescale: Q1 2023**
**Person responsible: Area Manager**

| **Proposed timescale:**<br><br>**Timeline: Q1 2023** | **Person Responsible: Area Manager** |
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**Standard 10**
**Substantially Compliant**

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

1. The Child Abuse Substantiation Procedure social worker position was vacant.

2. Not all cases related to allegations or serious concerns were responded to in a timely manner.

3. Record keeping required improvement.

4. Oversight of any allegations and serious concerns made against private foster carers required improvement.

**Action required:**
Under **Standard 10 you** are required to ensure that:

An allegation of abuse complies with Children First and that where an allegation of abuse is made an assessment is carried out of possible risk to all children in the foster placement.

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

1. The post for a CASP Worker in the Kerry Area was filled in October 2022, prior to the publication of the HIQA Report.
    a. A Principal Social Worker has governance and oversight of the CASP worker. The Regional CASP Lead for Implementation is also supporting the CASP worker regarding implementation of the process and embedding good practice regarding the management of the case work.

    b. Time frames regarding a timelier response to allegations reported, will be more effective in light of the appointment of the CASP worker.

**Proposed timescale: Completed**
**Person responsible: Area Manager**

2. The Area will continue to conduct a classification meeting between the Duty pillar, Children in Care pillar & the Fostering Resource Unit when there is a concern regarding an allegation or serious concern in relation to a child in care. A Performa template will be created to accurately record the outcome of the classification meeting and actions. At the time of the inspection the CASP worker post for the Kerry Area was vacant, hence the delays in

assessing the allegations. The CASP worker recently appointed, will now be allocated referrals where appropriate upon completion of the classification meeting. This should significantly reduce the timeframes for the completion of the necessary assessment. The Principal for Children in Care will create a new tracker to capture all allegations and serious concerns pertaining to Children in Care. This tracker shall be reviewed in supervision between the Principal Social Worker & Social Work Team Leaders.

**Proposed timescale: Immediate**
**Person responsible: Area Manager**

3. The Quality Assurance Officer will create a standardised proforma template for the recording of the classification meetings. This will ensure quality and consistent recordings of the meetings.

**Proposed timescale: Q4 2022**
**Person responsible: Area Manager**

4. The Children in Care Principal Social Worker will maintain a separate tracking system regarding allegations and serious concerns made against private foster carers. The tracker of all active allegations and serious concerns will be submitted with the children in Care monthly pillar report to the Senior Management Team Meeting. This will ensure the Senior Management Team are aware of all allegations and serious concerns on a monthly basis.

**Proposed timescale: Immediate**
**Person responsible: Area Manager**

| **Proposed timescale:** | **Person Responsible:** |
|---|---|
| **Q4 2022** | **Area Manager** |

**Standard 15**
**Substantially compliant**

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

1. The frequency of supervisory and support visits were not always in line with policy.

2. Regular supervision and support for foster carers caring for children with a disability or additional complex needs required improvement.

3. The support group for foster carers required improvement.

4. Oversight of and the timely processing of Garda Vetting of foster carers required improvement.

**Action required:**
Under **Standard 15** you are required to ensure that:

Health boards assign a named social worker, known as the link worker, to provide information, advice and support to them. Link workers meet with foster carers on a regular basis and have separate meetings with the foster carers own children. Health boards ensure that there are support groups for foster carers and their children in each local area.

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

1. Where cases of Children in Care have additional needs then additional visits will be provided by the Social Care Leader and/or the allocated Social Worker. This plan for additional support will be created with the Social Work Team Leader and the allocated Social Worker and/or Social Care Leader.

**Proposed timescale: Immediate**
**Person responsible: Area Manager**

2. The Fostering Resource Unit has increased the staffing compliment to ensure that all cases are prioritised for allocation. This should improve the frequency of the supervision and support for foster carers caring for children with a disability or additional complex needs. The Principal for the Fostering Resource Unit will review the supervision and care planning needs of the children on a quarterly basis with the allocated Social Work Team Leader. This process will ensure that the Foster Carers caring for children with a disability or additional complex needs will receive adequate governance and oversight within Tusla Kerry. A Social Care Leader will be secondary allocated to Foster Carers who are caring for a child with disabilities and/or additional complex needs.

**Proposed timescale: Immediate**

**Person responsible: Area Manager**

3. The Area will schedule support groups in Q1 2023 for the full calendar year to include guest speakers/ workshops for the Foster Carers. Foster Carers will be supported and encouraged to attend and participate and these groups will be facilitated by the Fostering Resource Unit.

**Proposed timescale: Q1 2023**
**Person responsible: Area Manager**

4. The Principal for the Fostering Resource Unit has embedded a robust tracker to ensure that Garda Vetting is renewed in a timely manner. The issue as noted in the HIQA Report arose from an issue regarding the wording due to new guidelines combined with a delay in processing with the National Vetting Bureau. The Principal for the Fostering Resource Unit will ensure a four-eye review of each application prior to forwarding same to the National Vetting Bureau to ensure all the information is accurate.

**Proposed timescale: Immediate**
**Person responsible: Area Manager**

| **Timeline: Q1 2023** | **Person Responsible: Area Manager** |
|---|---|

**Standard 19**
**Substantially compliant**

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

1. Vacant positions and the movement of staff continued to impact on the delivery of services to children in care and foster carers.

2. Governance in relation to the Priority Action meetings and the *'Joint Protocol for interagency collaboration between the Health Service Executive and TUSLA to promote the best interests of children and families',* required improvement.

3. Governance in relation to the quality of practice as identified under standard 5 and 10 required further improvement.

4. Governance in relation to oversight of allegations made against private foster carers required improvement.

5. Governance in relation to oversight of children placed outside of the area required further improvement.

6. Governance in relation to the quality of supervision identified understand 19 required further improvement.

Under **Standard 19** you are required to ensure that:

Health boards have effective structures in place for the management and monitoring of foster care services.

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

1. This issue regarding staffing is been addressed both locally and nationally. Due to the challenges of filling the Social Work posts locally, Tusla Kerry have diversified the staff team to include more Social Care Leaders in the Child in Care pillar. Unfortunately Tusla Kerry has ongoing and recurrent vacant positions across the various Departments which they have been unable to fill. This coupled with internal staff changes, has had a direct impact on the delivery of services to children in care and Foster Carers. Additional staff are currently onboarding for the Children in Care pillar. To note, a number of experienced staff members are due to return from maternity leave in Q2 2023, to both the Children in Care Pillar & the Fostering Resource Unit.

**Proposed timescale: Q2 2023**
**Person responsible: Area Manager**

2. The Principal Social Worker will continue to attend the interagency meetings with the HSE and continue to advocate for collaborative working and funding of these complex cases. As noted in the report, the requirement that the children and issues discussed at the local

interagency meeting need to be captured at the regional interagency meeting. The discussions and decisions at these meetings need to be progressive in their actions with clear outcomes for children. The Area ensures that all cases that require escalation are done so in a timely manner, as the Area is committed to advocating for children with disabilities and additional needs for interventions through the Interagency Forum with the HSE. The Principal Social Worker attending the interagency meetings will robustly review the minutes of these meetings to ensure the minutes accurately reflect the action and decision making regarding these cases. Such cases that are identified and deemed appropriate, are escalated accordingly to the Area Manager & Regional Chief Officer & CEO of the HSE in line with the Joint Protocol for further decision making

**Proposed timescale: Immediate & on-going**
**Person responsible: Area Manager**

3. The respective Principal of each pillar shall continue to conduct both quantitative and qualitative local audits to review a range of topics pertaining to practice. The audits will be peer reviewed, and the outcome of the audits shall be disseminated to the team for further analysis. The embedding of trackers to monitor the issues raised within the HIQA report will continue and will be reviewed quarterly by the Quality Assurance Officer. PASM are due to commence internal audits of practice in Children in Care in Q4 2022, which will provide external overview and validation of the quality of the recordings.

**Proposed timescale: Immediate**
**Person responsible: Area Manager**

4. The Principal for Children in Care has devised a tracker to capture any allegations made against private Foster Carers. Also, the CASP worker has commenced their role in early Q4 2022, where all allegations against Foster Carers will be assessed by the CASP worker.

**Proposed timescale: Immediate**
**Person responsible: Principal for Child Protection**

5. To ensure good governance of children placed outside of the Area the Principal Social Worker for Children in Care will review the supervision and care planning needs of the children on a quarterly basis, with the allocated Social Work Team Leader. This process will ensure that the children residing outside the area will receive adequate governance and oversight from the Department. Issues identified from the quarterly audit will be addressed directly with the private provider by the Principal Social Worker. The allocation of the new Social Care Leaders to the Children in Care pillar, may be able to provide additional visits to children residing outside the area, in line with their care planning needs

**Proposed timescale: Q1 2023**
**Person responsible: Area Manager**

6. The area acknowledges that the Children in Care pillar went through a significant period of change throughout 2021 & 2022. However, the pillar now has a dedicated permanently appointed Principal Social Worker, a third Social Work Team Leader and Social Care Leaders have also been assigned to the Children in Care Team, which will ensure good governance and oversight of the pillar. The Principal Social Worker of the Fostering Resource Unit & the Principal Social Worker in the Children in Care Pillar are monitoring and reviewing the

existing audit findings and trackers to ensure the structures embedded are effective in identifying actions required and ensuring these actions are completed.

The maternity back fill of the Social Work Team Leader for the Fostering Resource Unit has commenced her post since the HIQA inspection. This post will further support the Principal Social Worker regarding governance and oversight of the pillar and supporting the staff team. In creating an agenda of audits to be completed by PASM in 2023 Tusla Kerry has identified supervision within the Fostering Service. The current trackers noted in the report in both the Children in Care pillar & the Fostering Resource Unit will continue to be embedded and reviewed to ensure good quality of data collation and recording. The Quality Assurance Officer will facilitate a workshop with the Social Work Department, focusing on the principles of quality recording.

**Proposed timescale: Q1 2023**

**Person responsible: Senior Management Team & PASM**

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|---|---|
| **Timeline: Q2 2023** | **Person Responsible: Area Manager** |