Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Child Protection and Welfare Service

Name of service area:	Kerry
Name of provider:	Tusla
Type of inspection:	Focused CPNS
Date of inspection:	08 – 10 March 2022
Lead inspector:	Lorraine O' Reilly
Support inspector(s):	Olivia O' Connell Ruadhan Hogan Sabine Buschmann
Fieldwork ID	MON-0035603

About monitoring of child protection and welfare services

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

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

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

In order to promote quality and improve safety in the provision of child protection and welfare services, the Authority carries out inspections to:

- **assess** if the Child and Family Agency (the service provider) has all the elements in place to safeguard children and young people
- **seek assurances** from service providers that they are **safeguarding children** by reducing serious risks
- **provide** service providers with the **findings** of inspections so that service providers develop action plans to implement safety and quality improvements
- **inform** the public and **promote confidence** through the publication of the Authority's findings.

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

Theme 1: Child-centred Services	☐
Theme 2: Safe and Effective Services	☒
Theme 3: Leadership, Governance and Management	☒
Theme 4: Use of Resources	☐
Theme 5: Workforce	☐
Theme 6: Use of Information	☐

How we inspect

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

The key activities of this inspection involved:

- the analysis of data
- interview with the area manager
- interview with two principal social workers
- focus groups with three social work team leaders
- focus groups with eight social workers
- the review of local policies and procedures, minutes of various meetings, staff supervision files, audits and service plans
- remote observation of a child protection conference
- the review of ten children's case files
- phone conversations with eight parents
- phone conversations with two children.

The aim of the inspection was to assess compliance with national standards the service delivered to children who are subject to a child protection case conference and whose names are entered onto the CPNS.

Acknowledgements

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

Profile of the child protection and welfare service

The Child and Family Agency

Child and family services in Ireland are delivered by a single dedicated State agency called the Child and Family Agency (Tusla), which is overseen by the Department of Children, 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 manager known as a regional chief officer. The regional chief officers report to the national director of services and integration, who is a member of the executive management team.

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

Service area

Kerry is one of Tusla's Child and Family Agency's 17 areas and forms part of the South Region. The 2016 Census recorded a total population 147,707 in Kerry with a child population (0-17 years) of 34,527, representing 23.4% of the area's total population. The area was under the management of the interim regional chief officer for the Tusla South region, and was managed by the area manager who has responsibility for the senior management team. The senior management team consisted of:

- area manager
- 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 team and aftercare team
- manager - prevention, partnership and family support
- principal social worker - family centre and independent chair for the foster care committee
- principal social worker - child protection case conference chairperson.

Kerry child protection and welfare services was delivered through three social work teams based in two office sites located in Killarney and Tralee. One team was dedicated to duty and intake and two teams were dedicated to child protection and welfare. These teams reported to two principal social workers for child protection and welfare in the area. The child protection conferencing service was delivered by one principal social worker and one part-time administration staff was employed to assist them. There were 24 children listed on the CPNS at the time of the inspection and all children listed on the CPNS were allocated a social worker.

At the time of the inspection, there were two whole time equivalent social work vacancies, across the child protection and welfare service. No social work posts were being filled by agency staff.

Compliance classifications

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

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

This inspection was carried out during the following times:

Date	Times of inspection	Inspector	Role
08 March 2022	0930 – 1700	Lorraine O' Reilly Olivia O' Connell Ruadhan Hogan	Lead Inspector Inspector Inspector
09 March 2022	0900 – 1700	Lorraine O' Reilly Olivia O' Connell Ruadhan Hogan Sabine Buschmann	Lead Inspector Inspector Inspector Inspector (remote)
10 March 2022	0900 - 1700	Lorraine O' Reilly Sabine Buschmann	Lead Inspector Inspector (remote)

Views of people who use the service

Efforts were made by inspectors, in conjunction with the service area, to engage with children as part of this inspection. From what inspectors viewed, heard and observed, it was challenging for children to be involved in the child protection conference process. This was due to a number of reasons including the age of children and circumstances that children and families may have been experiencing at that point in time. As part of this inspection, inspectors spoke with two children and eight parents of children who were listed on the child protection notification system.

Children spoke positively about their social workers. Some of the things that children told inspectors were:

- "social workers getting involved was a good thing, they would always listen to me"
- social workers "keep asking me questions about keeping safe"
- "my social worker is nice"
- "when the team leader spoke to me, they understood me"
- "they came to the house and asked how I felt"
- "they asked me what I wanted to change"
- "I always look forward to seeing the social workers".

Children spoke briefly about safety plans and told inspectors they were aware of what they were. They told inspectors "I was told to ring my social worker or text my social worker" and also described other aspects of their safety plans for the inspector.

Children told inspectors about their safety networks and how people were aware of what was happening for them and their families. For example, "the teachers are great, they know what's going on" and they spoke about other supports such as a counsellor and extended family members.

Children told inspectors they were happy about what social workers had done for them. One child said "the whole situation is very sad" but acknowledged "I think Tusla did what they could". Another child told inspectors "things have changed for me, they are better now".

Parent's spoke with inspectors about their experiences of the service provided to them and their children in line with the focus of this inspection. The majority of parents spoke very positively about their social workers and the support they provided to them. They spoke about social workers visiting on a regular basis. Some parents provided very positive feedback also with regard to their family support

worker, with one parent stating "I am a better parent because of her". They also told inspectors:

- "the social worker was very helpful, she was brilliant"
- "I was listened to"
- "they are helpful"
- "social workers are a great help to us"
- "when they first became involved it was terrible, I was not in a good place" "reflecting on it now it was a good thing as they helped out"
- "I had a few different social workers… now one social worker for all children"
- "she was just brilliant and she did a lot for us"
- "at the beginning it was harsh but then they were really good and they did everything they said they would".

Parents described their experience of child protection conferences for inspectors. Parents spoke about social workers preparing them for meetings, informing them about who would be there and what would be discussed. They said "information was provided and we were told about our rights" and that the "team leader always made sure I could talk and I was listened to". They said that the process was explained to them. With regard to what impact the conference had for their family, one parent said "things are getting better".

Parents shared how the initial child protection conference was a difficult experience. The told inspectors:

- "the first instance was very rough but once children were on the register, it got better"
- "we were out-numbered"
- "kept head down and got on with it"
- "language used…all very strange…not the language I use"
- "did not have enough credit" on their mobile phone when the meeting was a teleconference
- "very worried about children being placed on the CPNS"
- they "found it very hard".

Parents told inspectors about their safety networks and about safety plans being developed. "Tusla did help to set up support network" and "safety was developed". They spoke about how the networks and supports helped them, "I found the first network meeting was so embarrassing" but "I am now much stronger". One parent stated "everyone is helping us" while another said while they were aware of the plan, they felt communication "could be better".

Parents talked with inspectors about the various supports which were put in place to support families and the positive impact they had on their children's lives. Activities and supports included outdoor pursuits, anger management and parenting classes.

Some parents' children had been delisted from the CPNS as they were no longer assessed as being at significant risk of ongoing harm. Parents said they were "delighted to be delisted", "that was great". One parent acknowledged that they would continue to work with the social worker and family support worker as there was "still a bit of work that needs to be done".

Parents told inspectors that they received written minutes from child protection conferences and copies of the safety plans which promoted the safety and welfare of their children.

Parents, children and professionals were provided with feedback forms after they attended a conference. This started in the area in January 2022. Inspectors reviewed five feedback forms completed by four parents and one professional. All of the feedback provided to date was positive about their experiences of child protection conferences in the area.

Capacity and capability

The Kerry service area child protection and welfare service provided a good quality, safe service to children identified as at ongoing risk of significant harm in the area. Children listed on the CPNS received a social work service which had effective leadership, governance and management arrangements. Governance arrangements were strong, clearly defined and provided assurance to senior managers that children on the CPNS were in receipt of a safe service. Organisational structures set out lines of authority and accountability and included local, regional and national levels of accountability, specific to individual roles and responsibilities. The area manager was assured about the quality of the service through well-established systems of oversight of the child protection conferencing service. These included senior management meetings, complex case forums, staff supervision and informal communication. Mechanisms had been established to review and assess the effectiveness and safety of the child protection and welfare service during the twelve months prior to this inspection. However, improvements were required in areas such as auditing and recording to ensure complete oversight of the quality of social work interventions.

The focus of this inspection was on children listed on the CPNS who were subject to a child protection safety plan and the aligned governance arrangements in place to ensure effective and timely service delivery to these children. As per *Children First* (2017), when concerns of ongoing risk of significant harm are identified during the assessment and intervention with children and families then Tusla is required to organise a Child Protection Conference (CPC). In circumstances where a child has been identified as being at ongoing risk of significant harm at a CPC, their name is listed on the Child Protection Notification System (CPNS). Children on the list were closely monitored by the social work department to ensure they were safe and interventions were provided to children and families to reduce risks to children. Children who have child protection safety plans continue to live at home, unless it emerges that a child is at ongoing risk, or if the child protection plan is deemed not to be working. These cases may result in a decision to remove the child from the home. This inspection also reviewed children files, whose names had recently been made inactive on the CPNS, in the twelve months prior to the inspection. These children had been assessed as no longer being at risk of significant harm.

The interim national guidelines on child protection case conferencing and the child protection notification system had not been subject to review since 2018. These guidelines required updating by the Child and Family Agency, as a means of assuring quality and consistent practice. The national guidelines were in the process of being reviewed by Tusla National Office at the time of this inspection. While this impacted on the consistency of the service nationally, the area had effective local policies and procedures in place to guide staff, to ensure a timely service and to keep children on the CPNS safe.

The service actively reviewed national policies and standards to determine how they would impact on the service provided to children and their families. They were reviewed in forums such as regular team meetings as well as departmental days. Inspectors reviewed team meeting minutes which were well attended. Issues such as timeframes around processes, safety planning, home visit templates were discussed with staff. This meant that all staff were informed of and familiar with changing practices and what was expected of them as allocated social workers.

Social workers and managers demonstrated their knowledge of legislation, policies and standards for the protection and welfare of children when talking with inspectors and it was also reflected in their practice. For example, the local policy about the frequency of visits to children listed on the CPNS stated that children were to be visited fortnightly for the first two months that they are listed and subsequently on a monthly basis at minimum. Social workers and their managers told inspectors about

this arrangement in interviews and the recording of the visits on children's records was reflective of this policy.

The service took appropriate actions based on recommendations made by regulatory bodies. For example, the service provided to children listed on the CPNS had improved greatly since a previous inspection in January 2021. There was greater managerial oversight of social work practice as well as social workers visiting children listed on the CPNS in line with their local policy. This showed the area's commitment to improve the standard of the social work service provided to children and their families.

There were appropriate resources in place to ensure the care and protection of children listed on the CPNS. All children listed on the CPNS had an allocated social worker and were visited in line with local policy. Social work team leaders reviewed caseloads on a monthly basis to ensure cases were allocated appropriately depending on social worker's capacity.

Managers demonstrated good leadership and a commitment to continuous improvement. This was evident through interviews with staff as well as through actions taken by management to improve the service. They spoke about how the previous twelve months had been focussed on the restructuring of the service to have distinct pillars within the child protection and welfare service. For example, there were dedicated teams assigned to duty and intake work and child protection and welfare work. All staff spoke about the positive impact this had on the service and at the time of the inspection, they described things as being quite 'settled'.

Following on from putting these structures in place, managers committed to developing local policies in line with national policy as well as service improvement plans. The area developed service improvement plans for each pillar of the service from recommendations of various internal and external audits throughout 2021 as well as from the service's compliance plans arising from inspections and this was clearly recorded in the plans. Senior managers involved social workers in developing these plans and this was something social workers appreciated and valued as their views were taken into consideration. Inspectors reviewed these documents and found that all the team members of the child protection and welfare service had signed their improvement plan, demonstrating joint ownership and shared governance regarding the actions agreed. Managers told inspectors the service improvement plans would be reviewed after six months.

The child protection and welfare service improvement plan had specific actions noted with regard to cases listed on the CPNS. For example, it noted that during the first home visit after a child is listed on the CPNS, the CPC safety plan should be discussed with parents with a copy being provided to them. It noted that the social worker would then record who was present and the details of the discussion and safety plan on the child's file. Inspectors saw these case notes when reviewing children's files, noting that social workers were implementing what had been agreed in the service improvement plan.

There were strategic and operational plans which were aimed at delivering a good quality service. These plans took account of how to meet the needs of children and their families while also considering resources available such as external agencies, working in line with policies and standards and considering all information relevant to the provision of a safe service.

The area had a comprehensive standard operating procedure which clearly outlined the procedures and practices for child protection conferences. It detailed the required actions from the point of discussing in supervision the need to request a child protection conference through to removing a child's name from the CPNS. Each task was assigned a person responsible, and a timeframe for completing the task. For example, a social worker is responsible for providing the chairperson with their social work report five working days in advance of the CPC to provide the chairperson with the time to prepare for the conference and to circulate the report to the other professionals involved with the family. Another process was that the chairperson would send a reminder about a review CPC to both the social worker and social work team leader one month in advance of the review CPC. Although the procedure did not state the timeframe as to when the initial CPC should occur, the practice in the area was to hold initial CPC's within 15 days and this was noted as an area of good practice in the service improvement plan.

The national office had devised a number of templates for the CPC service and CPNS. It was planned that they would be incorporated into social work practice as this year progressed. The CPC chairperson noted in their service improvement plan that this would commence with the invitations to the conferences and with the social work report. The chairperson had planned to meet with other senior managers to review the templates and to consider the most appropriate way to introduce the changes to practice and then attend team meetings to embed new practices and answer any queries social workers had.

There was effective oversight of the management of child protection case conferences for children on the CPNS. The area manager delegated conferencing duties to one

principal social worker who was the independent child protection chairperson and their part-time administration staff. The area manager delegated oversight of the day-to-day implementation of child protection safety plans and monitoring of children listed on the CPNS to one principal social worker and their two respective social work teams. The CPC chairperson ensured the timely scheduling of conferences through effectively planning schedules in advance. For example, in January 2022 the CPC chairperson and their administration staff planned out the conferences until May 2022. This meant that children received a timely, responsive service to discuss their safety and plan actions as required.

The area had developed good practice for consulting with the CPC chairperson as early as possible about children who may require an initial CPC and if they had identified particularly vulnerable families. For example, the service had identified the additional vulnerability of unborn and new-born babies and had taken proactive measures to ensure their safety as much as possible. The area had established monthly meetings between senior social work managers and the management team of the maternity services. This meant that if there were any concerns arising from either service, these were discussed as early as possible to plan working with the parents of unborn children where there may be concerns for their baby's safety and well-being. This in turn meant that social workers could request an initial CPC as soon as possible to explore supports for the family before the baby was born. The service had also dedicated one social worker to work specifically with families of unborn babies.

Whilst social workers had developed good practice in consulting with the CPC chairperson as required, this was undertaken in an informal manner and was not formally recorded by the CPC chairperson. This meant that the service may not be accurately capturing the level of work undertaken by the CPC chairperson in this informal way. This would lead to further quality improvement of their process rather than being indicative of any risk within the service or regarding children and their families.

The service had monitoring systems in place which reported on the compliance of the service with national standards and legislation. There were several monitoring mechanisms in place such as trackers, audits, supervision, a complex case forum, as well as various management meetings.

The principal social workers had good systems in place to identify and mitigate potential risks to the safety and welfare of children listed on the CPNS. This was evident through monthly principal social worker audits and trackers as well as social work team leader audits of children's records. Principal social workers told inspectors

that over the previous year gaps had been identified in visits to children and that the measures now in place were to mitigate against that risk. Information contained in the tracker also noted when the home visit template was used and when it was put on children's records. This meant that the principal social worker was assured about home visits occurring as required and that children's records were kept up to date.

Social work team leaders also completed audits on a monthly basis with cases being selected randomly, including children listed on the CPNS. While this was working effectively to ensure children were visited and various documents were completed, there was little focus on the quality of the work recorded on children's records.

Improvements were required at managerial level to capture the quality of the work undertaken with children and their families. While both the tracker and the audits ensured that required actions occurred, they did not check for the quality of the actions undertaken. For example, the tracker noted when the visit occurred but what happened during the visit was not looked at. Similarly, with the monthly audits, dates of various documents such as the safety plan and the home visit template were recorded, yet the quality aspect was missing from the audit template. Also, social work team leaders were auditing cases for which they had oversight, rather than the audits being undertaken by a manager independent of the case. Managers were aware of this issue and told inspectors about their plans to focus more on the quality aspect of their work throughout 2022 given that trackers and audits had only been established in the previous twelve months.

There was effective oversight of children on the CPNS through regular reporting at senior management meetings. Each principal social worker provided a pillar report to the senior management team. The area manager convened monthly senior management meetings in order to communicate and manage issues relevant to all teams across the service. Inspectors reviewed minutes of meetings and found standing agenda items associated to quality and risk management as well as the reporting of social work activity. This provided the area manager with assurances about social work practice relating to children listed on the CPNS and the number of child protection case conferences occurring on a monthly basis. This was an effective mechanism to ensure managers could identify areas for improvement, manage any risks and to have the knowledge about the work being undertaken and ensuring that staff were carrying out their roles in line with policies and procedures.

The area also had a principal social worker forum which focussed on the development of the service provided and the development of their respective teams to ensure an ongoing high quality service. The forum facilitated discussion regarding any issues

arising, sharing of learning/knowledge and dissemination of tasks for completion to ensure appropriate policies and procedures were in place to support practice. The forum also proposed actions for the area manager, reviewed documents and consolidated responses for the area manager when required.

Complex case forums were used in the area to facilitate objective review of cases listed on the CPNS and to provide scrutiny of the effectiveness of child protection safety planning. Cases were referred into the forum for discussion by social workers and their team leaders where there were challenges and complexities which required objective review. Managers and social workers who spoke to inspectors said that these meetings were a strong mechanism for assurance and accountability in relation to practice and service delivery and children on the CPNS were discussed as required. They provided case examples to inspectors in terms of what was discussed and what actions arose from the meetings. Actions were agreed to ensure that appropriate measures were in place in response to risks posed to the children on the CPNS in order to reduce the risk of harm and prevent drift in these cases.

The level of supervision embedded throughout the service both at frontline and management levels ensured a good quality service to children listed on the CPNS. Supervision between social workers and social work team leaders as well as between social work team leaders and principal social workers, occurred in line with policy. However, the discussion on cases was not always clearly recorded. The quality of the recording of supervision was inconsistent across teams which meant the level of detail on the discussions on children's files varied. Inspectors reviewed case supervision notes on children's records which were not always clear in terms of what had been discussed and if previously agreed actions had been completed. While the quality of the recording required improvement, social workers and managers told inspectors that children listed on the CPNS were discussed at every supervision session which meant that there was no significant risk posed to children listed on the CPNS.

There was a risk register which was reviewed regularly and quarterly risk and service improvement reports were completed. There was a process in place to escalate individual risks within the service through 'Need to Know's which were reported to the area manager and regional chief officer as required. There were staff vacancies in the area, however, the area mitigated against this risk for children on the CPNS by ensuring that all children listed on the CPNS had an allocated social worker. This ensured that children assessed as being at ongoing risk of significant harm received an appropriate level of social work support to promote children's safety through adequate service provision.

The restrictions associated with COVID-19 had a significant impact on the delivery of the service in the area but these were managed well. Social workers engaged with children and families in alternative ways and there was an Interim Child Protection Conference Guidance which set out measures to mitigate against challenges in the facilitation of conferencing due to COVID-19. The area had access to technology to facilitate teleconferencing. At the time of the inspection, "hybrid" conferences were occurring. These facilitated the chairperson, administration staff, social worker, social work team leader and the parents to meet in the same room with other professionals then joining the conference by phone. Staff acknowledged that this was also challenging at times given everyone could not be in the same room for discussions. The quality of the calls also brought difficulties. Staff and managers were hopeful that having everyone in the same room would return when possible to do so.

An inspector remotely observed a review CPC through teleconferencing and heard discussions about what people were concerned about as well as what was working well for the family. Risks were openly discussed and an appropriate plan was put in place to maintain the child's safety. The chairperson clearly described the reasons for decisions made and provided everyone with the opportunity to contribute to the discussion.

Managers responded appropriately and promptly to appeals of decisions of child protection conferences. Inspectors were told that there were no complaints relating to the scope of this inspection and there were four appeals of decisions made at CPC's in the twelve months prior to the inspection. Inspectors reviewed two appeals of decisions made at CPC's which were appropriately responded to.

Effective arrangements were in place to manage and learn from adverse events, complaints and serious concerns to ensure they were appropriately managed, actioned and to learn from what had occurred. Discussions and the sharing of information with staff was documented in team meeting minutes, workshops, departmental days and in practice notes. Information shared included revised standard business processes, changes to social work practices arising from complaints and information about the employee assistance program.

Staff had mixed views about the sharing of learning arising from some things and some staff told inspectors that this could be improved upon. For example, they told inspectors it would be useful to receive further information and updates from senior management about any escalations such as 'Need to Know's or rapid reviews.

The service area reported on the effectiveness and safety of the service at a national level on a regular basis. This information was available to the public on the Tusla website and inspectors reviewed this information when preparing for this inspection.

Information reported on a monthly basis included information such as how many children were listed as active on the CPNS and if those children had an allocated social worker.

Standard 3.1

The service performs its functions in accordance with relevant legislation, regulations, national policies and standards to protect children and promote their welfare.

Staff demonstrated their knowledge of legislation and policies relevant to their roles and this was reflected in practice. The area had taken learnings from previous inspections and from local and national audits. The area took into consideration how policies impact on practice and had local standard operating procedures in place to address gaps in the national policy. Tusla National Office were reviewing national guidelines at the time of the inspection.

Judgment: Substantially compliant

Standard 3.2

Children receive a child protection and welfare service, which has effective leadership, governance and management arrangements with clear lines of accountability.

Overall, the service had effective leadership, governance and management arrangements. The quality of the recording of case supervision on children's records to reflect what was discussed required improvement and more consistency across social work teams.

Judgment: Substantially compliant

Standard 3.3

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

There were effective systems in place for review and assessment of risks associated with the delivery of a child protection conferencing and child protection notification system. Risks were appropriately notified to the regional and national office as required. Auditing on children's records required improvement as they were completed by the social work team leader who had case oversight. Not all audits identified required actions as there was no qualitative analysis or scrutiny of the work completed. In this respect, there is scope for further service improvement.

Judgment: Substantially compliant

Quality and safety

The service area demonstrated a strong commitment to providing a good quality service to children listed on the CPNS. Effective actions were taken to ensure children's safety when they had been assessed at being at ongoing risk of significant harm. Children received a responsive service in a timely way which prioritised their safety and this meant that children and their families received support when they required it most. There was good communication between social workers and the child protection chairperson which allowed for good planning to meet children's needs. It was evident that safety planning was active from the initial stages of the child's involvement with the service with initial and interim safety plans in place. Child protection safety plans were of good quality and were reviewed as required. Children were appropriately made inactive when they were no longer at significant risk of ongoing harm and continued to remain open with the service for ongoing safety planning where required.

There was good oversight in relation to the thresholds for the requirement of a child protection case conference. Immediate and interim safety plans were put in place prior to the child protection conference when required. When an initial safety plan was not working, a CPC was convened. Conferences were chaired by independent professional who had no direct involvement in the assessment or management of the case. Social workers and their managers told inspectors that when they determine that an initial CPC may be required, they had an informal consultation with the CPC chairperson to discuss the case and obtain the chairperson's views on meeting the threshold for a CPC. Inspectors found that there were good levels of consultation between the chairperson, social work staff and managers and cases reviewed by inspectors were appropriately referred for CPC.

The service held timely initial child protection conferences for children who had been assessed by social workers as being at ongoing risk of significant harm. The service had a local child protection conference policy in place. Although the policy did not state the timeframe for when an initial CPC should occur, inspectors found that for the majority of children whose files were reviewed initial CPC's were timely.

Inspectors reviewed six children's records for the timeliness of the initial child protection conference. All requests for initial CPC's were approved within one week. Inspectors found that five children had their initial child protection conference held within three weeks of a request for an initial CPC being approved. The sixth child had

their initial CPC held within six weeks and this was delayed due to circumstances outside of the service's control. This family received an appropriate social work service in the weeks prior to the CPC and therefore this delay did not have a negative impact on the child's safety. Social workers and managers told inspectors that reasons for delays included lack of availability of parents, members of the network or specific professionals involved with the family. This meant that all children had their safety needs assessed in the most suitable way to their circumstances and child protection conferences happened in the most-timely manner to meet their individual needs.

Urgent initial child protection conferences occurred when required. For example, when a family was due a baby, a pre-birth conference would occur before the child was born. This meant that the baby's safety and their needs were prioritised and it allowed social workers to ensure families were provided with the relevant support services. Social workers and their managers told inspectors that these worked very well to ensure the baby's needs would be met when they were born and staff were also very mindful of supporting families as soon as possible rather than waiting for when the baby was born and parents were adapting to massive change in their lives.

When initial CPC requests were declined, the reasons were clearly explained to social workers. Inspectors reviewed one file where the initial child protection request was declined as the chairperson recommended that further assessment of new information should be undertaken before holding a CPC. The rationale was clearly recorded on the child's file and when further assessment was completed, a CPC occurred.

Children and their families were invited to attend child protection conferences. Inspectors reviewed six children's files to see if parents and children attended conferences. Five of the six children's records noted parents had attended initial child protection conferences and all parents attended review child protection case conferences. Only one child was old enough to attend their conference but declined to do so. The social worker met with the child prior to the conference to obtain their views using child-friendly tools. It was also noted that the social worker met with the child after the CPC to explain what had happened as well as talking through the safety plan with the child. Inspectors found that five of the six children were too young to attend their conferences or express their views. However, the social worker's description, observations and assessment of children's needs were clearly recorded on children's files.

Child protection safety plans were based on initial and ongoing assessments, as well as other relevant specialist assessments. Inspectors found that initial assessments were comprehensive and clearly outlined the concerns for children. This meant that

decisions were made in a timely manner about whether children were at risk of ongoing significant harm and required a child protection safety plan.

Inspectors reviewed six children's records for the quality of the child protection safety plans. They found that child protection safety plans were of good quality, comprehensive and were adapted to meet the changing needs and situations of families. Child protection safety plans clearly identified children's more immediate needs as well as long term needs. Child protection safety plans stated what actions were required to be taken and who was responsible for these actions. Monitoring arrangements were clear such as the frequency of social work visits and when the review child protection case conference would occur.

There were safety networks identified to support children and families and child protection safety planning meetings were used to monitor the implementation of child protection safety plans. Initial network meetings occurred with the parents, social worker and social work team leader to discuss who may form a network around the family. Some safety networks included extended family as well as a professional network. Inspectors found that the recording and frequency of network meetings were of good quality.

Safety plans were reviewed and revised with children, their parents and their network when required. This occurred with families between child protection case conferences as well as being formally reviewed at them. Inspectors found that risks were re-assessed to determine if safety had improved with actions taken by the parents and networks. The principal social worker told inspectors they had discussed with the CPC chairperson that getting parties to sign the plans was proving very time consuming and came to the agreement they would dispense with obtaining signatures. When this was queried by inspectors, the principal social worker said they were assured by this practice and that social workers were required to record the details of the discussions with families about their safety plan.

Safety planning templates were used for all home visits. This meant that children's records were clear and consistent about the purpose of the visit, any identified actions and what had been agreed with families. The use of the template was tracked by the principal social worker and the social work team leader.

The CPNS was updated and managed in line with Children First. The CPC administration staff updated the CPNS immediately following a decision to list a child or to change their status to inactive. Children's names were placed on the CPNS system where there were unresolved child protection issues. Inspectors reviewed the

CPNS with administration staff during the inspection and found that children had their status changed from active to inactive on the day the decision was made and it had been agreed that they were no longer at risk of ongoing significant harm. Any other changes required to the CPNS were completed by national office such as children being removed when they reach 18 years old.

Review child protection conferences were held in a timely manner. Inspectors saw this on children's records and were told by staff that CPC reviews were scheduled at the initial CPC which greatly assisted in ensuring they occurred within six months of the previous CPC. This meant that families, their support network and professionals working with the family had plenty of notice about when the next conference would occur. Inspectors reviewed four children's records to determine the timeliness of review CPC's. Three were held as planned with two occurring after six months and one review after three months as it was assessed that it was required to review the child's safety. One review was appropriately delayed given family circumstances and the rationale was clearly recorded on file. Three of the four review records were of good quality. Inspectors found that the fourth record did not record how actions from the initial CPC had progressed and had not captured the views of the parents and child.

When children were no longer assessed as being at significant risk of harm, their status changed from active to inactive on the CPNS. Inspectors reviewed five inactive cases on the CPNS. Inspectors found that families were appropriately informed when children were no longer active on the CPNS and the reasons why this had been decided. The decision and rationale to make children inactive was also formally recorded on the child protection case conference record. Managerial oversight was clearly recorded and the decisions being made were child-centred and based on what had been achieved to increase the level of safety for children.

There was good multi-agency consultation between social workers and a vast range of services involved with children listed on the CPNS. The service clearly supported and promoted interagency and inter-professional cooperation and input to ensure children's safety needs were met. The service had policies and procedures in place to support information sharing with external agencies such as mental health services and An Garda Síochána. Senior managers also met with managers from other services such as hospitals and domestic violence support services on a monthly basis.
The area identified the need to increase external professional's awareness about the purpose and function of child protection case conferences. Social workers and managers spoke to inspectors about the need to provide external agencies with more information about what would be required of them when they attend a conference,

particularly if professionals had never been to a conference. Since identifying the need to enhance awareness about child protection case conferences and the national approach to practice, the service had taken action to address this issue. The CPC chairperson had commenced this work having met with a number of services and there were plans to meet with more services in the future.

Principal social workers told inspectors that there were plans in place to undertake interagency training with other services. This had occurred prior to COVID-19 restrictions and social work managers spoke about interagency recommencing the month of the inspection. Inspectors found that there was a commitment by social workers and their managers to further enhance relationships with external agencies and they recognised this was very much required for their national approach to practice to be fully effective in protecting children within their communities. They told inspectors there was a need to really highlight the "shared responsibility" among all professionals involved with the family in keeping children safe.

Effective working relationships were noted, information was shared as required through meetings, letters and phone calls on a regular basis. Good quality information was gathered by social workers from professionals in preparing for meetings with children and their families. This was evident through talking with social workers and social work managers. Inspectors reviewed six children's records for interagency collaboration and found strong evidence of this in all six records. Social workers actively sought information and updates from support services working with families such as addiction services, public health nurses, mental health services, youth support services, family support workers and child care workers. This meant that social workers had a greater understanding of what services were doing to support families and could assess how this impacted on the safety of children.

The service ensured there was a regular and timely reviews of the progress of interventions with families. This occurred through social workers maintaining regular contact with professionals, through network meetings and at child protection case conference reviews. At child protection case conferences, discussions occurred as to what would be offered by each service and what the expectation would be. These plans were reviewed at subsequent conferences. The national approach to practice which was embedded in the area lent itself to discussing what was working well for families and what needed to improve to ensure children's safety.

Standard 2.6
Children who are at risk of harm or neglect have child protection plans in place to protect and promote their welfare.

Overall, initial CPC's were timely. Safety planning was in place while waiting for the initial CPC to occur which meant that children were protected from harm. Children and families were encouraged and facilitated to attend and participate in CPC's. There was multi-disciplinary input. Comprehensive recording of minutes as well as an inspector remotely attending a CPC showed that discussions were robust and allowed parents to respond to concerns raised.

Child protection safety plans were of good quality with actions listed and discussed at network meetings. Children were visited regularly and network meetings were held to monitor and progress actions in safety planning. Social workers proactively implemented safety planning which was in place for all cases reviewed by inspectors. Safety plans were regularly reviewed and updated depending on safety requirements.

Judgment: Compliant

Standard 2.7
Children's protection plans and interventions are reviewed in line with requirements in Children First.

Review CPC's were held within required timeframes. One review was delayed for a justifiable reason which was clearly recorded on the child's file. There were clear and detailed decisions recorded in the review of the child protection plan and there was good evidence of safeguarding visits to monitor the child protection plan. Safety plans were updated in a timely manner and were effective in ensuring children's safety. Children were appropriately made inactive on the CPNS when they were no longer assessed as being at risk of ongoing significant harm.

Judgment: Compliant

Standard 2.9 Interagency and inter-professional cooperation supports and promotes the protection and welfare of children.
The service promoted positive and cooperative relationships with other agencies to ensure effective case management and to improve outcomes for children and their families. There was a gap identified by social workers and managers about the knowledge held by other agencies with regard to case conferences. Further child protection and welfare training was required on an interagency basis to ensure child protection case conferences were as effective as possible.
Judgment: Substantially compliant

Compliance Plan for Kerry Child Protection and Welfare Service OSV – 0004374

Inspection ID: MON-0035603

Date of inspection: 08 – 10 March 2022

Introduction and instruction

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

This document is divided into two sections:

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

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

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider has generally met the requirements of the standard but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

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

Section 1

The provider is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Standard Heading	Judgment
Standard 3.1	Substantially Compliant

Outline how you are going to come into compliance with Standard 3.1: The service performs its functions in accordance with relevant legislation, regulations, national policies and standards to protect children and promote their welfare.

- At time of writing this compliance plan a date had not been confirmed by the Executive Management Team of Tusla regarding the launch of the National Policy on Child Protection Conferences & the Child Protection Notification System. It has been indicated by the Executive Management Team of Tusla, that the proposed implementation of this policy will be by year end 2022. Following the launch, the Child Protection Conference Chairperson will be responsible for fully implementing the policy into practice in Tusla Kerry.
  Timeframe: At the latest Q4 2022

- Following the launch of the National Policy on Child Protection Conferences & the Child Protection Notification System the Chairperson will give a presentation on the Policy as part of the next Departmental Meeting, thus ensuring all staff are informed of the new Policy and the changes in practice that may occur as a result.
  Timeframe: the next scheduled Departmental Meeting following the launch of the new Policy.

Standard 3.2	Substantially Compliant

Outline how you are going to come into compliance with Standard 3.2: Children receive a child protection and welfare service, which has effective leadership, governance and management arrangements with clear lines of accountability.

- The Area Manager has requested the National Practice Assurance and Service Monitoring (PASM) Team to undertaken an Audit in respect of Supervision practice in Tusla Kerry.
  Timeframe: 31st September 2022.

- The Audit findings from the PASM audit will be reviewed & a plan will be devised to

address any issues identified in the audit findings.
Timeframe: 31st December 2022.

- The Principal Social Work Group, in collaboration with the Social Work Team Leaders will review the current Supervision Record Proforma and will amend the template to enhance the quality of the information recorded in supervision. Regarding implementation, the newly created Supervision Record Proforma will be introduced across all pillars and will be presented at the Autumn Departmental Meeting
Timeframe: 31st September 2022.

Standard 3.3	Substantially Compliant

Outline how you are going to come into compliance with Standard 2.6: Children's protection plans and interventions are reviewed in line with requirements in Children First.

- Peer auditing will be introduced across the Child Protection & Welfare pillar. Social Work Team Leaders will audit cases for whom they have no direct supervisory or governance responsibility, on a monthly basis.
Timeframe: 31st September 2022.

- The Principal Social Worker Group will ensure audit findings are reviewed on a monthly basis at the Principal Social Worker Meeting and actions identified will be assigned & at the meeting.
Timeframe: 31st September 2022.

- The Principal Social Work Group together with the relevant Social Work Team Leaders will consult with the Signs of Safety Training & Development Officer, to ascertain her professional opinion with regard to evidencing a quality recording of a home visit- through the lens of the Signs of Safety framework.
Timeframe: 31st September 2022.

- The Principal Social Work Group together with the relevant Social Work Team Leaders will develop guidance to improve the quality of the recording of home visits to children listed to the Child Protection Notification system. On completion, the new guidance will be introduced across the Social Work Teams via team meetings followed by the issuing of a Practice Guidance to all staff.
Timeframe: 31st September 2022.

- The current Auditing Tool Proforma will be updated to capture the newly created guidance on quality recording and to monitor implementation of same.
Timeframe: 31st September 2022

- The Child Protection & Welfare Principal Social Worker will amend the monthly Child Protection Notification System tracker, to monitor the implementation of the new practice guidance. End Q3 2022.

- The Child Protection & Welfare Principal Social Worker will undertake an audit of the

quality of the home visits to children, listed on the Child Protection Notification System.
Timeframe: 31st December 2022

Standard 2.9	Substantially Compliant

Outline how you are going to come into compliance with Standard 2.9: Interagency and inter-professional cooperation supports and promotes the protection and welfare of children.

- The Child Protection Conference Chairperson has commenced inter-agency meetings with external stakeholders regarding:
  - The Child Protection Conference process
  - The importance of external professionals attending the Conference
  - The importance of invited Professionals providing a Report in advance of the Conference.

  Timeline: ongoing throughout 2022.
- The Child Protection Conference Chairperson will issue the Tusla Interim National Guidance leaflet, in addition to the Signs of Safety Report template, with every invitation to attend a Child Protection Conference. This will encourage external professionals' attendance and participation at each Child Protection Conference.
  Timeline: To commence immediately, 1st May 2022
- With the reduction in Covid related Risk, the Child Protection Chairperson has reverted to inviting all professionals to attend in person at the Conference to promote more effective inter-agency workings.
  Timeline: ongoing throughout 2022.
- Tusla Kerry's Child Protection Chairperson will arrange Briefings to relevant agencies, following the launch of the National Policy on Child Protection Conferences & the Child Protection Notification System.
  Timeframe: Briefings will occur following the launch of the new policy.

Section 2:

Standards to be complied with

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

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

Standard	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Standard 3.1	The service performs its functions in accordance with relevant legislation, regulations, national policies and standards to protect children and promote their welfare.	Substantially Compliant	Yellow	Completion by Q4 2022 (awaiting confirmation from Executive Management Team)
Standard 3.2	Children receive a child protection and welfare service, which has effective leadership, governance and management arrangements with clear lines of accountability.	Substantially Compliant	Yellow	31st December 2022
Standard 3.3	Children's protection plans and interventions are reviewed in line with requirements in Children First.	Substantially Compliant	Yellow	31st December 2022

Standard 2.9	Interagency and inter-professional cooperation supports and promotes the protection and welfare of children.	Substantially Compliant	Yellow	31st December 2022