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:	Dublin South Central
Name of provider:	Tusla
Type of inspection:	Focused CPNS
Date of inspection:	8th – 10th August 2022
Lead inspector:	Sue Talbot
Support inspector(s):	Erin Byrne Mary Lillis Hazel Hanrahan Niamh Greevy
Fieldwork ID	MON-0037270

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 and Youth Affairs 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	**x**
Theme 3: Leadership, Governance and Management	**x**
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, and with two principal social workers and child protection chairpersons
- focus groups with four social work team leaders
- focus group with four social workers and two social care leaders
- the review of local policies and procedures, minutes of various meetings, staff supervision files, audits and service plans
- observation of a child protection conference
- the review of 24 children's case files
- phone conversations with five parents/wider family members
- phone conversation with one child.

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 senior manager known as a regional chief officer. The regional chief officers report to the national director of services and integration, who is a member of Tusla's executive management team. Child protection and welfare services are inspected by HIQA in each of the 17 service areas.

Service area

The Dublin South Central service area has a population of 305,278 people[1] including 65,562 children 0-17 years of age. Children represent 21.5% of the area's population. The population is ethnically diverse and includes representation of Other White (11.8%), Asian/Asian Irish (4.3%), Black/Black Irish (2.5%) and White Irish Traveller backgrounds (0.6%). A total of 8,119 people live in areas of high social and economic deprivation; 2,457 of whom were children.

The service area is under the management of the regional chief officer for the Dublin Mid-Leinster region and is managed by an area manager. At the time of this inspection, the principal social worker posts for child protection and welfare (CPW) and the intake teams were vacant, but appointments had been made. These senior management posts each had oversight of four locality teams. Further restructuring was taking place to provide for five intake and five CPW teams to help strengthen capacity to deal with high levels of demand and reduce waiting times for assessment. The service area also had a principal social worker and team leader post

[1] 2016 Census data

who were responsible for chairing child protection conferences. All children listed on the CPNS had an allocated social worker.

At the time of this inspection, 66 children were listed on the Child Protection Notification System (CPNS). Of these, 35 were listed for neglect, 21 for emotional abuse, seven for physical abuse and three for sexual abuse. A total of 26 children had their names removed from the CPNS since December 2021. Ten were de-listed due to their admission to care. Seven children on the CPNS had been previously listed.

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
02/08/2022	11.30-13.00	Mary Lillis	Remote inspector
03/08/2022	12.00-15.00	Mary Lillis	Remote inspector
04/08/2022	10.30-17.50	Mary Lillis	Remote inspector
05/08/2022	09.00-17.00	Mary Lillis	Remote inspector
08/08/2022	09.00-17.00 09.00-17.00 12.00-17.00	Sue Talbot Erin Byrne Niamh Greevy	Inspector Inspector Inspector
09/08/2022	09.00-17.00 09.00-17.00 09.00-17.00	Sue Talbot Erin Byrne Hazel Hanrahan	Inspector Inspector Inspector
10/08/2022	09.00-16.00 09.00-16.00 09.00-16.00	Sue Talbot Erin Byrne Hazel Hanrahan	Inspector Inspector Inspector
17/08/2022	10.00-11.30	Sue Talbot	Inspector
18/08/2022	15.00-16.30	Sue Talbot	Inspector

Views of people who use the service

Inspectors spoke to one child, four parents and a close family member about their experience of child protection services in the Dublin South Central Tusla service area. Most feedback was very positive and focused on the quality of relationships they had with their social workers and how much they valued the help they had been given. They said they saw their social worker regularly and were kept informed about everything.

A child said:

- *'I like my social worker. We just talk. She is nice. My Mum has her phone number'.*

Parents said their social worker was easy to contact, that they understood what was going on at home and the problems they faced. They had received additional help for themselves and their children. They felt they had been given all the information they needed, including minutes of child protection meetings and safety plans. This helped them know what they needed to do to take better care of their children.

Comments from parents included:

- *'My new social worker and her boss are great- they go above and beyond for me'.*
- *'I don't feel panicked when I see my social worker, I feel very comfortable around her'.*
- *'Tusla had a big impact in helping to make changes for me and my family. I feel the kids are happy now'.*
- *'The family support worker is amazing'.*

An area for improvement highlighted by parents related to changes of social worker:

- *'We have had a lot of different social workers over the past year'.*

Parents also said they had been well-prepared for and supported at meetings:

- *'The social worker prepared me well for the child protection conference- they went through the form with me before the meeting to make sure I understood what would be said. It was not a shock, they made me feel really comfortable- really lovely people'.*
- *'Everyone is there to help us. No blame'.*
- *'Everyone got a say. I had my counsellor speak for me'.*
- *'I felt listened to- 100%'.*

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

Capacity and capability

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

Overall, inspectors found that the Dublin South Central service area's arrangements for protecting children at ongoing risk of significant harm were clear and effective. Service delivery was in line with relevant legislation, regulations, national policies and best practice standards. The service area had good leadership and management systems that prioritised the safety of children on the CPNS. Its governance and workforce development arrangements were comprehensive and regularly evaluated. Service managers actively encouraged a culture of learning, continuous improvement and innovative practice. Risk, at an individual or systems level, was appropriately identified and managed. All children on the CPNS had an allocated social worker. Staff at all levels recognised their accountabilities for engaging families, promoting child-centred practice and joint working with partner agencies. However, supervision of frontline practitioners required strengthening to ensure the standards set out in Tusla's policy and guidelines for supervision and case recording were consistently met.

The service area had a clear strategic direction which was underpinned by service and team plans that sought to continuously strengthen the capacity and quality of local services. The service area had ambitious plans to expand and make best use of the skill mix and experience of its frontline teams. Wider plans to provide better access to services for local children, their families and communities included commissioning other agencies with relevant expertise and capabilities to strengthen its capacity to do preventative work with families. Service plans for 2022 gave priority to safeguarding children exposed to high levels of domestic violence. Improvements to practice included commissioning additional forensic assessment expertise for the assessment and management of high risk offenders. All plans had a strong focus on the safety and welfare of children.

The service area was open to and had taken learning from other areas and jurisdictions. Senior managers sought to learn from complaints, adverse events and from HIQA inspections, and ensured effective review of progress in driving improvements. Inspectors found a culture of good communication and supportive team working between the intake and child protection teams and the child protection conference (CPC) team. The CPC team comprised a principal social worker, a team leader and two business support officers who were responsible for conference planning, maintaining the conference tracker and the timely production of correspondence including minutes from meetings.

At the time of the inspection, there were changes taking place to the membership of the senior management team. The area manager had been appointed to a new role, and two new principal social workers for intake and child protection and welfare had been appointed to fill vacancies. Other frontline posts in the intake and child protection and welfare teams were being appointed in order to establish additional teams and fill vacancies. The area manager together with experienced team leaders had provided additional cover and support for frontline practitioners. These interim arrangements overall had worked well, with additional support provided by the regional chief officer's management team. Frontline staff told inspectors they felt well-supported by their managers.

The regional chief officer, risk and HR leads provided good support to help the service area address historical gaps in its capacity, and to assist with its restructuring plans. Governance and management meetings at regional and service area levels ensured regular monitoring of organisational risks, with ongoing review of performance data, complaints and workforce capacity. Child protection chairpersons played an active role in wider Dublin Mid-Leinster and national working groups to share learning and promote consistency in implementation. Joint working with other services areas recognised the transitional nature of some families moving between service areas and shared accountabilities for keeping children safe.

The service area had reviewed and updated its standard operating procedures in line with Tusla's new National Guidelines for Child Protection Conferences and the Child Protection Notification System. Managers were working to strengthen the timeframes for referral and approval of child protection conferences. The service area monitored its performance and highlighted an improved trend from 40% achieving timeliness targets in April, to 100% in June and July 2022. The cause of delays was captured within a management tracker held by the child protection conference co-ordinator. These were largely due to the need to include key professionals or agencies and the availability of parents. However, the reason for delays or re-scheduling CPCs was not always sufficiently clear on children's records.

Service managers ensured social work practice adhered to Tusla's national safeguarding approach and promoted a strong focus on learning from research. Practice developments reflected the range and diversity of child protection issues within the service area. For example, the impact of neglect on children with complex health needs or disabilities was clearly recognised, with effective joint monitoring and review of risks. The involvement and expertise of hospital consultants and specialist disability professionals helped inform assessment of risk and actions to help strengthen parental capacity.

Senior managers had a clear and well-structured approach to the identification and management of risk. This included updating and reviewing the area's risk register in response to new and escalating concerns about the safety of children or the quality of services provided. Areas of risk subject to regular review included team capacity and progress in filling vacancies, delays or challenges in finding suitable care placements, and children awaiting allocation of a social worker.

Staff vacancies and turnover remained an area of ongoing risk and was being addressed through the development of a new recruitment and retention policy and working group. Its work programme had clear priorities and was informed by the views and experiences of frontline practitioners. There were a number of actions in progress to improve retention rates, strengthen staff morale and participation, and promote innovative practice. These included strengthening induction, mentoring and supervision, regular checks of caseload intensity and complexity and the additional time staff worked, including out-of-hours. Senior managers reviewed feedback from staff exit interviews and offered a range of personal and professional development opportunities, including additional training or career breaks, to enable staff to feel valued and well-supported.

The area manager and his team maintained good oversight of caseloads and organisational pressures. Most children on the CPNS had been handed over to child protection and welfare teams in a timely manner following the initial case conference (ICPC). However, the child protection and welfare teams continued to support approximately 20 children who were awaiting transfer to children-in-care teams. Actions to help manage caseload pressures included targeted support from a social care leader until such time that the children could be allocated to children-in-care social workers.

Inspectors reviewed management records and found they contained clear actions to address organisational risk, with regular review of operational challenges or barriers to service improvement. The area manager regularly sought assurances that the required standards of child protection practice were being met. The area manager, in turn, provided assurances to the regional chief officer about '*Need to Know*' [2] escalations for children on the CPNS, including any child awaiting a care placement.

At the time of the inspection, there were no children on the CPNS awaiting a care placement. Where there had been previous delays in finding a suitable placement, risks to children were well-managed and monitored, with creative use made of short breaks, holidays, and additional support and oversight of any interim care provided by wider family members. Legal advice was regularly sought, and other statutory actions, such as applying for Supervision Orders, were used to strengthen monitoring until risks of harm to children had reduced or the threshold for care proceedings was met.

The complex cases forum was effectively used as a system of governance and for promoting organisational learning and practice development. The forum was chaired by the area manager and provided review of safeguarding arrangements for children who had been on the CPNS for longer than 18 months or who were at risk of being listed for a lengthy period of time. The complex cases forum also considered the needs of children with high health risks or disabilities where parents were struggling to provide the required standard of care. This ensured effective monitoring of whether the threshold for listing on the CPNS had been met. Records reviewed by inspectors contained detailed discussion of children's experiences and ongoing risks of significant harm. Priority was given to securing additional support including specialist expertise from partner agencies.

Practitioners and their managers told inspectors that the process of case discussion in the complex cases forum was helpful in enabling them to creatively think about risks and inform next steps in cases where there was limited or insufficient evidence of improvement in parental capacity. Senior managers recognised the need to bring cases to the complex cases forum at an earlier stage and to strengthen their follow up reviews of children who were at increased risk of remaining on the CPNS for longer periods of time. Inspectors reviewed the records of children from one family who had been on the CPNS for longer than 30 months and found they would have benefited from more frequent review. This was acknowledged by service managers and promptly addressed following the inspection.

[2] Tusla's system of risk alerts to inform senior managers about significant concerns

The service area received nine compliments from parents/other agencies over the past year. These included positive feedback about the quality of communication by social workers and CPC chairs, joint working arrangements and the value of additional support received. Feedback was shared with senior managers who in turn formally acknowledged good practice with relevant individuals and teams.

The service area had received three complaints about its child protection arrangements over the past year which were managed in line with Tusla's policy and procedures. One was resolved locally and two were being managed through the service area's formal complaints management system. Training in dealing with complaints was mandatory, and a total of 73 staff had attended training to date in 2022. Managers closely monitored timescales for completion, and aimed to ensure that no complaint was open for longer than nine months. At the time of the inspection, there was one complex complaint where there was a risk that the target timeframe would not be met. A plan had been agreed to help bring it to a conclusion. Inspectors reviewed one complaint that had achieved an agreed outcome. A family mediator played an important role in repairing parental relationships with Tusla which ensured their ongoing engagement.

Managers actively used the outcome of complaints to inform wider organisational learning about the perspective and experience of children and parents. This included ensuring parents clearly understood individual and joint agency accountabilities for information-sharing and confidentiality, balancing the rights and best interests of children with their right to a private family life.

CPC chairs conducted quarterly audits of children listed as active on the CPNS. This included all children presented to an initial child protection conference, three monthly audits of children on child protection safety plans, and a follow up audit following review child protection conferences. This helped to ensure a rigorous focus on what was changing for children and whether actions to help strengthen parental capacity had been effective and sustained over time.

The service area's system of quality assurance and audits helped build a shared understanding of the areas of governance and practice to strengthen. Inspectors found that there were audits on almost all children's records. These were detailed and provided additional scrutiny of whether records were up to date, including supervision and management case notes. Feedback from audits supported joint discussions about continuous improvement and priority actions to address any gaps in the quality of practice and management oversight.

Feedback to frontline social workers, team leaders and principal social workers identified good practice and provided further guidance about required actions in line with children's needs and individual safety plans. Audits had a strong focus on whether children were regularly seen and spoken to and the levels of engagement of parents and their supporters in safety network meetings. Issues highlighted for improvement were promptly addressed, including the need for protected time or additional support from business services staff.

CPC chairs conducted quarterly review meetings with operational managers to discuss issues and learnings from audits. Gaps in consistently achieving the required standards of performance were addressed through practice workshops, group and individual supervision.

Child protection pillar management meetings and joint liaison meetings with An Garda Síochána reviewed practice in notifying incidents of child abuse and neglect. This helped ensure notifications were timely and supported good information-sharing about the progress of investigations and individual and joint agency accountabilities.

Inspectors reviewed the supervision records of senior managers and found the approach benefited from a strong focus on service improvement and continuous professional development. The area manager regularly sought assurances from principal social workers about the quality and safety of children listed on the CPNS. Supervision records together with senior manager interviews indicated regular exploration and review of risks including the management of complex cases. This helped ensure the area manager was kept well-informed about the needs and experiences of children listed on the CPNS.

Child protection conference chairpersons had benefited from additional training in coaching, mediation and conflict resolution, and were making good use of findings from research. Practice development initiatives included safeguarding unborn babies where parental substance misuse was a significant concern, with the associated risks of pre-mature birth. The CPC team was working closely with intake teams to ensure a timely and co-ordinated approach to identifying risks and reviewing safety plans in advance of the ICPC. This included actions to strengthen practice guidance and tools, promoting the engagement of parents and improving the timeliness and quality of pre-birth assessments. The service area benefited from close collaboration with Tusla's safeguarding national leads in developing and testing new approaches.

Child protection chairpersons set high standards for the way conferences were run. They sought to ensure the key principles of respect, kindness, empowerment and empathy underpinned their approach to exploring risk and assessment of protective factors within families. On occasion, chairpersons observed each other chairing conferences and regularly held de-briefing sessions on what went well and what could be improved. Such reflections actively informed service development discussions with wider colleagues and the area manager. They had also observed the style and approach of chairpersons in other service areas to provide additional review and challenge of their own practice. In verbal discussions and letters to parents, CPC chairpersons sought to ensure parents were aware of their right to appeal the conference decision to list their children on the CPNS. The service area had not received any appeals over the past five years.

Child protection conference feedback forms completed by partner agencies and parents praised the quality of facilitation of conferences, and made specific reference to the care taken by chairpersons to ensure everyone's views were heard and respected. Respondents reported they had been enabled to have a shared focus on the safety of children, and were clear about their role in work to help reduce the ongoing risks of significant harm.

The service area offered a wide range of training to its workforce to help promote continuous professional development, which reinforced practice standards and promoted strong team working and a child-centred organisational culture. The impact of this training was evident within the high quality of assessments of risk and safety plans seen on children's case records. Practitioners and managers said they had felt confident and equipped to make decisions in the best interests of children in what were often difficult and complex circumstances. Practice tools helped promote recognition of the impact of cumulative harm to children exposed to adverse childhood experiences. The area manager had recently commissioned a programme of trauma-informed practice to further strengthen workforce skills. Additional counselling and one-to-one support was available to help children understand and build strategies for dealing with their experiences and the impact of abuse and neglect.

Managers aimed to provide monthly supervision to practitioners carrying caseloads of children listed on the CPNS but this was not consistently achieved. Inspectors' review of children's case records showed some gaps in the frequency of supervision, and the recording and uploading of management case notes onto children's case records in line with Tusla's policy and guidance. Inspectors spoke to social workers and team leaders about these gaps and were assured of prompt action. Similar gaps had been identified within local audits and reflected periods of high workload pressures within frontline staff and management teams.

Overall, most supervision records seen by inspectors were of good quality and used the approved supervision template. They demonstrated ongoing monitoring of risks, progress and challenges, including the effectiveness of safety network arrangements and the impact of safety plans. Risks were generally well-managed as they arose in individual cases. An example seen of re-listing a child demonstrated clear systems and prompt decision-making in responding to the recurrence of significant concerns. Where safety plans were assessed as failing to achieve the required outcomes for children, consideration was given to the use of alternative statutory powers.

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.
The service area had well-developed systems and processes that reflected the performance standards set out in legislation, regulations, national policy, procedures and best practice guidance. The approach was underpinned by a strong learning and continuous improvement drive.
Judgment 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.
Managers and staff clearly recognised their accountabilities for protecting children and promoted strong engagement of parents, safety network members and partner agencies. The service area had strong governance and risk management systems for monitoring the safety of children and took appropriate action when children required additional support or protection. However, supervision of frontline practitioners required strengthening to ensure the standards set out in Tusla's policy and guidelines for supervision and case recording were consistently met.
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.
The service area had strong and effective review and performance monitoring systems in place. It had a strong track record of using audits to help drive continuous improvements in governance and child protection practice.
Judgment Compliant

Quality and safety

Overall, inspectors found a high standard of practice in promoting the safety and welfare of children on the CPNS. Child protection conferences and associated safety planning was well-managed with good engagement by parents and other agencies. Partnership working supported effective oversight of risks to children, with good use made of the involvement and expertise of wider community networks. Practice tools such as case chronologies and mapping of cumulative harm were appropriately used to inform analysis of past dangers and current levels of safety. Areas for further improvement related to ensuring the standards for frequency and recording of home visits and management case notes were consistently met. The service area was aware of these issues and was taking action in response to its own audit findings.

The service area's standard operating procedures set out clear expectations for the management of casework prior to, during and following child protection conferences. This included requests for a CPC to be made within three working days of the outcome of the initial assessment agreed with a team leader that a child was at ongoing risk of significant harm. Procedures specified that the initial child protection conference (ICPC) should be convened in a timely manner, allowing for 10 days' notice for all participants. Inspectors found recent improvements in the timeframes from referral to sign off by the team leader, to approval by the CPC chairperson and holding the ICPC.

Most delays on records reviewed by inspectors related to earlier periods in 2022. In one case, this had amounted to a three-week delay in sign off by the team leader, with a further five-week delay before the ICPC was held. The team leader was able to provide an outline of the reasons for the delay which were due to the complexity of the case and need for parental engagement. Chronologies of key events and tools for engaging children and mapping cumulative harm were appropriately used to inform analysis of past dangers and current levels of safety. Where there had been delays inspectors found that appropriate actions had been taken to keep children safe awaiting the scheduling of the ICPC.

Child protection conference chairpersons were suitably skilled and experienced social work professionals. They worked closely with frontline teams, families and other agencies to help them prepare for conferences and ensured discussions took account of relevant issues and challenges in improving safety for children. They spent time getting to know families, including on occasion seeing them at home with their children, and encouraging them to make contact before the conference about any queries they had. They managed their role as an independent person well, whilst promoting a culture of working together to improve outcomes for children.

The principal social worker had good oversight of checks made of children on the CPNS, within and outside office hours, including those made by relevant partner agencies.

The service area provided information in a range of languages about the CPC and the CPNS listing process to parents and professionals. Parents were encouraged to attend with their supporters, and where their first language was not English, an interpreter was provided. Good attention was paid by the CPC chairperson to family dynamics and risks, and holding additional conferences or taking breaks within conferences to ensure all relevant people could be involved. The CPC team ensured parents received letters in a timely manner about decisions to list or retain their children's names on the CPNS. They were also routinely provided with a written copy of safety plans.

Children's experiences and feelings were explored through the use of age-appropriate assessment tools, and children were encouraged to complete the *'Me and My Meeting'* booklet. Good use was made of children's own words and pictures to describe their lived experiences. Time was scheduled within the conference to ensure full discussion of children's needs and wishes. Their experiences actively informed decisions about the effectiveness of management of risk and need for additional safety. Children over the age of 12 years were routinely invited to attend, for some or all of the meeting; but few said they wished to do so. Most case records indicated children were spoken to about the child protection conference outcome and the safety plans that had been put in place to protect them. Social work practice in this area was routinely checked in case audits.

Inspectors observed an initial child protection conference for an unborn baby and found it was well-managed. Relevant partner agencies such as An Garda Síochána and maternity staff were actively involved as were parents and wider family members. The CPC chair engaged parents using clear and simple language. She explained processes when necessary, and used visual aids and notes to illustrate key points. She regularly checked for parents' understanding of Tusla concerns and the changes in their behaviour that were required to ensure the baby would be safe and well cared for. Her approach was respectful and compassionate throughout, clearly setting out next steps before the next conference which helped inform the further development of the child protection safety plan.

Child protection safety planning focused strongly on parents and safety network members' engagement and ownership of the plan and their commitment to attend regular four to six week scheduled network meetings. All safety plans reviewed by inspectors were clear, carefully worded, targeted to areas of highest risk and had measures for tracking improved outcomes. They contained relevant information about

everyone's responsibilities for implementing the safety plan and how this would be monitored by the lead social work professional.

Safety plans included key actions in relation to the immediate and longer term needs of children. This included arrangements to support their regular school attendance and address their individual health or development needs, wider parental and housing concerns. However, the process for reviewing and updating child protection safety plans varied and was influenced by practitioner capacity and the frequency and effectiveness of safety network meetings.

Some child protection safety plans demonstrated creative and highly effective practice in supporting families in crisis. This included the engagement of diverse faith and community-based organisations for parents who did not have a local network of family support. Social workers and their managers were mindful of cultural differences in relation to parental responsibilities and appropriately sought advice to promote parental understanding of child care law. Parents with intellectual disabilities or mental health needs were helped to understand Tusla's concerns and to give their views.

Managers ensured good and timely handover of child protection cases from the intake to the child protection teams. Transfer summaries were available on children's records. Joint visits to introduce new social workers to children and their families were routinely made. Records indicated social workers gave explanations of the reason for the transfer of the case and the role of the new social worker in supporting them to address issues highlighted within the safety plan.

Inspectors found a mixed picture in relation to the frequency and standard of management case notes on children's records. Good examples indicated timely discussion and analysis of escalating risks, with key details well-summarised and underpinned by clear actions and follow up. However, gaps in the quality and frequency of management case notes were found on six children's records (25% of records reviewed).

Inspectors found that most RCPCs were held on time in line with standard operating procedures, and if they needed to be re-scheduled, this promptly took place. Efforts were made to ensure RCPCs were chaired by the same person to provide continuity of relationships and familiarity with the issues of ongoing concern.

Senior managers paid good attention to the length of time children were on the CPNS and were vigilant to risk and delay. Most children had been listed for up to 12 months

at the time of the inspection, and seven children were on the CPNS for longer than 12 months. There were no children listed for more than 18 months.

The service area had three children who had been listed for more than 30 months. Review of these records indicated that over time there had been regular announced and unannounced home visits and communication with partner agencies. However, improvements in parental care had not been sustained. Audits of casework provided additional guidance to practitioners on work required to strengthen the safety network and the need for further direct work with the children. Legal advice was being sought about whether the threshold for admission to care had been met.

Review child protection conferences ensured key processes such as safety plans and networks of support had been tried and tested for impact, with tight monitoring and quality assurance of practice between review meetings. The CPC chairperson provided important challenge as to whether listing of children on the CPNS had led to sufficient improvements in their safety and levels of parental care. Where there was evidence of drift and delay in establishing or sustaining safety network meetings or progressing priorities outlined in safety plans, this was carefully considered in relation to the effectiveness of child protection arrangements and the best interests of children.

Overall, the frequency of visits to see children (both announced and unannounced) was generally in line with the minimum three-weekly requirement, with some good examples of frequent and effective practice in promoting relationships with children. This included encouraging children to feel safe in talking about their hopes, worries and what they enjoyed. Where risks remained high or where plans were being made for children to be admitted to care, social workers and other agencies ensured daily visits and spoke to children in other settings such as school. Inspectors reviewed a sample of records of children who had been admitted to care. They found clear case recording and management decision-making in response to lack of progress in addressing risk as set out in child protection safety plans.

Good examples of additional safety checks included the use of an emergency roster for home visits when the allocated social worker was unavailable. Joint visits with team leaders or child protection chairs were made in complex cases. However, there were occasions where the expected frequency of two/three weekly visits as set out in children's safety plans had not been consistently achieved or sustained or there was insufficient detail within records about seeing and speaking to children. These were themes which had been identified within the area's own internal audits.

The process for de-listing children was clear and well-managed, and subject to close scrutiny for evidence of improved outcomes for children. De-listing was planned for in a phased manner through ongoing discussion within safety network meetings and supervision. The use made of and review of safety scores within supervision ensured regular tracking of progress, risks and the sustainability of changes made. Step-down arrangements routinely included the development of a Tusla-led safety plan that addressed any ongoing areas of risk where lower level support was required. Inspectors found that children had been appropriately de-listed and that An Garda Síochána and GPs were informed of this in writing.

Where children were re-listed, it was primarily due to changes in their particular family circumstances that were not known at the time of the de-listing. One case record reviewed by inspectors indicated timely re-listing of children and responsiveness to the concerns reported by children. Service managers checked for learning from the circumstances that led to the re-listing of children and additional safeguards that may be helpful to consider going forward. There were appropriate arrangements in place for the de-listing children following their admission to care.

Partnership working with other agencies overall was strong, with evidence of shared learning and joint review driving continuous improvements in child protection practice. Joint protocols, professionals meetings and safety plans clearly outlined individual and joint agency roles and responsibilities for working together at a service and child-specific level. Professionals were appropriately engaged in and kept informed through strategy and safety network meetings and regular case updates from the lead social work professional which included joint review of progress and interventions on a multi-agency basis.

Attendance by relevant professionals and agencies at child protection conferences was good, with reports submitted to the chairperson in advance where required. Child protection conference chairpersons had undertaken a range of briefings with other agencies to help build wider knowledge of *Children First* requirements. Case records denoted good working relationships with a wide range of agencies that made effective use of community and specialist knowledge and expertise.

Standard 2.6 Children who are at risk of harm or neglect have child protection plans in place to protect and promote their welfare.
Children who were at ongoing risk of significant harm were appropriately identified and protected. The quality of child protection safety plans overall was of a good standard and was appropriately informed by the needs and vulnerabilities of children in a diverse range of circumstances. Although some case records evidenced delays in manager sign off of requests for the initial child protection conference in the earlier months of 2022, this was being addressed and the impact for children had been minimal.
Judgment Compliant
Standard 2.7 Children's protection plans and interventions are reviewed in line with requirements in Children First.
The service area's children protection safety plans and interventions were appropriately reviewed in line with *Children First* requirements and reflected Tusla's national safeguarding children approach. Safety network meetings and review child protection conferences provided effective review of progress and the impact of safety plans. However, the process for reviewing and updating child protection safety plans varied and was influenced by practitioner capacity and the frequency and effectiveness of safety network meetings. There were occasions where the standards of practice in relation to the frequency and recording of home visits and of management oversight were not consistently delivered. These issues were recognised within case audits with clear actions to address gaps. The processes for de-listing children were well planned for and managed.
Judgment Substantially compliant
Standard 2.9 Interagency and inter-professional cooperation supports and promotes the protection and welfare of children.
Child protection conference chairpersons and lead social work professionals had strong and effective joint working arrangements with partner agencies. Casework demonstrated a high standard of joint practice. These arrangements ensured children and their families benefited from relevant advice and specialist support.
Judgment Compliant

Compliance Plan for Dublin South Central Child Protection and Welfare Service OSV – 0004416

Inspection ID: MON-0037270

Date of inspection: 8th August 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 3.2	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.

New Social Work Graduates will receive supervision every 2 weeks for their first 3 months in practice and thereafter once every 4/6 weeks, they will also be allocated a protected case load, Social Workers/Senior Practitioners/Social Care Leaders/Workers will receive supervision every 4/6 weeks.

All allocated cases will have a supervision record detailing the content of discussions pertaining to the individual child/family, this will be signed off on and agreed at Supervision by the Principal Social Worker/Team Leader and Social Worker, these completed supervision records will be uploaded to NCCIS within a 72 hour period hour period. Individual Supervision records pertaining to individual workers, recording, professional development, support and complexity of cases etc (TUSLA Supervision Pro Forma) will be signed off and agreed by the Supervisor/Supervisee within a 72 hour period and both will retain a copy for their files and records will be reviewed at the next supervision in order to track progress on outstanding work and recommendations made by CPC Chairs from their completed Audits. There will be 6 monthly Audits undertaken by the Principal Social Worker in respect of Supervision records.

Standard 2.7	Substantially compliant

Outline how you are going to come into compliance with Standard 2.7: Children's protection plans and interventions are reviewed in line with requirements in Children First.
Audits will continue to be completed on the files of children listed as active on the Child Protection Notification System, these will be completed by the Independent CPC Chairs at regular intervals, within 1 week of an Initial Case Conference/Review Child Protection Case Conference happening – this will clearly record if the standard business process has been adhered to in terms of time frames, at 3 monthly intervals, this will be crucial in determining if safety plan/safety network is working in respect of safety of the children and that the scaling at Safety network meetings is going up at each meeting – any issues with the plan or changes in the safety network will be recorded and escalated to the Principal Social Worker/Team Leaders, the files will also be audited just before the Review Case Conference which will be at the 6 month period of the safety Plan. All recommendations made by the Auditors will be discussed at individual Supervision sessions and agreed timeframes for completion of any outstanding work will be recorded and then reviewed at the following Supervision session.

Safety Network Meetings are planned at intervals of 4-6 weeks and the dates are recorded when the CPC safety planning form is launched in the week the case conference is happening, dates are agreed and shared with families, there have been times when these dates needed to change to accommodate conflicting appointments for the family, at the 3 monthly audits, there should be at least 2 safety network meetings recorded and when this is not evident on NCCIS, the matter is escalated to the Team Leader and the Principal Social Worker.

The CPC Chairpersons will produce a report every quarter which will record the themes emerging from the Audits and there will be interactive presentations to the CPW Pillar in respect of Themes and examples of good practice will be shared with the teams regularly and DSC is fully committed to creating a culture of learning for all workers/Managers. Children made active on the CPNS are the most vulnerable children in Dublin South Central and as such they will be visited in their home at the very least every 3 weeks (more often when there are few agencies involved), through the completion of Audits the Chairpersons requested that Child Protection Home Visits be recorded in case notes under the Heading Statutory Child Protection Home Visit – CPC Chairs have begun to see evidence of this through their Audits and this will be continuously promoted by the Chairs/ Principal Social Worker and Team Leaders – during Supervision sessions.

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 3.2	Children receive a child protection and welfare service, which has effective leadership, governance and management arrangements with clear lines of accountability.	Substantially complaint	Yellow	By end of Quarter 4 2022
Standard 2.7	Children's protection plans and interventions are reviewed in line with requirements in Children First.	Substantially complaint	Yellow	By end of Quarter 4 2022