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:	Midlands
Name of provider:	Tusla
Type of inspection:	Focused CPNS
Date of inspection:	07 - 09 December 2021
Lead inspector:	Ruadhan Hogan
Support inspector(s):	Olivia O'Connell Lorraine O'Reilly
Fieldwork ID	MON-0034174

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
- focus group with two principal social workers
- focus group with two child protection chairpersons
- focus groups with social work team leaders
- focus group with social workers
- 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 15 children's case files
- phone conversations with five 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. Child protection and welfare services are inspected by HIQA in each of the 17 service areas. The areas are grouped into four regions, each with a regional manager known as a service director. The service directors report to the chief operations officer, who is a member of the national management team. The Midlands service area is one of the four Tusla areas within the Dublin Mid – Leinster region.

The Tusla Midlands area comprises the counties Laois, Longford, Offaly and Westmeath, totaling an area of 6451.27 sq. km. Based on Census 2016 data, the area has a total population of 289,695 (2016). This represents 6.1% of the state population (4, 761,865). The number of children (0-17yrs) increased by 5%, from 2011 to 2016. As of 2016, the child population (80,193) of area as a percentage of total population is 6.7%. The average monthly child protection and welfare referral rate to the child protection service is between 500 – 600 referrals, making the area one of the highest referral areas within the country, with a rate of 18.1 per 1,000 of the population.

The area is under the direction of the service director for Tusla, Mid-Leinster region, and is managed by and area manager. There are two principal social workers who manage social work team leaders who in turn manage teams comprising social workers and social care leaders. Two additional principal social workers operate as chairs of the child protection conference service. The area also has a manager of the partnership, prevention and support service (PPFS). Area services are based across the four counties.

Four duty intake social work teams were responsible for the screening, preliminary enquiries and initial assessment of new referrals and reported to a principal social worker. They made requests for child protection case conferences (CPC's). Referrals that require a more long-term intervention, and children active on the child protection notification system (CPNS), are managed by the long-term child protection team, comprising a principal social worker and four social work team leaders.

The child protection conferencing service was delivered by two principal social workers and administration staff were employed to assist.

There were 77 children listed on the CPNS at the time of the inspection and all of these children had an allocated social worker.

At the time of the inspection, there were seven social worker and four social work practitioner whole time equivalent vacancies across the child protection and welfare service. Three social worker and two social work practitioner positions were vacant on the duty intake teams, with four social worker and two social worker practitioner vacant on the long-term child protection and welfare teams. There were no staff employed on a temporary basis.

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
07 December 2021	09.00- 17.00 09.00- 17.00 09.00- 17.00	Ruadhan Hogan Olivia O'Connell Lorraine O'Reilly	Inspector Inspector Remote Inspector
08 December 2021	09.00- 17.00 09.00- 17.00 09.00- 17.00	Ruadhan Hogan Olivia O'Connell Lorraine O'Reilly	Inspector Inspector Remote Inspector
09 December 2021	09.00- 15.00 09.00- 15.00 09.00- 17.00	Ruadhan Hogan Olivia O'Connell Lorraine O'Reilly	Inspector Inspector Remote Inspector

Views of people who use the service

As part of this inspection, inspectors spoke with two children individually over the phone, who described their experience of the child protection and welfare service, and in particular the child protection conference (CPC) service. These children gave generally positive feedback. They told inspectors that social workers 'talk to me' and 'listen to me'.

Children said they sometimes attended meetings with their parents and social work team by choice. It was the experience of children who spoke to inspectors that some found attending the child protection conference as 'awkward' but 'it was good'. Children told inspectors that at these meetings, they knew everyone was proud of them because of the progress they had made.

Children described supports that social workers had put in place for them as part of their child protection plans. For example, supports for them to return to education and support services for their families. They thought these worked well and told inspectors 'things are much better now', and social workers 'did good by me so I can't complain' and 'they [social workers] couldn't have done better'.

Inspectors spoke with five parents who had experienced the child protection conference process and whose children were, or had been, listed on the child protection notification system (CPNS). All parents shared positive overall experiences of the service provided to them and their children. Some examples of what parents said were:

'I was terrified when they [social workers] were involved at first but I couldn't have done this without them'.
'they [social workers] improve things for both me and my husband as well as the kids'
'it was scary and it was good in the end'.

Parents told inspectors about their experience of attending CPC's. All five parents said that their views were sought and valued by social workers and the child protection conference chairperson. They said that conferences 'ran well' and they 'were told everything'. They told inspectors that they were actively involved in the meetings and were asked their views. They were satisfied that there was 'good communication' between them and social workers, and that the CPC chairs 'always asks my point of view', and 'everything was explained to us'. One parent said that the CPC chair was "not one-sided at all' and that they 'challenged social workers'.

Some parents experience of CPCs was 'quite difficult', owing to the CPC being held remotely via teleconference and video conference, as they found it difficult at times to hear professionals views that were relayed over the phone.

When the CPCs had finished, parents said that they received minutes of the meetings and were well informed about safety plans which promoted the safety and welfare of their children. One parent said that following the CPC, the social worker 'came out to visit every week or two' to check in with them and their children.

Parents described their allocated social workers as 'brilliant' and 'absolutely wonderful'. One parent said 'I don't have a bad word to say about them, I wouldn't have got through everything without them'.

Parents told inspectors that they were provided with family supports and linked with local community services. One parent said that their child 'got a place in crèche which is great'. Another parent said that the child's allocated social worker 'always asks if we need more support'.

The next two sections of the report present the inspection findings in relation to how the service was managed and how the governance arrangements in place impacted on the quality of the service provided to children and their families.

Capacity and capability

This inspection found that this was a well-managed and well led service with good governance arrangements in place. The area operated in accordance with required legislation, regulation and national policy, and this resulted in a good service to children listed on the child protection notification system (CPNS). Strong leadership in the area promoted a culture of collaboration and respectful challenge, which led to ongoing service improvements. The mechanisms in place to manage risk and audit practice were embedded and used effectively to assess and review the quality and safety of services provided to children and their families. While the service area addressed gaps in national policy and procedure, there was a need to ensure Tusla's interim national guidelines on child protection case conferencing and the child protection notification system were reviewed and updated, as a means of assuring quality and consistent practice.

The focus of this inspection was on children subject to a child protection case conference and listed on the CPNS, and the aligned governance arrangements in place

to ensure effective and timely service delivery to these children. As per Children First: National Guidelines for the Protection and Welfare of Children (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).

Where children are assessed as being at ongoing risk of significant harm at a CPC, their name is placed on the child protection notification system (CPNS). The children on this register require close monitoring by the social work department to ensure interventions are effective at keeping them safe and reducing assessed risks. Children who have child protection safety plans continue to live at home, unless it decided that a child is not safe to do so, or if the child protection plan is deemed not to be working. In these circumstances, the child's parents may organise a private family arrangement, where the child lives with a relative or family friend. In other scenarios, Tusla may decide to remove the child from their home and place them in care, either with a foster carer or in residential care. This inspection also reviewed children files, whose names had recently categorised as 'inactive' on the CPNS, in the six months prior to the inspection. These children had been assessed as no longer being at ongoing risk of significant harm.

This inspection assessed the service delivered to children on the CPNS in the 12 months prior to the inspection. This time period was a challenging time nationally, for social work teams and children and families engaging in these services, due to the risks and public health restrictions associated with the COVID-19 pandemic. In addition, during 2021 Tusla had been the target of a cyber-attack which compromised their national child care information system (NCCIS) for several weeks between 14 May 2021 and 31 July 2021. In this context, HIQA acknowledges that services needed to adapt how they worked with children and families to ensure they continued to receive essential support to ensure safety. These issues, and how they were managed, were reviewed within the overall assessment of local governance.

The service had policies, procedures and processes in place to guide social workers on the application of thresholds for a CPC, safety planning and maintaining the CPNS. These national policies reflected the requirements of Children First Act 2015 and Children First (2017). Tusla's interim national guidelines on child protection case conferencing and the child protection notification system had not been subject to review at the time of the inspection and required updating, as a means of assuring quality and consistent practice. For example, timeframes for the scheduling of initial CPCs were not made explicit within these guidelines. In addition, basic minimum requirements relating to the monitoring and implementation of child protection safety plans, such as frequency of visits and safety planning meetings, were not explicit and

this could potentially impact on a consistent service being delivered nationally. However, this inspection found that the governance arrangements in place ensured that locally written standard operating procedures (SOPs) were in place to guide staff and provide clarity. For example, the local SOPs outlined the requirements for the transfer of cases from duty intake teams to long term child protection teams and connectivity between the CPCs and the implementation of safety planning by social work teams. This promoted the protection of children by bridging known gaps in the national policy.

The area had strong leadership that promoted a culture of collaboration and respectful challenge, where a focus on learning led to service improvements. There was an established and experienced management team who were familiar with children's cases listed on the CPNS, and the circumstances in which they lived. During interviews with inspectors, the senior management team members demonstrated a shared vision and a commitment to identifying areas of, and implementing continuous improvements to service delivery, which in turn led to safe and effective interventions for children and families. The area manager said that core principals of child-centeredness and professional responsibility were promoted across staff teams. Staff who spoke to inspectors were familiar with the policy and legislative context that guided their work, were clear about their roles and the management structure, and were of the view that the service was good quality, well led and managed well.

There were strategic and operational plans in place which were aimed at delivering a good quality service. These plans were aligned with Tusla's national corporate plan 2021-2023 and outlined the key objectives for the whole service area including the CPNS service, over 2021. Inspectors found that the objectives for service delivery children on the CPNS were being met.

The service area had clearly defined roles and responsibilities for managing children who were subject to a multi-disciplinary child protection case conference (CPC). Child protection conference chairpersons were responsible for reviewing requests for a CPC and approving where appropriate, that a CPC would be held. The scheduling, organising and facilitation of CPCs was delegated by the area manager to the child protection chairpersons, while the social worker and their respective managers were responsible for the case management, including the implementation and monitoring of child protection safety plans. All of these staff ultimately were accountable to the area manager of the service area. This approach was working well in the area.

The area had effective communication systems in place. A range of governance and team meetings were established including area management meetings, child protection and welfare (CPW) management meetings, CPC team meetings, duty/intake team meetings, and long term CPW team meetings. Inspectors reviewed a sample of minutes of these meetings and found they were well attended and well recorded. The frequency of meetings was appropriate and proportionate to roles of its members. For example, the senior management team in the area met on a weekly basis, while CPC team meetings met on a monthly basis. Records of meetings showed that key information was communicated between staff and managers. This meant that decision-making and risk management was shared effectively and in a timely manner, to ensure the service met its strategic and statutory obligations in a safe way.

There were effective governance arrangements in place for the area manager to be assured on the quality and safety of the service delivered to children listed on the CPNS. During interview, the area manager outlined the assurance mechanisms she relied on which included, supervision with principal social workers (PSW) for the duty/intake and the long term child protection teams, and supervision with the CPC chairs. She explained that the Midlands service area had strong and effective approach to auditing practice, and she chaired an audit forum where findings and learning were discussed and actioned. She periodically reviewed the CPNS register herself where required. Some individual cases were highlighted to her through these assurance mechanisms and when necessary, she reviewed these cases on Tusla's information technology system- National Child Care Information System (NCCIS). She also chaired the complex case forum and was kept informed as to the progress and outcome of complaints. These mechanisms are discussed in greater detail throughout this report.

Formal supervision, as a means of providing assurance on the quality of service provided to children listed on the CPNS, was used appropriately in the area. Individual case supervision was evident across all cases reviewed by inspectors. A template was used consistently and comprehensively to record supervision between social workers and their respective social work team leaders. Case supervision was held regularly and was effective at monitoring the progress of social work interventions. This meant that case supervision became a reliable foundation for PSWs and the area manager to be assured on the service delivered by social work teams. A review of supervision records between the area manager and PSWs and the CPC chairpersons showed regular supervision took place in line with Tusla policy. Overarching issues impacting the service were discussed during these sessions. By way of an example, CPC chairs confirmed whether CPCs were scheduled in a timely manner. Additionally, cases of concern were highlighted by PSWs to the area manager for learning within this process.

The area operated a complex case forum chaired by the area manager. The purpose of this forum was to provide support, advice and governance to the service area teams in relation to specific cases. The terms of reference guiding its operation stated that once a child was subject to a fourth CPC, had been listed on the CPNS over 18 months, or there were other circumstances indicating complexity, then the case was required to be presented at a complex case forum. At the time of the inspection, none of the 77 children listed on the CPNS inspection met the criteria for the complex case forum. Inspectors reviewed two cases related to children removed from the CPNS in the six months prior to the inspection, which were reviewed at the complex case forum, and found it to be an effective system in providing an objective review of decision making and practice in these cases.

There were strong monitoring arrangements in place to provide oversight and assurance to senior management that a safe service was provided to children on the CPNS. An auditing governance forum, chaired by the area manager with the senior management team in attendance, was held on a quarterly basis. This forum reviewed the progress and findings of all ongoing audits across the service including local audits related to children on the CPNS. These meetings also set out plans for future auditing programmes. This forum was effective at ensuring that audits supported managers in the service to identify areas for improvement, to manage risk and to let them know if staff were carrying out their roles in line with policies and procedures. In one example, inspectors found evidence that practice related to social work visits to children on the CPNS had improved.

The Tusla national office directed audits to be undertaken, and Tusla's Practice Assurance and Service Monitoring (PASM) Team completed an audit in August 2020 related to the monitoring of children on the CPNS by social workers, during the COVID-19 pandemic. In addition, the area manager completed an audit of cases on the CPNS in July 2020. The findings of both audits provided an assurance that children had been visited as appropriate.

Local systems of auditing were a significant feature of the areas monitoring arrangements, as a large proportion of files related to children on the CPNS were subject to an individual audit. Audits of children's case files were undertaken by a social work team leader who did not have direct line management responsibility for that child. They were completed using a 'critical friend concept', which staff explained to inspectors as a competent trusted friend who asks critical questions. This was aligned with the culture of respectful challenge that was promoted within the area. Audits were consistently recorded on a specific CPNS template, were comprehensive and where necessary, actions were identified for follow up by the allocated social worker. The audits also required the reviewer to question the appropriateness and effectiveness of social work interventions with children and families. Inspectors reviewed these audits on cases sampled as part of the inspection, and found they were effective at achieving their stated purpose and had positively influenced practice.

Completed audits were sent to the PSW for the long term child protection and welfare team. She summarised findings from the individual audits and produced an overview report with higher level findings. Inspectors were provided with a copy of this summary audit report for the period January – December 2021. That report outlined that 91 individual audits were undertaken over that period, and no risks to children were identified which required escalation. Good practice was acknowledged by managers including: efficient handover of cases from the duty intake teams to the long term teams, regular and purposeful visits to children and that the voice of children was being heard. Learning was also identified in this summary report and included improved consistency in recording, and improved use of child and family friendly language in reports. Recommendations were made and were to be included in the CPW service improvement plan for 2022.

There were effective risk management systems in place. Risks were appropriately identified and had effective responses and measures in place to mitigate against the impact on the delivery of service to children on the CPNS. Inspectors reviewed individual cases that had been escalated through Tusla's 'Need to know' escalation system. One of these risk escalations related to the potential lack of placements for a large sibling group on the CPNS, who required an admission to care. Inspectors reviewed the children's' records and found that risk escalations were timely. Short term measures were put in place, such as placing the children with relatives while longer term placements were found. This risk escalation facilitated the Tusla Midlands service area to access Tusla's national private foster care and residential placement team, so that placements could be sourced without delay. It also ensured that immediate decisions on funding were agreed with the respective service director. As a result of these interventions, inspectors found that these children were suitably placed in a mixture of foster care and residential area within a relatively short time frame.

The area had a risk register system in place, and this register was appropriately populated with risks to service delivery such as staffing, health and safety issues related to a Tusla premises, and the challenges in adherence to timeframes in line with Tusla standard business processes. None of these risks specifically impacted the service delivered to children on the CPNS.

Restrictions and changes to working practices arising from the COVID-19 pandemic remained a significant challenge on the delivery of services in the area. This risk was also on the area risk register and overall, inspectors found these were well managed. Inspectors found that in the main, CPCs were held face to face with parents and the chairperson. A hybrid model was also facilitated, such as the use of teleconferencing and video conferencing, and was in line with Tusla National Guidelines. In addition, individual risk assessments were completed to support face to face family contact. For example, in one case, records showed that the allocated social worker continued with safeguarding visits to children on the CPNS despite the family being diagnosed with COVID-19, with visits conducted outside and for 15 minutes only, in line with public health guidelines. This demonstrated a commitment to ensuring children's safety was monitored, and that progress continued to be made. It was also indicative of a good quality service.

As stated, Tusla had been the target of a major cyber-attack which had compromised the NCCIS for several weeks during the summer of 2021. At the time of this inspection, Tusla's IT systems were in a recovery phase and were operating effectively. Nonetheless, issues and the impact of the cyber-attack remained on the area risk register for the entire service. The residual effects on IT systems identified were: electronic diaries lost, some external emails being quarantined and remaining backlogs in uploading documents onto NCCIS. The risk register listed appropriate measures to mitigate against their impact. Inspectors found negligible impact on the service delivered to children on the CPNS as data management for these children was prioritised and good. For example, all required case records for the summer period had been retrospectively uploaded to the electronic system, including handwritten case notes and social work assessments. This meant that the progress of child protection interventions for children on the CPNS could be measured, and decisions at subsequent review CPCs were informed by accurate, up to date and reliable evidence.

CPC chairpersons within the area participated in various governance forums that led to improvements in service delivery. The CPC chairs participated at a regional CPC forum where chairpersons from other service areas within the Dublin Mid-Leinster region. Records of these meetings showed that the role of CPC chairs and examples of how to maintain independence and impartiality was discussed along with procedural matters. The CPC chairs also held meetings to review standard operating procedures (SOPs) for CPCs. The chairs ensured that updates to these SOPs were appropriately disseminated to duty/intake and long term social work teams through videoconferencing seminars. They also reported back to the area manager on the progress of changes through their individual supervision with the area manager. Some of the changes included ensuring that CPC chairs updated child protection safety plans with the recommendations following the CPCs. This meant that additional governance mechanisms ensured better connectivity between the CPCs and the implementation of safety planning by social work teams.

Effective arrangements were in place to manage and learn from adverse events, complaints and serious concerns to ensure they are appropriately managed, actioned and to learn from what had occurred. Learning from national review panel reports was discussed at various team and management meetings held in the area. Inspectors reviewed three complaints from parents and relatives of children who were placed on the CPNS. All complaints were at early stages of investigation. The area manager explained that she had oversight of all complaints, and that this provided her with additional insight into how well the service was operating, and where improvements could be made.

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.
Governance structures in place at local, regional and national levels supported the delivery of the CPNS service, in line with relevant legislation, standards, policies and procedures. Interim national guidelines on child protection case conferencing and the child protection notification systems had not been subject to review and required updating by the Child and Family Agency. In order to ensure quality and consistent practice nationally, the policy required review to align it with best practice in other jurisdictions. For example, basic minimum requirements relating to the monitoring and implementation of child protection safety plans, such as frequency of visits and safety planning meetings, were not explicit and this could potentially impact on a consistent service being delivered nationally. The Midlands service area had local policies, procedures and processes in place to guide social workers on the application of thresholds for CPC, safety planning and the management of the CPNS. These policies reflected the requirements of Children First Act 2015 and Children First (2017). At local level, the Midlands had implemented local standard operating procedures (SOPs) and guidance to provide clarity to staff around some of these practices. These local SOPs and guidance ensured that the gaps in national policy were bridged and as a result, the protection of children was enhanced in this area.
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.
The service had effective leadership, governance and management arrangements. The area had strategic and operational plans in place. Strong leadership in the area promoted a culture of collaboration and respectful challenge, which led to service improvements. Governance arrangements, such as supervision, risk management, and auditing were effective mechanisms for senior managers in the area to be assured on the service delivered to children on the CPNS.
Judgment: 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 Midlands service area had effective systems in place to monitor and review service provision for children on the CPNS. Risks were appropriately identified and had effective responses and measures in place to mitigate against the impact on the delivery of service to children on the CPNS. Monitoring arrangements, particularly the use of auditing was used to provide assurance to senior management that a safe service was provided to children on the CPNS.
Judgment: Compliant

Quality and safety

Children listed on the child protection notification system (CPNS) received social work interventions which were child centred and promoted their safety. Children who were assessed as being at on-going risk of significant harm had an initial child protection conference (CPC) which was timely in the majority of cases, but some improvements were needed to ensure all were held promptly. The service ensured that children and families were encouraged and facilitated to attend and participate in CPCs. Children on the CPNS had regular visits from an allocated social worker and supports were put in place to support families to address known risks. The service was proactive and made timely and proportionate decisions which children benefited from. Inter-agency working to protect children at ongoing risk was good, and plans put in place to promote their safety were well monitored for their implementation.

Initial child protection conferences were held for children who required one, but there were some delays. Requests for an initial CPC were made by the child's social worker and approved and scheduled by the CPC chairs. Although national guidelines for CPCs and the CPNS do not specify required timeframes for the scheduling of initial CPCs, child protection chairs told inspectors that the Midlands service area aimed to schedule an initial CPC within three weeks of their approval of the request. Of the nine children's files reviewed for timeliness of initial CPCs, two were convened within three weeks of the request being made, six were convened between four and six weeks. The remaining case was held within seven weeks and there were justifiable delays owing to an illness of a key participant. Inspectors found that all cases had appropriate interim safety planning in place while awaiting an initial CPC, and this promoted the safety of these children.

Parents and children were consulted with prior to the CPCs to explain what would happen at the meeting. Records showed that social workers met with children and families, where appropriate and whenever possible, in the week prior to the CPC, to go through the content of their social work report and the recommendations that they would make. CPC chairs met with parents just prior to the CPC to reiterate the independent role of the CPC chair. This was important, as it promoted a fair and objective process which parents said they were satisfied to engage with.

Child protection conferences were planned well and facilitated by appropriately trained and skilled professionals. CPC chairpersons were not directly involved in the assessment or management of children's cases and consequently were independent. Parents attended CPCs usually in person or remotely through teleconference and/or videoconference and children attended where appropriate. The child's allocated social worker and the respective social work team leader attended all initial CPCs. The area

was also proactive at ensuring the participation of external agencies at CPCs, and this ensured the needs of children were presented at the CPC and plans to keep them safe were developed in collaboration with relevant professionals.

Child protection conferences were held remotely in the service area and although there were challenges to using this approach, there were also advantages. The Midlands service area received feedback from parents who had attended CPCs, some of whom said that they found using telephones to access CPCs difficult, owing to calls cutting off. Inspectors observed one review CPC remotely and saw that although it was a well facilitated meeting and inclusive of all attendees, it was a challenge to ensure individual voices were heard. CPC chairs acknowledged these challenges and prepared for them, but they also described the opportunities remote meeting provided. Some examples included improved attendance by other professionals such as paediatricians and general practitioners, as there was no need to travel.

This service area ensured a continuity of social work service when cases transferred from duty intake teams to the long term child protection team. The duty intake social worker usually completed the initial assessment, CPC social work report and presented the case at the initial CPC. This allocated social worker and their respective social work team leader attended all initial CPCs along with the new social worker form the long term team and their respective social work team leader. This ensured the new social worker was fully aware of the circumstances of the case and that the service delivered was child centred and focused on ensuring the safety of children, along with the best possible outcome for all involved.

CPC records were comprehensive and clearly outlined the identified risks and what was required to reduce them. In all 15 files reviewed by inspectors, the views of all attendees were recorded, which led to comprehensive multi-disciplinary assessments of children's needs. Detailed discussions were recorded which led to robust decision making, based on the evidence and information presented. In one case reviewed by inspectors where there were risks related to domestic violence, the allocated social worker provided an in-depth and insightful analysis on the potential short and long term impact of domestic violence on the child during the CPC. In this case, a decision was taken for the child to remain on the CPNS. Risks were clearly communicated to parents and the family at the CPC, along with what needed to happen for there to be an appropriate level of safety for the child.

Child protection safety plans (CPCPs) were consistently of good quality. These plans clearly articulated the actions identified during the CPC that were to be implemented and monitored by the child's social worker, in order to promote the child's safety. These plans also outlined what safety measures were to be addressed following the

CPC, at safety planning meetings; the scheduling of which was specified by CPC chairs during the CPC. Inspectors found that all CPSPs reviewed had comprehensive actions that addressed the assessed needs and identified risks to children, along with the supports to be provided. Having a good quality CPSPs provided a structured approach for social workers to work with families so that children were safe. If it became apparent that CPSPs were not adhered to, additional action was taken by social workers. For example, in one case where there were concerns with parental mental health and domestic violence, the CPSP clearly set out the actions to be taken and an expected trajectory of improvements to be achieved, in order for the safety of children to be maintained. The actions included families engaging with support services and identifying members of a safety network. A subsequent review CPC held six months later found that these actions were not progressed, despite the best efforts of the social work department. The social worker subsequently recommended that legal advice would be sought, for example seeking a supervision order from the Court, so as to ensure there was no drift in the case.

Child protection safety plans were well monitored and implemented by social workers. According to Tusla guidelines for CPCs and the CPNS, safety planning network meetings should take place following a CPC to monitor the progress of the child protection safety plan and develop detailed safety planning arrangements from the CPSP. In the majority of cases reviewed by inspectors, network meetings were held shortly after the CPC with the parents and others identified to support the children's safety. Where appropriate, children were included in this process. Inspectors found that meetings and other social work home visits were effective at developing the detailed safety planning arrangements that were focused on achieving tangible and sustainable improvements and positive outcomes for children. By way of an example, one case reviewed by inspectors showed that there were concerns about domestic violence that was linked to parental substance misuse. Records showed that the social worker implemented a very structured and detailed safety plan with the family. These details included 'what to do' scenarios that were discussed at length with one parent who was the predominant protective factor for children. In parallel, the social worker put together a plan for the children to return to live with both of their parents once Tusla were satisfied that the risks to the children had reduced to an acceptable level. This provided the parents with clear goals and outcomes which could be measured by social workers.

The Midlands service area creatively used child friendly safety plans for children listed on the CPNS. Inspectors reviewed a sample of three cases where social workers created safety plans specifically for children. All plans reviewed had age appropriate drawings and words that set out what being safe looked like and who children could go to in the event of feeling unsafe. In one of these child friendly plans, a safety

object was identified by the child and if this object was moved, then the persons identified to support the children's safety were alerted to check in with the child. Case records showed that social workers or a social care leader met with children on their own, to go through these plans in a way they understood. This was a child centred practice that ensured children knew the reasons for the actions taken and that they were at the centre of plans to keep them safe.

The monitoring of children on the CPNS was good, as social work visits were frequent and proportionate to identified risks. The social work team ensured regular visits to children in their homes took place including unannounced visits, particularly where an assessment of parent's capacity to safeguard children was needed. All cases reviewed as part of the inspection had appropriate monitoring of the safety of children on the CPNS. One of the cases reviewed by inspectors provided a good example of monitoring, and it related to a new-born baby. Records showed that the social worker coordinated frequent home visits - up to 52 separate visits over a six month period, with additional monitoring of the baby's development by a public health nurse. Regular network meetings between the initial and review CPCs assessed if enough progress was being made and the child's safety was being maintained. In another case, a child was living in a place of safety with a relative under a private family arrangement. In this case, the risk was lower and consequently visits were at a frequency of every three weeks. These two cases showed the ability of the service area to respond appropriately and proportionately to the level of risk to children at any given time.

Review CPCs were usually held within the six months following the previous CPC, and played a key role in monitoring the implementation of safety plans. Inspectors reviewed six cases where a review CPC was held. All six reviews took place within the required timeframe and some were scheduled after four or five months. Inspectors found that the progress of actions to reduce risks to children was assessed during these meetings, and appropriate decisions were taken in relation to next steps.

Case supervision was used effectively to ensure the effective implementation of safety arrangements for children listed on the CPNS, and that actions arising out of child protection case conferences were followed through. All social work cases reviewed by inspectors had regular supervision by a social work team leader. It was evident that social work monitoring arrangements were assessed and scrutinised at team leader level and enhanced where needed. Inspectors saw in one case, that supervision was utilised effectively and ensured that regular (almost weekly) home visits and network meetings took place for a child, which provided strong monitoring of the safety plan in place. Overall, case supervision was an effective means in the service area of making sure children on the CPNS received a safe and good quality service.

Children were appropriately de-listed from the CPNS following a review CPCs. Of the five cases reviewed by inspectors which had been de-listed from the CPNS in the six months prior to the inspection, each case had clear rationales for decisions taken to remove a child's name from the CPNS. In one of these cases, safety planning implemented by the social worker with the family, was effective at reducing known risks. While in another cases, children were appropriately admitted to care and therefore were no longer at on-going risk of significant harm.

Inter-agency working was of good quality and ensured information was appropriately shared to support the assessment and planning of interventions for children. Principal social workers and social work team leaders met with corresponding managers in An Garda Síochána, to strengthen working relationships and to clarify working practices. A review of a sample of cases by inspectors showed that network checks with agencies and services were undertaken by social workers between CPCs, to inform all child protection assessments, planning and interventions. Strategy meetings were also used between CPCs, to establish if risks had escalated, and whether prompt action was required to ensure the immediate safety of children. Inspectors reviewed cases where social workers proactively used inter-agency working to promote good safeguarding practice. For example, in cases involving children with a disability, the allocated social worker liaised with all external support agencies to coordinate safety planning and regular home visits. In particular, the social worker made good use of strategy meetings, along with communication via emails and telephone calls to other agencies to ensure actions identified on the child protection safety plan were being progressed. This was good practice.

Standard 2.6 Children who are at risk of harm or neglect have child protection plans in place to protect and promote their welfare.
CPCs were facilitated in a comprehensive manner. Child protection safety plans that were formed at CPCs were consistently of good quality. The implementation of safety planning by social workers was of good quality. In addition, the monitoring of children on the CPNS was good as social work visits were frequent and proportionate to identified risks. Initial child protection conferences were held with some delays in the Midlands service area. While inspectors found that children were safe while awaiting a CPC, given the significant child protection concerns for these children, the scheduling of initial CPCs needed to be timely. It is for this reason that the judgement is substantially compliant.
Judgment: Substantially compliant
Standard 2.7 Children's protection plans and interventions are reviewed in line with requirements in Children First.
Review CPCs were used effectively to monitor the progress of child protection safety plans in line with the requirements of Children First. There were no delays in the convening of review CPCs. Children on the CPNS were appropriately de-listed, and there were clear rationales recorded for the decision to de-list the child.
Judgment: Compliant
Standard 2.9 Interagency and inter-professional cooperation supports and promotes the protection and welfare of children.
The Midlands service area established and maintained strong working relationships between the service and agencies such as An Garda Síochána, Health Service Executive, child and adolescent mental health service (CAMHS), adult mental health services and addiction services. This enabled the sharing of information and the promotion of good safeguarding practices. Interagency working was embedded in social work practice, and was evident on all cases reviewed.
Judgment: Compliant

Compliance Plan for Midlands Child Protection and Welfare Service OSV – 0004422

Inspection ID: MON-0034174

Date of inspection: 07 December 2021

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. The National Interim Policy is under active review and liaison has been on-going with HIQA. In the interim, until the National Policy is finalized, the Midlands will continue to implement the local Area Standard Operating Procedure (SOP) and guidance which ensures that the gaps in the National Interim policy are bridged and the protection of children enhanced.	
Standard 2.6	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. Until the National Revised CPC Guidance is finalised and implemented, the local Area Guidance will be amended to include an emphasis on adherence to timeframes for convening CPCs. A clear rationale shall be documented on NCCIS where this is not possible.	

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	30/04/2022
Standard 2.6	Children's protection plans and interventions are reviewed in line with requirements in Children First.	Substantially Compliant	Yellow	28/02/2022