Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Health Information and Quality Authority Regulation Directorate monitoring inspection of Child Protection and Welfare Services

Name of service area:	National Out of Hours Service
Type of inspection:	Child Protection and Welfare
Date of inspection:	20 – 27 August 2024
Lead inspector:	Hazel Hanrahan
Support inspector(s):	Sharon Moore Saragh McGarrigle Sabine Buschmann
Fieldwork ID	MON-0044340

About this inspection

HIQA 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 national 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 continual improvement so that children have access to better, safer services.

HIQA 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 and the Child and Family Agency.

This inspection was a monitoring inspection of the National Out of Hours Service (OHS) to monitor compliance with the National Standards for the Protection and Welfare of Children (2012). The scope of the inspection included the following standards:

- Standard 1.3 Children are communicated with effectively and are provided with information in an accessible format.
- Standard 2.2 All concerns in relation to children are screened and directed to the appropriate service.
- Standard 2.3 Timely and effective action is taken to protect children.
- Standard 2.5 All reports of child protection concerns are assessed in line with Children First and best available evidence. (Initial Assessment Only)
- Standard 2.12 The specific circumstances and needs of children subjected to organisational and/or institutional abuse and children who are deemed to be especially vulnerable are identified and responded to.
- Standard 3.2 Children receive a child protection and welfare service, which has effective leadership, governance, and management arrangements with clear lines of accountability.
- Standard 5.3 All staff are supported and receive supervision in their work to protect children and promote their welfare

How we inspect

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

The key activities of this inspection involved:

- the analysis of data
- interview with the area manager
- interview with one principal social worker
- interview with three social work team leaders
- interview with one quality assurance manager
- focus group with 24 social workers
- focus group with eight external stakeholders
- the review of local policies and procedures, minutes of various meetings, seven staff supervision files, audits and service plans
- observation of meetings relevant to the standards being assessed
- observation of practice relevant to the standards being assessed this included social workers on duty
- the review of 40 children's case files.

The aim of the inspection was to assess compliance with national standards of the service delivered to children who are referred to the National Out of Hours Child Protection and Welfare Service.

Acknowledgements
HIQA wishes to thank Tusla staff and external stakeholders 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.

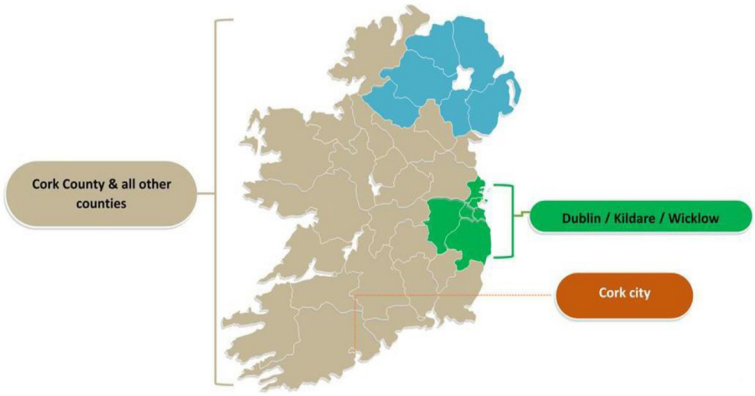
Child and family services are organised into 17 service areas and are managed by area managers. The areas are grouped into six regions, each with a regional manager known as a regional chief officer. The regional chief officers report to the chief operations officer, who is a member of the national management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

Child protection and welfare services are inspected by HIQA in each of the 17 service areas. The National Out of Hours Service provides an emergency child protection and welfare response when required outside of office hours, when service area offices are closed.

Profile of the Service

Tusla's National Out of Hours Social Work Service (OHS) aims to ensure the safety and welfare of children not receiving adequate care and protection in out of hours circumstances. The OHS provides emergency placements for children as required and operates 365 days a year from 6pm to 7am daily and from 9am to 5pm at weekends and bank holidays. However, there are three categories of Out of Hours service operating currently within the country, one for counties Dublin, Wicklow and Kildare, another for Cork city and a third for all other counties - as shown in the Child & Family Agency (Tusla) map below.

NOHS Service Divisions



The OHS assists An Garda Síochána by phone in providing consultation and advice regarding their decision to invoke Section 12 of the Child Care Act[1]. However, only in exceptional circumstances, such as where the child (ren) has suffered extreme trauma and in the best interests of the child (ren), will the local On-Call social worker be called to attend to assist the Gardaí.

The OHS provides a day service called CISP (Crisis intervention Service Partnership). It is a partnership project with Focus Ireland in place via a Service Level Agreement overseen by Children's Residential Services. The service is comprised of three Tusla staff and four Focus Ireland staff. The day service role within the OHS is to:

- follow up on all referrals and placements made by OHS at night-time and at weekends.
- assess requests for monitoring home visits for the Dublin Wicklow and Kildare area during weekends and bank holidays.
- link the child and family to the local area team for follow-up on the next working day and ensure an immediate response to serious situations.
- confirm that move-on plans are agreed upon with the area teams to ensure that a young person's stay in emergency placement is as time-limited as possible.
- respond to requests for emergency foster care placements when all options within the areas have been explored, and they cannot identify a placement. Options for emergency residential care are limited, and if there is a vacancy in Crisis Intervention Service (CIS) emergency residential centres, a request can be made to the centres via the day service to access the placement.

[1] Where a member of the Garda Síochána has reasonable grounds for believing that (a) there is an immediate and serious risk to the health or welfare of a child, and (b) it would not be sufficient for the protection of the child from such immediate and serious risk to await the making of an application for an emergency care order by a health board under Section 13, the member, accompanied by such other persons as may be necessary, may, without warrant, enter any house or other place and remove the child to safety.

There are some critical standard national components of OHS:

- Access to the national Emergency Fostering Support Service (EFSS) - a phone based Out of Hours emergency support service.
- The management of the Mandated Person's line Out of Hours.
- Access to the Child Protection Notification System Out of Hours[2].

[2] The CPNS is a secure database that contains a national record of all children who have reached the threshold of being at ongoing risk of significant harm and where there are ongoing child protection concerns. The list helps to support professionals such as An Garda Siochána, make decisions about the safety of a child.

Compliance classifications

HIQA will judge the service to be **compliant, substantially compliant or not-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 report sets out the findings of a monitoring inspection against the following standards:

Theme 1 : Child-centred Services	
Standard 1.3	Children are communicated with effectively and are provided with information in an accessible format.

Theme 2. Safe and Effective services	
Standard 2.2	All concerns in relation to children are screened and directed to the appropriate service.
Standard 2.3	Timely and effective action is taken to protect children.
Standard 2.5	All reports of child protection concerns are assessed in line with Children First and best available evidence.
Standard 2.12	The specific circumstances and needs of children subjected to organisational and/or institutional abuse and children who are deemed to be especially vulnerable are identified and responded to.

Theme 3:Leadership, Governance and Management	
Standard 3.2	Children receive a child protection and welfare service, which has effective leadership, governance, and management arrangements with clear lines of accountability.

Theme 5: Workforce	
Standard 5.3	All staff are supported and receive supervision in their work to protect children and promote their welfare.

This inspection was carried out during the following times:

Date	Times of inspection	Inspector name	Role
20/08/2024	11:00hrs to 17:00hrs	Hazel Hanrahan	Lead Inspector
20/08/2024	10:00hrs to 17:00hrs	Saragh McGarrigle	Support Inspector
22/08/2024	14:00hrs to 21:00hrs	Hazel Hanrahan	Lead Inspector
22/08/2024	14:30hrs to 21:00hrs	Saragh McGarrigle	Support Inspector
22/08/2024	14:30hrs to 21:00hrs	Sharon Moore	Support Inspector
22/08/2024	14:00hrs to 18:00hrs	Sabine Buschmann	Support Inspector
23/08/2024	14:00hrs to 23:00hrs	Hazel Hanrahan	Lead Inspector
23/08/2024	17:30hrs to 23:00hrs	Saragh McGarrigle	Support Inspector
23/08/2024	14:00hrs to 18:00hrs	Sharon Moore	Support Inspector
23/08/2024	14:00hrs to 17:00hrs	Sabine Buschmann	Support Inspector
24/08/2024	10:30hrs to 13:00hrs	Sharon Moore	Support Inspector
26/08/2024	09:30hrs to 11:00hrs	Saragh McGarrigle	Support Inspector
27/08/2024	12:00hrs to 13:00hrs	Hazel Hanrahan	Lead Inspector
27/08/2024	11:00hrs to 17:00hrs	Sharon Moore	Support Inspector

Children's experience of the service

Children's experiences were established through the review of case files, complaints and feedback also provided evidence on the experience of children in receipt of a child protection and welfare service.

Hearing the voice of children is very important in understanding how the service worked to meet their needs and improve outcomes in their lives. Due to the sensitive nature of the experiences of children who have to navigate through the child protection and welfare services pathway, it was determined, that a review of their case files would provide an insight into their experiences and lessen any further distress.

Although, there was a culture within the service that valued children's participation rights, the service was primarily responding to emergencies. There was limited practice of staff using participatory tools, where appropriate, when speaking with children to gain their views so that they were heard. The OHS promoted a child's right to be heard through the use of interpreters to facilitate communication. Two cases of children seeking international protection were reviewed where the service used an interpreter via telephone. This provided a space for the child to provide information about their lived experience but to also understand what information they were being given by Tusla. However, the services complaints register indicated that no complaints had been received from a child to the service. Inspectors found three complaints made by children but these were not categorised appropriately. Although the OHS team provided a safe space for children to raise a concern, the team failed to identify that the disclosures made by children were complaints. There was reliance on written communication that was not tailored to the needs of this vulnerable cohort of children. As a result, vulnerable children were faced with barriers to being heard and to having the right to be supported to access and participate in a complaints process tailored to their needs.

From a review of case files, inspectors found no evidence that tailored communication methods were used for children with speech, language and communication needs to participate in decisions impacting their care The voice of children with additional needs or a disability had become lost in the OHS system. The overall practice within the service in promoting the participation rights of children was not consistent and not in line with Tusla's *'Child and Youth Participation Strategy 2019 – 2023'*.

In relation to children placed in special emergency arrangements (SEA), there was mixed practice found of OHS social workers meeting with the child in person. Of the four cases reviewed, only two of the children had been met with by a social worker. However, when a social worker did meet with the child there was good record of interactions on the child's file where it was explained the reason for the child being placed in the SEA. These four cases were broken down into one child seeking international protection, two placement breakdowns and one emergency placement request.

Some good practice was found in the OHS staff capturing how they listened to the voice of the child. In one case a child contacted the service as they did not feel safe at home. The child was provided with a safe space for their views to be heard to understand their lived experience and effective action was taken to support them. In a second example of a new born baby, consideration was given to their best interests in terms of a suitable placement and OHS ensured that all relevant information that included feeding routine was shared with the foster carers.

When children had experienced crisis situations in their life and required the assistance of the OHS, the team took immediate protective action. For example when a baby needed an immediate placement, the OHS immediately made contact with a private foster care provider to secure a placement that would meet the needs of the baby. While improvements in practice is required, as outlined in this report, generally children received an immediate response when required.

Capacity and capability

This report reflects the findings of the inspection of the Child Protection and Welfare service provided by the National Out of Hours service, through the national call centre team based in the Dublin Office. The inspection focused on seven child protection and welfare standards.

In this inspection, HIQA found that, of the seven national child protection and welfare standards assessed:

- Four standards were not compliant
- Three standards were substantially compliant

Governance of the OHS service was poor and required significant improvement. There was a lack of strong leadership in setting the strategic direction of the service and for the planning, prioritising and monitoring of progress. There was an absence of clear expectations and clear lines of responsibility of roles within the service for improving outcomes for children and young people. The service was not operating under Tusla's existing governance and information systems to allow for the monitoring of performance and improvement. This practice did not assist in holding leaders to account. Risk management systems were weak and did not promote the identification, evaluation and prioritisation of all service risks to ensure that appropriate action was taken to mitigate against them. The impact was the service was reactive rather than proactive in meeting the emergency needs of vulnerable children and young people accessing Tusla out of hour's service. It also impacted on the ability of Tusla to ensure staff received regular and effective supervision and support to promote the safe delivery of the service.

Managers had introduced some methods to improve its governance and oversight however, some of these measures had only been introduced prior to the commencement of the inspection. Therefore, these new methods were at the early stages of implementation, so it was not possible to assess their effectiveness. Despite the challenges, management had ensured that vulnerable children who were referred to the service were assessed and emergency action and intervention measures taken when required. This included the placement of children in an emergency placement and or speaking with children in care who contacted the service directly to prevent placement breakdown.

The data provided by the OHS in advance of the inspection indicated that the service received 1,120 referrals from December 2023 to August 2024. This was broken down into the following regions:

- Dublin Mid Leinster Region: 388
- Dublin North East Region: 356
- Mid-West Region: 68
- South East Region: 115
- South West Region: 98
- West North West Region: 95

The OHS commenced operation in 2015 and was overseen by the Dublin North East (DNE) Regional Chief Officer, until May 2024. This structure saw the principal social worker report directly to the Regional Chief Officer until 2022. In 2022, Tusla established a new area manager position and a new structure was established. The principal social worker reported directly to the area manager, who in turn reported to the DNE Regional Chief Officer. Whilst this new governance structure was in place no review was undertaken by the Regional Chief Officer that provided assurances that this structure was and continued to be effective. In June, 2024, Tusla had changed the governance structure of the service further by establishing a separate National Director for the OHS. This new position replaced the area manager reporting to the Regional Chief Officer. Instead the area manager reported to the new National Director.

The service was managed by an area manager since 2022 and they had focused their initial attention on the financial governance of the service. The area manager while working with Tusla in a full-time capacity, could only devote part of their time to this service as they also had other functions which they were responsible for. The area manager told inspectors that the OHS had *'operated under the radar' and* that *'staff had seen that they are outside Tusla processes and framework'*. The area manager and staff told inspectors that the remit of the OHS was vast and there was a lack of clarity as to what the purpose and function of the OHS was. Despite a review undertaken into the service in March 2023, the challenges echoed by staff and management continued to remain. Even though Tusla had developed a proposed revision of the service purpose and function. Tusla have statutory responsibilities for the delivery of children's services and providing corporate leadership to champion the needs and improved outcomes for children and young people. Tusla has a crucial role to ensure that services are supported to fulfil their role however, this was slow to materialise.

The service is divided into four teams with three shifts per team to cover the operational hours. The teams were broken down as follows:

- two teams that consisted of three senior social worker practitioners and five social workers;
- one team consisted of two senior social work practitioners, six social workers and one social care worker; and
- the fourth team was the national out of hours day service named the Crisis Intervention Service Partnership (CISP). This team consisted of one social worker, one social care worker and four Focus Ireland staff members.

Each team was overseen by a dedicated social work team leader. All social work team leaders reported to the principal social worker. The principal social worker reported directly to the area manager. From observations and interviews with staff inspectors found that the teams were working in isolation to one another and relied on handover documents and emails for the transfer of information across the service. Staff told inspectors that the night service and day service were isolated teams that did not interact in person. Upon review of the rota, inspectors found that the principal social worker had not been rostered to work nights or weekends to support the monitoring of the service. Staff and managers told inspectors that the service operated a blended working model where staff or the social work team leader would work from home. Inspectors found that there was no consistent practice guidance in place and that each social work team leader had or were in the process of developing one tailored to their teams. The impact was there was no direction or leadership from senior management in the delivery of the service. There was no evidence that the principal social worker or the area manager undertook a review of this practice model to ensure that it was meeting the needs of the service. In effect, there was a lack of direction and leadership from senior management. There was a culture instilled in the service where practice was not being documented by management at all levels. The area manager told inspectors, review of case records by management, including their own role, was not being recorded. As a result, there was an absence of oversight of records by management.

Management provided poor leadership in commencing the development of a Service Improvement Plan (SIP), in light of Tusla's review into the service in March 2023. The aim of the Tusla review was to develop options for a revised operating model for the OHS that included a 24-hour/7-day-a-week provision. Tusla documented that it was required because there are *'daily gaps in Tusla's service between 7am to 9am and 5pm to 6pm and three different systems of service provision across the country'*. The findings from the review documented that:

- the role of the service had *'become more blurred in recent years … which had led to a lack of consistency and clarity and, at times, increased frustration between services'*
- Tusla should provide 24-hour nationwide coverage with no gaps in service delivery
- there was a lack of suitable alternative care placements and that placements should be available within each region
- training should be provided for staff not working directly in child protection to assist with risk management and emergency child protection assessments
- hubs should be established around the country to provide a safe and appropriate location where children could be brought for a face-to-face assessment or as a temporary place of safety.

Management told inspectors that the HIQA inspection prompted the development of a SIP, one year after the Tusla review. Prior to this, the area manager, regional quality assurance manager and principal social worker told inspectors that a local SIP had never been introduced or discussed. No meaningful interim measures were put in place to address the gaps identified from the Tusla review in order to support safe practice in the service. The transformation needed to improve the service could not be achieved because it was lacking effective direction and monitoring of its progress.

The service had 30 actions listed on their new SIP, all of which were related to the remit of the inspection. Some of these actions were; to clarify a policy on use of interpreters, to include a summary of assessment paragraph at the end of case notes, develop an audit schedule, develop an audit tool for out of hours files, risk register to be added to the Tusla online risk register and line managers to develop personal development plans with their staff. Management approach to the development of the local SIP had not taken into account the OHS business plan 2024 which stated that the recommendations from the Tusla National review 2023 of the service would *'inform specific actions for 2024 and beyond'.* Action from senior management was reactive and no time was taken to conduct an analysis of data and obtaining feedback from staff to understand what was working well, and what needed improvement. Staff told inspectors that they were not consulted as part of the development of the local SIP. The management approach was not in line with the OHS Business Plan 2024 goal of *'delivering an independent regulatory service focused on the safety and wellbeing of children and young people through continuous improvement and partnership with stakeholders'*.

The quality and effectiveness of senior management meetings, service plan meetings and team meetings required improvement across the service. Inspectors reviewed the minutes of these meetings and found that improved focus on action planning and using data to help inform service improvement planning was required. For example; it was documented in the April 2024 service plan meeting that a working group would be formed to find gaps in the service however, at the time of the inspection this action had not been progressed from the discussion phase as stated by the principal social worker. In addition, in June 2024 service plan meeting, a commissioned service was to develop a 'daily log' to report their interactions with children placed in special emergency arrangements. However, this had not materialised when HIQA commenced the inspection. For both of the examples provided these matters did not translate over into management or team meetings for further review. Inspectors observed a team meeting and found that there was a clear structure to review actions from previous team meetings that allowed for information to be shared with the team. However, these meetings focused largely on the sharing of information and lacked discussion on the identification of key risks and how to address difficulties experienced by the team. For example; in securing placements for children. These forums did not support managers and staff to examine a range of data that supported their understanding of practice in the service. Staff told inspectors that they were not supported to have a voice and for their concerns about service delivery to be meaningfully taken on board.

National Approach to Practice

Data provided to HIQA prior to the inspection indicated that the service had received 167 requests, in the previous eight months, from service area social workers to assist in the monitoring of a safety plan for a child. Inspectors found that the implementation of Tusla's national approach to practice required further improvement. The OHS team had stopped using Tusla's national approach to practice since the service transferred to the new case management system, TCM in November 2023. Leadership required strengthening as there was a lack of knowledge and slow progress made by managers to embed the national approach into practice in the eight months prior to the inspection. The area manager said to inspectors that they *'had not seen evidence of the national approach'* being used in practice within the teams. In addition, the principal social worker said to inspectors that the national approach to practice was *'not being used on a regular basis'* by the teams. Upon review of children cases files, inspectors found that the national approach to practice was not being recorded on the Tusla case management system, TCM, under the required formats. However, elements of the practice could be seen in case notes. There was an absence of guidance and leadership from managers to support staff in implementing Tusla's national approach to practice. The Area Manager told inspectors that they had made contact with practitioners assigned as Tusla practice leads to support the OHS on

how best to implement the approach. However, there was no plan or timescale yet in place as to when this would commence.

Risk Management

Risk management was extremely poor which left the service exposed to an unacceptable level of risk in relation to poor governance. This impacted on other aspects of service delivery that included quality assurance and information governance. Management lacked the knowledge of risk management practices, good governance and accountability arrangements that would provide the structures, processes, training and other supports needed to implement *'Tusla's Organisational Risk Management Policy 2022'.* Management were not aware of Tusla's risk management policy to support the identification and management of risk within the service. The impact was that management were not carrying out risk assessments to identify potential risks or how they would manage these risks. For example, where poor practice in the completion of garda vetting forms was identified, the potential risk of harm, the likelihood of it reoccurring nor the consequences of the risk were not assessed. In addition this risk was not identified as a risk or placed on the risk register by management. Although, management had introduced limited control measures, such as training, to manage the risk, no evaluation of the risk was undertaken to understand whether the risk had reduced or if further alternative control measures were required. The level of understanding of risk by staff required significant development.

The risk register was not effectively used as the management team had not identified all risks the service faced that included garda vetting, children missing from care as documented in the RORMSIC meetings, information governance, complaints and allegations, monitoring and oversight. There were six items documented on the service risk register. These risks were previously held on the regional risk register in DNE, as a collective risk, for the region before the transfer to the new service director in June 2024. This included the management of SEA's, lack of placement options, and compliance with section 12 of the Child Care Act 1991, impact of lack of Health Service Executive placements and Violence Harassment and Aggression against staff. Five of these risks were placed on the register in 2024 with one placed on the register in 2023. No risk ratings were used by management to help identify the most critical risks to the service and the control measures in place to reduce the likely impact on service provision were absent.

The OHS was part of the Regional Operations Risk Management and Service Improvement Committee (RORMSIC) meetings under the DNE service area. Although these meetings occurred on a regular basis, risk management was absent in discussions related to the OHS. Inspectors reviewed the minutes of these meetings and found that discussions were documented on the impact of the

national review of the service. In addition, discussions took place related to the increase of children missing from care, that information of children placed in SEA's was not up-to-date on Tusla case management system, TCM. Information provided to these forums was solely reliant on the area manager with no input from the regional quality assurance team. The regional quality assurance manager told inspectors that the OHS *'was not part of the area structure'*, that the service were *'brought in where needed'* and that management attendance at RORMSIC was '*tokenistic and more from a learning point of view'*. The meeting was not used to determine the impact of each risk to the service and how to mitigate against these. In relation to the OHS, the RORMSIC meetings were not effective for the service as they did not monitor, address gaps in service provision or validate data in relation to service delivery.

Under the new service director, who commenced in June 2024, a RORMSIC forum had been newly established however, it was too early to determine whether its effectiveness had been strengthened.

Special Emergency Arrangements

Significant strengthening of the *'National Standard Operating Procedure – Special Emergency Arrangements'* (National SOP) by the service was required to ensure strong levels of governance and oversight of these arrangements. The National SOP was implemented on the 10 July 2023. The OHS use special emergency arrangements (SEA) [3] in the form of hotels, to ensure that children who need an immediate placement that could not be sourced in fostering or a regulated children's residential centre could be accommodated. There was an absence of evidence that the approval of SEA's was authorised by the DNE Regional Chief Officer. The area manager and regional QRSI manager told inspectors that the approval of SEA's was not put in written format but was conducted in an adhoc manner on a weekly basis. This practice was not in line with the National SOP as the SEA approval request form was not used nor was a decision approval letter sent to the area manager along with the Service Provider Agreement. The OHS were working outside the confines of the national SOP. This is a particular concern given that the service was using hotels in Dublin, which had not been risk assessed, nor reviewed to ensure that they provided a safe place for children. Staff told inspectors that hotel accommodation was sourced by the service on a weekly basis and that risk assessments were completed. However, inspectors reviewed cases where children were placed in hotels and did not find evidence that these risk assessments had been completed prior to their placement. Furthermore, the practice by management, in the continued use of SEA's did not

[3] Tusla National Standard Operating Procedure for Special Emergency Arrangement (SEA) refers to emergency settings where a child/young person is accommodated in a non-statutory and/or unregulated placement e.g. Hotel, B&B, Holiday Centre, Activity Centre, Tusla property, Privately Leased property.

ensure a process of continuous improvement in line with Tusla's Business Plan 2023 Strategic Goal 1: Objective 1.1 that *"100% of Special Emergency Arrangements will be approved and governed in line with Tusla Standard Operating Procedure for Special Emergency Arrangements (SEA)".*

The area manager and principal social worker said to the inspector that the announcement of the HIQA inspection prompted the management team to develop a local SOP. The local SOP needed further improvement to come into compliance with the National SOP in order to ensure that the checklist requirements were undertaken. Previously, the teams were working without written practice guidance. As a result, management could not ensure that there was consistent and safe practice across teams as there was a lack of support for staff to understand their role and responsibilities. In addition, there was an absence of monitoring of SEA arrangements across all levels of management. It was the view of the OHS management team that the service areas held overall responsibility for SEA arrangements. However, as outlined in the national SOP, the overall responsibility for the child and or young person placed in a SEA arrangement *"remains with the placing area and region".* Given that the OHS was placing children in hotels prior to the service areas being aware of this, the safety of the SEA in the first instance should have been established by the placing service. Therefore, this responsibility remained with the OHS, but management had not followed this.

The risks associated with poor governance on the use of SEA's was escalated to the area manager, through an Urgent Compliance Plan, to provide assurances that effective levels of governance and oversight of these arrangements would be appropriately managed.

Information Governance

Prior to the inspection, HIQA requested data from the service on a range of areas to gain insight into how the service was performing. Management could only provide limited information as they did not have the necessary systems in place to capture such data. For example; the number of children about whom multiple referrals have been made, requests received to access the CPNS Out of Hours and children with a disability. This raised concerns that management could not measure the impact the service was having, how efficient the systems and processes were or where and how the service needed to be improved, or whether the capacity of the service was adequate, or indeed over-resourced. Information governance structures and practices required significant improvement. Roles and responsibilities were not clearly defined and how data was managed was not overseen by the management team. There was a culture within the service of information not always being used, shared or stored on the relevant systems.

The national call centre model did not provide an effective information governance system. Where complex or crisis phone calls were received to the service, there was no live call listening technology in place that would send an alert to the social work team leader to let them know that support for staff was required. Instead, staff and managers told inspectors that managers would try to listen to phone calls by sitting beside the social worker because they did not have the technology. As a result, management and staff told inspectors that phone calls had to be ended so that advice and support could be sought. This advice was then written down on paper and not officially recorded on Tusla's case management system, TCM. The service was not equipped with the required software to better manage inbound and outbound communication in the service as it lacked the capabilities of a call centre operation.

The OHS operated a system of recording incoming phone calls and enquiries manually, by writing it down on paper on a pro forma template. When a phone call was made to the OHS the initial contact was not taken by a social worker but it was triaged by an administration person. The administrative person would take basic information to establish the current situation to ensure that the social work team leader had all the relevant information to make a decision around whether an intervention or further enquiries were needed. However, this information was not securely placed on Tusla case management system, TCM, instead a paper record was handed to the relevant team leader. Once the social work team leader had reviewed the information, they wrote additional notes, assigned a social worker to the case, and this paper record was passed to them. In addition, inspectors observed that no call log was kept by the service and that not all referrals received were sent through the assigned route. For example; inspectors found, through case file reviews and interviews, that not all referrals or requests received by email to management were logged on the child's file or effectively tracked. This in effect did not provide an effective system for referrals that ensured that information was handled appropriately at each stage, to minimise risks.

There was an absence of clarity as regards roles and responsibilities for safely managing information on children throughout their involvement with the service. This included staff and managers understanding of their part in maintaining information integrity.

The OHS used Tusla's information system, TCM, however, it was not designed to collect and report on data about the service. Management were only required to report on specific data nationally, that included the number of referrals received, the number of children placed, and the number of nights of placement. This data was collected manually by the OHS up until November 2023 when it then ceased. Tusla had documented in its published monthly data reports for quarter 2 2023 that this area was under development. Management therefore were not able to

track key metrics to gain valuable insights into the effectiveness of the service and make decisions to drive continuous improvement.

The risks associated with poor information governance, in particular the management of calls and referrals coming into the service required significant improvement and the recording of information and decisions pertaining to children was escalated to the area manager, through an Urgent Compliance Plan, to ensure that effective levels of governance and oversight of these arrangements would be appropriately managed.

Audits

There was no schedule of audits planned for 2024 for the OHS, nor were there any audits undertaken within the service since its commencement in 2015. The area manager told the inspector that this was due to the OHS not being part of Tusla's strategic approach for 2024 in the management of cases awaiting allocation to a social worker. As a result, no audits had commenced on children's case files to monitor and review practice, no audits had been carried out on the implementation of the national approach to practice even when this had been identified as an area for improvement. In addition, where poor practice had been identified in the completion of Garda Vetting forms no audit or review had been carried out to ensure that practice had improved and the risk had decreased. Managers did not understand their quality assurance roles and responsibilities and that they had a role to play in improving quality. Management were not aware of the existence of *'Tusla's Quality Improvement Framework'* that provided guidance on best practice for embedding quality improvement in the service and tools the tools to use to assess quality and make improvements.

Complaints

Significant improvement was required in the identification and management of complaints made by children to the OHS. There was an absence of procedures and child centred practices in place. Inspectors reviewed the complaints register where there was one complaint documented, made by an external professional. Data provided by the service to HIQA prior to the inspection, indicated that no complaints had been received from a child and that one complaint had been received from a professional. However, upon review of a sample of case files by inspectors, three complaints were found that were made by children but these were not categorised appropriately. These complaints related to dis-satisfaction with advice provided by the OHS, care provided by care staff and social worker and not being happy with their placement. Although inspectors found that the OHS team provided a safe space for children to raise a concern, the team failed to identify that the disclosures made by children were complaints. There was a lack of consideration by the OHS of the barriers that may be encountered by children expressing their views freely. The system in place was not effective and did not

allow for complaints to be made by children in a verbal format. There was reliance by the service on written communication that was not tailored to the needs of this vulnerable cohort of children accessing the OHS. The impact, was that vulnerable children who accessed the service were faced with barriers to being heard and to having the right to be supported to access and participate in a complaints process tailored to their needs. Managers told inspectors that complaints made by children to the service had been and would be passed to the service areas.

The risks associated with poor management of complaints by children was escalated to the area manager, through an Urgent Compliance Plan, to provide assurances that effective levels of governance and oversight would be appropriately managed.

Supervision

The quality of supervision varied significantly across teams and was not streamlined in terms of standardised formats used. Staff told inspectors that they did not receive supervision on a regular basis and that case supervision *'is done on real time'.* Managers told inspectors that due to the rota schedule, it was difficult to have regular supervision with staff. As a result, managers could not ensure that they could implement Tusla's national policy, provide regular support or hold their staff to account. Upon reviewing supervision files, inspectors found the quality of supervision across teams was poor in terms of agenda items discussed and the recording of the meeting. There was an absence of recording by supervisors of discussion and oversight of cases and the rationale for decisions. It was not always clear what was needed to be progressed in terms of actions and where actions were identified there were no timeframes in place for completion. Supervision records reviewed showed an absence of discussions with staff on the identification of service risks, quality assurance activity and clarification on the role that each staff member and team play. There were examples of good practice of tackling performance issues across the service where supports were put in place for staff such as training and referral to Employee Assistance Programme (EAP). In addition, managers had availed of advice from other Tusla Human Resource department to how best to navigate the performance issue. Staff told inspectors that management were supportive, there was an *'open door policy'* and were available anytime that staff required their assistance.

Inspectors found that professional development plans (PDP's) had been recently completed for all staff whose supervision records were reviewed. However, staff told inspectors that it had been *'a couple of years since they did the previous one'* or that it was their *'first time doing it'*. It is not known how the PDP's would be effectively managed against the backdrop of a day and night rota system. Staff told inspectors that training *'can be a struggle'* and that it *'can be tricky to arrange training'.* The area manager told inspectors that they were aware of the challenges

related to facilitating training and that this was being reviewed. Inspectors found that some training had been undertaken in 2024 that included leadership training had been provided to management, child sexual exploitation training, case management , TCM, training and complaint handling training. However, the impact remained that in setting PDP goals for staff, management could not meaningfully map out actionable steps for continuous growth and development. Given that this service was operating since 2015 – the lack of strategic actions in resolving this difficulty was a concern, especially since as an emergency service, training and development for these particular staff members should have been a significant priority in order to equip them with the tools required to manage an emergency service effectively.

Inspectors asked to review the induction programme that the service had in place to support new staff joining the team. Inspectors found that there was no official induction programme in place for the OHS, apart from Tusla overall national induction plan. Staff told inspectors that the induction programme in the service was *'general building induction'* that allowed new staff to observe and shadow existing staff. Inspectors found that this practice required significant improvement. There was no official written guidance in place that had goals and learning identified to support the new staff to learn their new role.

Documents related to the supervision between the regional chief officer and the area manager were provided to inspectors and it was found that it had occurred four times in an eight month period. From review of records, inspectors found that supervision did not promote effective oversight and accountability of the risks affecting the service, review of governance structures and the implementation of processes, and procedures to effectively and systematically deliver a high quality, safe service.

Tusla Practice Assurance and Service Monitoring Team who is responsible for the internal quality assurance of all Tusla services in accordance with the Agency's Quality Improvement Framework, undertook an audit, on the 23 July 2024, into the quality of supervision prior to HIQA's inspection of the service. The PASM team conducted a review of staff supervision within the service in response to a request from the Service Director. This was the first audit the PASM team had undertaken since the service commenced operation.

Quality Assurance Team

The DNE region had a quality assurance team in place where the regional quality assurance manager provided only advice to the OHS. This support and advice ceased in May 2024 when the OHS transferred to the new National Director. The practice of providing only advice to the OHS did not foster a culture of constant ongoing improvement to monitor and improve quality. As a result, there was a

lack of policies, procedures and processes in place to guide staff in the day-to-day delivery of the service. This meant, the systems in place to support staff to meet the needs of vulnerable children or for managers to adequately monitor the service, were inadequate. Management had not identified the impact this risk had on vulnerable children and young people receiving a safe, effective service.

The case management system was not effectively designed to capture a range of data. The regional quality assurance manager understood their role to be *'advisory'* to the management of the OHS. There was a lack of understanding from both regional and management in OHS of what quality improvement was and how their roles contributed to the overall objectives of improving quality in the service. There was a disconnect between the regional team and OHS working in partnership to embed quality improvement in the service. The OHS was described as a *'standalone'* service by management and staff. The principal social worker said to inspectors that the OHS *'did not get the same support as service areas'* from the regional quality assurance team. There was little to no guidance from the area manager in the development of a quality assurance strategy. There was an absence of leadership by the area manager to ensure that the advice provided by the QRSI manager supported a continuous cycle of improvement in the service. At the time of the inspection the OHS had no quality assurance team in position and there was no indication of the next steps by senior management.

The OHS team showed great passion and determination in their role to provide a safe service to children who had found themselves in emergency crisis situations. It was acknowledged by management that improvements were required in the service however, the extent of the improvements needed to address the poor governance and risks identified could not be strengthened without the support and guidance of Tusla senior management.

Standard 3.2
Children receive a child protection and welfare service, which has effective leadership, governance, and management arrangements with clear lines of accountability.

Tusla conducted a review into the service in March 2023 and developed a proposed revision of the service purpose and function. However, there was a lack of clarity as to what the purpose and function of the OHS was and challenges continued to remain in understanding the remit of the service.

There was a culture in the service where practice was not being documented by management at all levels. Management provided poor leadership in commencing the development of a Service Improvement Plan (SIP). In light of Tusla's review into the service in March 2023 no meaningful interim measures were put in place

to address the gaps identified from the Tusla review in order to support safe practice in the service. The quality and effectiveness of senior management meetings, service plan meetings and team meetings required improvement across the service. Improvement was required on management using data to help inform service improvement planning and focused action planning. These forums did not support managers and staff to examine a range of data that supported their understanding of practice in the service.

The implementation of Tusla's national approach to practice required further improvement. The OHS team had stopped using Tusla's national approach to practice since the service transferred to the new case management system, TCM in November 2023. Leadership required strengthening as there was a lack of knowledge and slow progress made by managers to embed the national approach into practice in the eight months prior to the inspection.

Risk management was extremely poor which left the service exposed to an unacceptable level of risk in relation to poor governance. This impacted on other aspects of service delivery that included quality assurance and information governance. Management lacked the knowledge of risk management practices, good governance and accountability arrangements. The risk register was not effectively used as the management team had not identified all risks the service faced.

Significant strengthening of the *'National Standard Operating Procedure – Special Emergency Arrangements'* (National SOP) by the service was required to ensure strong levels of governance and oversight of these arrangements. There was an absence of evidence that the approval of SEA's was authorised by the DNE Regional Chief Officer. This practice was not in line with the National SOP. There was an absence of monitoring of SEA arrangements across all levels of management. It was the view of the OHS management team that the service areas held overall responsibility for SEA arrangements.

Information governance structures and practices required significant improvement. Roles and responsibilities were not clearly defined and how data was managed was not overseen by the management team. There was a culture within the service of information not always being used, shared or stored on the relevant systems.

Improvement was found to be required by the OHS to strengthen the effective implementation of the *'Tusla and An Garda Síochána Children First – Joint Working Protocol for Liaison between both Agencies'* in relation to the identification and completion of formal notifications of suspected cases of abuse to An Garda Síochána in a timely manner.

No audits were being undertaken by the service.

There was an absence of leadership by the area manager to ensure that the quality assurance team were working to embed a continuous cycle of improvement in the service. The regional quality assurance team had underperformed in their roles, with lack of clear leadership and skills in the area. At the time of the inspection the OHS had no quality assurance team in position and there was no indication of the next steps by senior management.

Judgment: Not compliant

Standard 5.3
All staff are supported and receive supervision in their work to protect children and promote their welfare.

The quality of supervision varied significantly across teams. Staff did not receive supervision on a regular basis due to the rota schedule. As a result, managers could not ensure that they could implement Tusla's national policy, provide regular support or hold their staff to account. There was an absence of recording by supervisors of discussion and oversight of cases and the rationale for decisions. Supervision records reviewed showed an absence of discussions with staff on the identification of service risks, quality assurance activity and clarification on the role that each staff member and team play.

Professional development plans (PDP's) had been recently completed for all staff. Management could not meaningfully map out actionable steps for continuous growth and development against the backdrop of a day and night rota system. Given that this service was operating since 2015 – the lack of strategic actions in resolving this difficulty was a concern. There was no official induction programme in place for the OHS, apart from Tusla overall national induction plan and this required improvement to support the new staff to learn their new role.

Judgment: Not compliant

Quality and safety

Overall, the OHS provided a timely emergency response to children when a referral was received to the service. However, inspectors found that the quality and safety of the OHS service required improvement. All of the cases reviewed were screened and prioritised on the same day to effectively consider whether further enquiries were required to determine if a child or children were in need of emergency care and protection. Good practice was found where the immediate consideration was given to the safety of the child and whether action was required to urgently respond. There was good practice in the OHS determining if there was sufficient safety present within the family and their network. The OHS use of child friendly tools to speak with children, where appropriate, was limited. The use of safety plans to protect children needed strengthening. There was poor practice in the recording and storing of information related to the next steps and decisions made by the social work team leader on actions that needed to be completed. For children placed in SEA's, there was poor safeguarding practice from the OHS. There was no duty on the care staff provider to submit reports to the service of children placed in SEA's, to give an update of the child's ongoing circumstances. Gaps were identified in the OHS role and responsibilities regarding the handling of complaints made by children. The OHS did not provide an accessible, safe, effective and child-centred complaints mechanism for vulnerable children. Further improvement was required from the OHS when placing a child into a family care arrangement after a Section 12 was invoked by An Garda Síochána. There was no evidence on Tusla case management system, TCM, of the OHS social worker having completed the family care arrangement form and that all safeguarding checks were undertaken to confirm the identity of the adults caring for the child. It was also found that there was inconsistency in practice from the OHS in the management of children who went missing in care. The lack of oversight and management of this key area of risk was escalated to the principal social worker for further assurances.

These issues outlined above had an impact on the quality and safety of the service provided to children.

Inspectors reviewed 40 children's case files on this inspection. The files sampled included, children seeking international protection, children missing from care, monitoring of safety plans, complaints, children placed under Section 12 of the Child Care Act and children placed in special emergency arrangements.

Of the 40 children's case files, all 40 of these were reviewed for the purpose of determining the quality of practice of the service in implementing Children First, and the National Standards for the Protection and Welfare of children. Tusla

process for ensuring compliance with Children First and Standards, is through their standard business processes (SBP) which outlines the steps to be taken when screening referrals. When a referral is received to Tusla OHS that indicates concerns for a child's safety and or wellbeing, Tusla have 24hrs to determine what type of response is required. Professionals, children, adults or family members and members of the public make contact through a variety of sources and by a variety of methods, including written referrals, via the phone, via email or via the Tusla portal. Inspectors found that there was a disconnect between OHS and the integration with Tusla's national approach to standard business processes for the management of child protection and welfare concerns. The OHS staff and managers described the service as an emergency service and a separate entity from Tusla child protection and welfare services. As a result, the OHS was not implementing the national standard business process in practice and there was a clear lack of knowledge and understanding of terminology used within the SBP guidance. However, of the 40 case files reviewed, inspectors found that all of these were screened and prioritised on the same day to effectively consider whether further enquiries were required to determine if a child or children were in need of emergency care and protection. Where a report to the service did not require a child protection and welfare intervention, consideration was given to other supports that could be provided. For example; where a placement provider contacted the service seeking assistance about a child in care attempting to abscond, the OHS staff provided a safe space for the child to talk through their concerns, de-escalated the situation and prevented a missing in care incident.

Once the screening was commenced, social workers began their investigations by conducting initial checks through Tusla case management system, TCM, to determine whether the child or family was known or had previous involvement with services provided by Tusla. Inspectors observed the work of the OHS team and found that this practice was undertaken. For example; inspectors observed contact made by an OHS staff from an airport where they had met with a child seeking international protection. Discussions were had with the social work team leader who undertook checks on the system. In a case reviewed by inspectors, a referral was received from the hospital related concerns for a parent ability to care for their newborn baby. The OHS social worker undertook a home visit to speak with the mother and observe the baby. The OHS social worker also spoke with the mother's extended family to gather information to assess the risks and protective factors.

Inspectors also observed that there was good practice where the immediate consideration was given to the safety of the child and whether action was required to urgently respond. Inspectors observed requests from areas to the service were reviewed by the social work team leader before being assigned to a social worker. Inspectors observed social work team leaders conduct checks on Tusla case

management system, TCM, to gather further information related to the needs and circumstances of a child or children. One social work team leader told inspectors that this was due to the referral form not having sufficient information to make an informed decision regarding actions required. Inspectors reviewed a case where a referral was received about a baby who needed an emergency placement, the OHS social work team leader considered the placement options that best suited the needs of the baby which resulted in a foster care placement.

The aim of the screening process is to assess whether preliminary enquiries were required. While the OHS did not use the terminology, nor the forms developed by Tusla for this purpose, inspectors found through observational opportunities and the review of children case files that referrals were screened within 24hrs by a social work team leader. Inspectors observed a phone call received to the service from An Garda Síochána related to concerns for the safety of children's living arrangements. The OHS social worker was observed to have clarified the details of the individuals with An Garda Síochána and searched for the children on Tusla case management system, TCM as part of their checks.

However, there was poor practice in the recording and storing of information related to the next steps and decisions made by the social work team leader on actions that needed to be completed. The social work team leader recorded this information on a piece of paper and this paper was shared with the social worker who was assigned to the case. There was no formal recording of directions from the social work team leader on the case management system, TCM. Inspectors found that due to the lack of effective systems in place this added to an adhoc response from the teams to respond to referrals that required immediate emergency intervention. Inspectors observed a social worker end a phone call to the service so that advice could be sought from the social work team leader. This advice was provided by the social work team leader verbally however, this was not recorded on Tusla case management system, TCM.

Initial Assessment

If, as a result of a referral, the OHS determines that there are indicators that a child is in need or there are concerns for their safety, OHS will conduct an assessment. 'Children First National Guidance for the Protection and Welfare of Children, and the Children First Act 2015' requires that assessments are carried out by Tusla social workers. The aim of an assessment process is to gather information and analyse the needs of the child and their family and the nature and level of any risk of harm to the child or children. It will also determine if there is existing safety present to address this harm.

Inspectors were concerned about the quality of the documentation related to the initial assessments undertaken. Management had developed an 'Assessment and Report Writing Prompts' guidance immediately prior to this inspection, in August 2024 for staff, however, it was too early to determine its effectiveness. Inspectors found that staff had not completed the assessment process using the national approach to practice, or utilised the standard business process and Tusla case management guidance, in using the relevant forms. The OHS use of the national approach to practice was not recorded as an assessment on Tusla's case management system, TCM, but was found as a case note on the child's file. Assessments are central to the planning, decision making and review of what actions, if any, were needed to support or safeguard children referred to the service. However, it was not always clear at the assessment stage the decisions that were made. The assessments lacked evidence of any management oversight. Inspectors found that for the majority of the case files reviewed, there was no evidence that the social work team leaders had reviewed and agreed on the decisions made at the assessment stage to progress the case further.
There was good practice in follow up contact made with a range of individuals, children and professionals, where appropriate. For example; where a child seeking international protection was identified at the airport, there was good communication between border control officers and OHS in gathering information about the child. In a second case, the OHS made contact with a residential centre to gather further information around a child's needs and circumstances to understand their lived experience. This played a vital role in the OHS identifying the child's existing needs, risks and protective factors. There was good practice in the OHS determining if there was sufficient safety present within the family and their network. For example; in one case observed by an inspector the social work team leader reassessed a request to telephone a child received from a service area social worker after undertaking a review of the child's file. The request had not taken into account the vulnerabilities of the children and that a visit to the children's family home was more appropriate instead of a phone call. The OHS assigned this case to a social worker for the home visit to be completed.

Inspectors found that the OHS use of child friendly tools to speak with children, where appropriate, was limited. In cases of children seeking international protection, where required, interpreters were secured for the child to participate in the assessment process. However, in all other children's files reviewed, there was an absence of communication tools used to ensure that the child's voice was captured at the assessment stage. This was especially the case for children who presented with additional needs or a disability. This is discussed in detail in a further section of the report.

The service had a system in place where information was shared between teams through handover meetings and handover documents. Inspectors observed a handover meeting and found that these meetings were well structured and that staff and managers had good knowledge of the referrals that were discussed. This process was seen to support the social work team leader with allocating cases and activities to a relevant social worker or social care worker. The handover document did not provide a full account of what was received by the service, or the rationale and decision-making process that took place. Once the handover document was reviewed, the handover information and any outstanding decisions or actions assigned to the social worker or social care worker for follow-up by the social work team leader was not always recorded on the child's case file. As a result, there was an absence of monitoring of this system to determine how effective the communication system was in the handling of information in order to facilitate and improve policy and practice.

Garda Notifications - Allegations

Inspectors examined two cases for the purpose of determining the quality of practice in the implementation of the *'Tusla and An Garda Síochána Children First – Joint Working Protocol for Liaison between both Agencies'*. Improvement was found to be required by the OHS to strengthen the effective implementation of the protocol in relation to the identification and completion of formal notifications of suspected cases of abuse to An Garda Síochána in a timely manner. In one case, no notification was made to An Garda Síochána even though there was an allegation of physical abuse made by a child to the service. Instead the child was provided with advice from the OHS to ring An Garda Síochána. There was no evidence that the Social Worker consulted with An Garda Síochána as to whether a notification may have been appropriate as per the protocol. In spite of this, good practice was found on the other case, whereby the OHS identified an allegation of physical abuse made by a child against a Foster Carer and a notification was made to An Garda Síochána and the Tusla service area. Emergency action was taken where the child was moved to an emergency placement as a protective intervention. There was good evidence of joint working between the OHS and An Garda Síochána regarding actions taken and information sharing.

This one child protection and welfare case was escalated to the principal social worker to provide assurances that the risks were appropriately recognised and managed. Satisfactory assurances were provided. This included the completion of a notification regarding the disclosure by the child and the outcome of the notification to be sought from the service area through the social work team leader. Communication had been sent to all OHS staff about the process to be followed when a disclosure of abuse is made by a child and the policy had been re-issued to staff to familiarise themselves with. In addition, how the OHS team

were implementing the policy would be a standing agenda item at management meetings.

The risk associated with poor management of allegations disclosed by children was escalated to the area manager, through an Urgent Compliance Plan, to provide assurances that effective levels of governance and oversight would be appropriately managed. However, as outlined in the capacity and capability section of this report, the lack of governance and oversight of cases meant that gaps in practise were not identified by the service in order to be assured that all relevant policies and procedures were followed consistently.

Special Emergency Arrangement

Inspectors reviewed four cases to determine the quality and effectiveness in the implementation of the national SOP for SEA's. These cases were broken down into one child seeking international protection, two placement breakdowns and one emergency placement request. Management told inspectors that a local SOP for the management of SEA's had only been introduced two weeks prior to the commencement of the HIQA inspection. Therefore, it was too early to assess its effectiveness. Prior to this, the service did not follow Tusla's already approved SOP for these arrangements. As outlined in the national SOP, the overall responsibility for the child and or young person placed in a SEA arrangement *"remains with the placing area and region" however*, the OHS was not adhering to this. The impact was that there was no monitoring of the SEA arrangements where vulnerable children were placed by the service. For example; where a child was reported by care staff to have brought friends to the SEA, no action was taken by management to risk assess the suitability of the placement and to put safety measures in place.

Care staff, provided by an external provider, were assigned to all four children for the duration of their placement in the SEA as a supportive and safeguarding measure. The area manager told the inspector that the care staff used by the OHS were cleared by the Central Staff Screening Compliance Team. There was no evidence of reports being submitted, for each of the four children, from the care staff to the OHS that provided an update of the child's ongoing circumstances. This was not in line with the National SOP in implementing the procedure for documenting and recording daily plans. Limited evidence was found of the OHS contacting the care staff to receive information about the child. As a result, it did not provide a picture of the child's time within the SEA setting. The impact of this practice, was that management could not be assured of the safety of the child placed in the SEA, and had not adhered to good record management in that records pertaining to a child's experience and care planning when placed in a SEA was not being recorded onto Tusla case management system, TCM.

There was mixed practice of OHS social workers meeting the child in person. Of the four cases reviewed, only two of the children had been met with by a social worker. However, when a social worker did meet with the child there was good record of interactions on the child's file where it was explained the reason for the child being placed in the SEA.

As part of the National SOP and local SOP, a risk assessment of the suitability of the premises is to be undertaken however, of the case files reviewed there was no evidence of risk assessments. In addition, there was no guidance document in place for the management of children's personal belongings. For example; where a child seeking international protection was placed in a SEA with two care staff, their personal phone and money was kept by the care staff. No information was recorded on the child's case file as to how that money was kept safe by the care staff and there was no guidance in place OHS on how best to manage this.

The risks associated with poor governance on the use of SEA's was escalated to the area manager, through an Urgent Compliance Plan, to provide assurances that effective levels of governance and oversight of these arrangements would be appropriately managed.

Complaints

Management told inspectors that the service had received no complaints from a child in 2023 and 2024. However, upon reviewing case files inspectors identified three cases where complaints had been verbalised by a child to a member of the OHS. In addition, an administration person told inspectors that children contact the service through phone calls to make a complaint and request to speak with a social worker. The administration person told the inspector that the last complaint received to the service from a child was six weeks prior to the inspection.
For the purpose of determining the quality of practice in the handling of complaints made by children, these three case files were examined. Significant improvement was found to be required from Tusla to strengthen the effective implementation of a child centred complaints process for vulnerable children through the OHS. Of the three cases examined, staff and management did not identify or implement child centred practice for dealing with complaints made by children when an event had impacted their life. For example; one child, in the care of Tusla, contacted the OHS and described inappropriate interaction they had with an external agency that caused them distress. The child had looked for the professionals details to make a complaint but was declined this information. Although a safe space for the child to raise this concern was provided, the complaint process was not followed. However, the OHS informed the social worker through a case note on Tusla's case management system.

The OHS did not provide a process where the child would be assured that the complaint would be taken seriously and that the concern would be addressed. In a second case, a child contacted the OHS directly and made a verbal complaint that they were not happy with the service and advice provided by the team. The OHS did not acknowledge the complaint made and the child ended the phone call early. The OHS did not categorise the complaint appropriately afterwards. The impact was that there was an absence of meaningful consultation with children about how they would like to be heard as part of the complaints process, nor were complaints analysed by management in order to learn from them and improve the service. In addition, children were not provided with information about the complaints process nor given the opportunity to involve a support person. The OHS did not provide an accessible, safe, effective and child-centred complaints mechanism for vulnerable children. Tusla did not take a multi-disciplinary approach to take into consideration the best interests of the child by engaging with other relevant agencies or services, where appropriate.

Voice of the child

Further improvement was required in the OHS capturing the voice of children placed in SEA's, children with additional needs or a disability and children who did not speak English. Staff and management told inspectors that no training had been provided to the team on how to communicate with children who presented with additional needs or a disability to the service. Staff told inspectors that they used their own knowledge on how to communicate with this vulnerable cohort of children. However, inspectors found through the review of two children's case files that further improvement was needed for staff to gain the appropriate skills and knowledge to support children with a disability to be involved in their care planning and communicate their needs. For example for one child who was received into care through a Section 12, they had a disability diagnosis and was non-verbal in communication. There was no evidence that the social worker made attempts to communicate with the child during what would have been a scary experience. In the second case reviewed, a child contacted the service through a phone call, to make a complaint regarding the care they had received from Tusla. Their case file noted that they had a disability. However, there was no evidence from the OHS social worker that this was taken into consideration to tailor speaking with the child. There was no evidence that methods were used for children with speech, language and communication needs to participate in decisions impacting their care as there was no evidence on case files. The voice of children with additional needs or a disability had become lost in the case files reviewed.

The OHS promoted a child's right to be heard through the use of interpreters to facilitate communication between the social worker and children who were not proficient in the same language. Inspectors reviewed two cases of a child seeking

international protection where the OHS used an interpreter via telephone. This provided a space for the child to provide information about their lived experience but to also understand what information they were being given by Tusla. However, it was unclear how the OHS staff identified the child's preferred spoken language as it was not documented whether language chart tools were used to help identify the child's language. Further development of the OHS team awareness of cultural differences in communication was required as there was no evidence that the OHS discussed with the child their preferences for the gender of the interpreter beforehand. In addition, there was no evidence on the child's case file that they were offered a choice in the gender of the social worker conducting the initial interview. This should be taken into consideration for all children and especially those who may have experienced significant trauma, sexual exploitation, or trafficking. Inspectors found that there was no practice guidance in place on how the service obtained a suitable interpreter for children or practice guidance for how the team worked with interpreters. However, management had identified this gap and formed an action as part of their SIP actions.

Some good practice was found in the OHS staff capturing the voice of the child. In one case a child contacted the service as they did not feel safe at home with their mother's partner. The child was provided with a safe space for their views to be heard, to understand their lived experience and effective action was taken to support them. In a second example, of a new born baby, consideration was given to their best interests in terms of suitable placement and OHS ensured that all relevant information that included feeding routine was shared with the foster carers. There was good practice found where the OHS used interpreters for children whose first language was not English.

The risks associated with poor management of directly hearing the voice of children was, to the area manager, through an Urgent Compliance Plan, to provide assurances that this would be appropriately managed. Assurances were provided by the area manager that direct contact would be made with children by the team, while they waited for an emergency response from the service.

Safety Planning

The purpose and function of the OHS required attention as there were conflicting views from staff and management provided to inspectors about their role and responsibilities in relation to safety planning. Where a request was received by the service from a social worker to monitor a safety plan, staff and management did not view the role of the OHS as a partner to support the implementation of the safety plan. This was not in line with the national review conducted of the service in 2023 that identified the service as having a clear role in monitoring safety plans outside of office hours, to ensure the child's safety.

The safety planning process focuses on building enough safety to reduce the risk of harm to a child, by Tusla working collaboratively with the child, where feasible the parents, the family or support network and partner agencies to support the management of the presenting issues. In addition, the safety planning process involves monitoring and reviewing of the safety plan to ensure that it is working and provides ongoing safety for the child. The OHS encountered challenges when the service transferred over to the new case management system, TCM, in November 2023. The national approach to practice did not continue to be embedded once the new case management system, TCM was installed. Management did not support staff to continue to embed the national approach to practice. This is explained earlier under capacity and capability.

Inspectors examined eight children's case files to determine the effectiveness of the safety planning process. Of the eight case files reviewed, five related to requests made to the OHS for the monitoring of a child's safety plan and three cases related to children seeking international protection. There was good practice identified in the services approach to the implementation of monitoring actions to ensure that the safety plan was being embedded. For example; where a referral was received from an international social worker organisation, further information was requested from the country the child had lived to help inform the services understanding of the safety plan. The outcome of discussions with their international counterparts was good and there were good records on the child's file. In a second case, where the OHS was requested to conduct home visits to ensure elements of the safety plan was being followed by the parent, the OHS staff followed up on the actions by visiting the family home and speaking with the parent.

There was mixed practice in the service identifying and developing robust interim safety plans for vulnerable children who arrived into the country seeking international protection. For example; when a child who entered the country and disclosed information for indicators of child trafficking, no steps were taken by the OHS to put in place an interim safety plan while the child was placed in a SEA. In a second case, a child seeking international protection, placed in a SEA by the OHS, presented with indicators of child trafficking however, no safety plan was put in place and the child went missing from the SEA within 12hrs of being placed. However, good practice was seen in a third case where a child seeking international protection was placed into emergency foster care accommodation whilst the OHS social worker took steps to confirm the identification details of the child's relatives in Ireland. The case was transferred to the Separated Children Seeking International Protection Team (SCSIP) the following working day where further safeguarding checks would be undertaken. Due to the inconsistent practice

in the use of safety plans by the OHS, management could not ensure effective safeguarding of children through the regular implementation of safety plans.

There was little to no monitoring and oversight of children's case files by management in relation to implementing safety plans by the teams and the monitoring of safety plan requests to the service.

Section 12

An Garda Síochána have the power to remove a child to safety under Section 12 of the Child Care 1991, as amended however, they must have reasonable grounds to believe that the child is at immediate risk of harm. Once An Garda Síochána have triggered this section of the legislation, they must deliver the child into the care of Tusla as soon as possible.

For the purpose of determining the quality of practice in the handling of Section 12's taken by An Garda Síochána under the Child Care Act 1991 to the OHS, four case files were examined. Of the four cases reviewed, three of the children were previously known to Tusla. The reasons for Section 12 being invoked were broken down into; parental difficulties, parental drug abuse and child behaviour difficulties. There was good practice of joint working and information sharing between the OHS and An Garda Síochána. An Garda Síochána had notified OHS before and after a Section 12 was invoked and there was good action planning around decisions made to move a child to safety. For example; when a parent could not care for their child at home due to challenging behaviour, An Garda Síochána invoked section 12 and brought the child to the Garda station. An Garda Síochána sought advice from the OHS regarding medical needs of the child. Both agencies agreed an action plan for the child to be brought to the hospital by An Garda Síochána and the OHS social worker met the child along with two social care workers there.

Further improvement was required from the OHS when placing a child into a family care arrangement after a Section 12 was invoked by An Garda Síochána. Upon reviewing a case of a two year old child, inspectors found that although checks were conducted by An Garda Síochána into the child's adult sister, no checks were conducted into the adult male in the family home by OHS. In addition, when the OHS social worker brought the child to the family home, inspectors found that here was no evidence that the social worker observed the condition of the home environment or whether there was sufficient food and equipment to meet the basic care needs of child of this age. Furthermore, there was no evidence on TCM, of the OHS social worker having completed the family care arrangement form. This was identified as a practice issue across the service by a social work team leader however, limited measures were put in place to

improve this, or address this, including training. No audit or review had been carried out to ensure that the practice had improved and the risk reduced.

The risks associated with the management and monitoring of the implementation of Garda Vetting of relatives and family members care arrangements was escalated to the area manager, through an Urgent Compliance Plan, to provide assurances that effective levels of governance and oversight would be appropriately managed. The principal social worker provided assurances that the policy had been re-issued to staff to familiarise themselves with and that the Garda vetting process and policy would be a standing agenda item at team meetings. In addition, all staff would undertake further training in the area.

Missing in Care

Inspectors examined six children's case files to determine the effectiveness of the implementation of *'Children Missing From Care, A Joint Protocol between An Garda Síochána and the Health Service Executive Children and Family Services'* (Joint Protocol). Inspectors found that there was some good practice in this area, however, in some cases there was poor practice. This inconsistency in practice was a concern, as it showed lack of oversight and management of a key area of risk. Inspectors found that the OHS management and staff did not always adhere to the Joint Protocol. For children placed in SEA's, staff and managers told inspectors that it was the responsibility of the care staff to report them as a missing child to An Garda Síochána. There was an absence of an agreed approach and written guidance between the OHS and the care staff provider on the process to follow and the expectations required from the OHS. Management told inspectors that there was no guidance in place and that the care staff did not submit reports to the OHS about the daily plans or any incidents that occurred. This approach was not in line with the Joint Protocol that states *'the Children and Family Services remain responsible for the child missing from care'.*

Inspectors found that there was poor practice in the OHS implementation of the Joint Protocol to ensure that all necessary documentation was gathered about the child. There was inconsistent practice in taking a photograph of the child to assist with any An Garda Síochána investigation. For example; when a child went missing from a SEA placement contact was made to An Garda Síochána by the care staff and not the OHS. No photograph of the child was taken as a requirement of the Joint Protocol. In a second case, where a child seeking international protection went missing from their SEA placement, the care staff had taken a photograph of the child along with a description, which was then placed on Tulsa case management system, TCM. External stakeholders told inspectors that An Garda Síochána were not aware of children seeking international protection placed in care homes until the child was reported as missing. In addition, inspectors were told that there was a reluctance from the OHS teams to

share information with hospitals and An Garda Síochána when a child was reported missing from care. External stakeholders told inspectors that improvements were needed in this regard.

There was mixed practice in action taken by the team that ensured that *'time missing cannot be used to determine whether a child qualifies as missing, rather it is a combination of the time period with all other circumstances of the case that must be considered'* as stated in the Joint Protocol. For example; where a child had been arrested by An Garda Síochána and their placement was ended as a result, the OHS met with the child and secured a placement in a SEA. However, the child absconded from the car and the OHS social worker went to the Garda station and reported the child as missing in care and documented their vulnerabilities, in a timely manner. However, in a second case reviewed a child was placed in a SEA and absconded from the placement. The child was not reported as a missing child in care by the care staff, the OHS social worker at the time of the incident or by the child's own social worker the following day. The vulnerabilities of the child was not taken into consideration in following the Joint Protocol.

For a child missing from care, who had not been seen for 24hrs, and flagged as at risk of exploitation, there was good evidence of discussion with An Garda Síochána around the risk to the child from an adult. There was also good practice of the OHS social worker/social care worker having completed the Child Sexual Exploitation Toolkit. This toolkit supports staff to safeguard children from exploitation through the identification of indicators. There was good joint working and information sharing between An Garda Síochána and the OHS when safeguarding concerns were found for children at risk of exploitation. Inspectors observed a phone call received from An Garda Síochána to share information of two children at risk of exploitation in an International Protection Accommodation Service (IPAS) centre so that this information could be shared with the children's assigned social worker. The OHS social worker confirmed the immediate safety of the children. The inspector observed the OHS social worker uploading the information on the children's case files.

Management oversight of records pertaining to children reported as missing from care was either inconsistent or absent on children case files. In addition, there was no tracking system in place for senior management and the area manager to monitor and review data on children who went missing from care, policies and procedures, staff practice, identify trends and training needs.

The risks associated with the management of children who went missing from care following being placed by the service, was escalated to the principal social worker to provide assurances that effective levels of governance and oversight would be

appropriately managed. The assurances provided included that guidance would be developed for staff on the management of children who went missing from SEA's. In addition, the OHS management team would meet with the care staff providers to their discuss roles and responsibilities and that a daily log would be sent to the OHS team that captured any incidences of children missing from care. A tracker would be developed and a schedule of audits would be implemented to ensure oversight of this.

Standard 1.3
Children are communicated with effectively and are provided with information in an accessible format.

Further improvement was required in the OHS capturing the voice of children placed in SEA's, children with additional needs or a disability and children who did not speak English. No training had been provided to the team on how to communicate with children who presented with additional needs or a disability to the service. There was no evidence that methods were used for children with speech, language and communication needs to participate in decisions impacting their care as there was no evidence on case files. The voice of children with additional needs or a disability had become lost in the case files reviewed.
The OHS promoted a child's right to be heard through the use of interpreters to facilitate communication between the social worker and children who were not proficient in the same language. Further development of the OHS team awareness of cultural differences in communication was required as there was no evidence that the OHS discussed with the child their preferences for the gender of the interpreter beforehand. The risks associated with poor management of directly hearing the voice of children, due to the delays of children waiting in garda stations and hospitals, was escalated to the area manager, through an Urgent Compliance Plan, to provide assurances that this would be appropriately managed.

Data provided to HIQA indicated that the service had received no complaints from a child in 2023 and 2024. However, upon reviewing case files three cases were identified where complaints had been verbalised by a child to a member of the OHS. These were not categorised appropriately.

Improvement was found to be required by the OHS to strengthen the identification and completion of formal notifications of suspected cases of abuse when a disclosure is made by a child. This concern was escalated to the principal social worker to provide assurances that the risks were appropriately managed.

Judgment: Not compliant

Standard 2.2
All concerns in relation to children are screened and directed to the appropriate service.

There was a disconnect between the OHS and the integration with Tusla's national approach to standard business processes for the management of child protection and welfare concerns. As a result, the OHS was not implementing the national standard business process in practice and there was a clear lack of knowledge and understanding of terminology used within the SBP guidance. However, cases reviewed were screened and prioritised on the same day. Where a report to the service did not require a child protection and welfare intervention, consideration was given to other supports that could be provided.

The OHS conducted initial checks through Tusla case management system, TCM, to determine whether the child or family was known or had previous involvement with services provided by Tusla. Requests from areas to the service were reviewed by the social work team leader before being assigned to a social worker. While the OHS did not use the terminology, nor the forms developed by Tusla for this purpose, inspectors found through observational opportunities and the review of children case files that referrals were screened within 24hrs by a social work team leader.

There was poor practice in the recording and storing of information related to the next steps and decisions made by the social work team leader on actions that needed to be completed. The information was recorded on a piece of paper and this paper was shared with the social worker who was assigned to the case. There was no formal recording of directions from the social work team leader on the case management system, TCM.

Judgment: Substantially compliant

Standard 2.3
Timely and effective action is taken to protect children.

The OHS provided a timely emergency response to children when a referral was received to the service.

The OHS encountered challenges when the service transferred over to the new case management system, TCM, in November 2023. The national approach to practice did not continue to be embedded once the new case management system, TCM was installed. Management did not support staff to continue to embed the national approach to practice. There was good practice where the immediate consideration was given to the safety of the child and whether action

was required to urgently respond. The services approach to implementing requests from service area social workers to monitor safety plans over the weekend was good. However, there was poor practice in the recording and storing of information related to the next steps and decisions made by the social work team leader on actions that needed to be completed.

Judgment: Substantially Compliant

Standard 2.5
All reports of child protection concerns are assessed in line with *Children First* and best available evidence.

The OHS had not completed the assessment process using the national approach to practice, or utilised the standard business process and Tusla case management guidance, in using the relevant forms. It was not always clear at the assessment stage the decisions that were made. The assessments lacked evidence of any management oversight. There was good practice in follow up contact made with a range of individuals, children and professionals, where appropriate. There was an absence of communication tools used to ensure that the child's voice was captured at the assessment stage.

There was mixed practice in the service identifying and developing robust interim safety plans for vulnerable children who arrived into the country seeking international protection. Due to the inconsistent practice in the use of safety plans by the OHS, management could not ensure effective safeguarding of children through the regular implementation of safety plans.

There was inconsistency in the implementation of the *'Children Missing From Care, A Joint Protocol between An Garda Síochána and the Health Service Executive Children and Family Services'* as it showed lack of oversight and management of a key area of risk. There was an absence of an agreed approach and written guidance between the OHS and the care staff provider on the process to follow and the expectations required from the OHS.

Inspectors found that the service required further improvements to embed effective practice in the management of complaints made by children.

Judgment: Substantially compliant

Standard 2.12
The specific circumstances and needs of children subjected to organisational and/or institutional abuse and children who are deemed to be especially vulnerable are identified and responded to.

The lack of governance and oversight of cases meant that gaps in practise were not identified by the service in order to be assured that all relevant policies and procedures were followed consistently.

There was no monitoring of the SEA arrangements where vulnerable children were placed by the service. Management could not be assured of the safety of children placed in a SEA. As part of the National SOP and local SOP, a risk assessment of the suitability of the premises is to be undertaken however, of the case files reviewed there was no evidence of risk assessments.

Furthermore, the use of safety plans needed to be strengthened as part of the assessment of the child's levels of needs and risk of harm.

There was mixed practice in the staff and management identifying indicators of trafficking and exploitation and developing robust interim safety plans for vulnerable children who arrived into the country seeking international protection. For two children who entered the country and disclosed information that highlighted indicators of child trafficking, no steps were taken by the OHS to put in place an interim safety plan while the child was placed in a SEA. The impact was that one of these children went missing in care after being placed in the SEA by the OHS. Good practice was observed in one case where the OHS completed the Child Sexual Exploitation Toolkit for a vulnerable child at risk of harm. Due to the inconsistent practice in the identification of indicators of trafficking and exploitation and the use of safety plans by the OHS, management could not ensure effective safeguarding of children.

Further development of the OHS team awareness of cultural differences in communication was required. There was no evidence that the OHS discussed with the child their preferences for the gender of the interpreter beforehand to gather information of any previous incidents of abuse to identify any possible patterns of abuse.

There was good joint working and information sharing between An Garda Síochána and the OHS when safeguarding concerns were found for children at risk of exploitation.

Judgment: Not compliant

Appendix 1 - Full list of standards considered under each dimension

This inspection was carried out to assess compliance with the National Standards for the Protection and Welfare of Children (2012). The standards considered on this inspection were:

Standard Title	Judgment
Capacity and capability	
Standard 3.2 Children receive a child protection and welfare service, which has effective leadership, governance, and management arrangements with clear lines of accountability.	Not compliant
Standard 5.3 All staff are supported and receive supervision in their work to protect children and promote their welfare.	Not compliant
Quality and safety	
Standard 1.3 Children are communicated with effectively and are provided with information in an accessible format.	Not compliant
Standard 2.2 All concerns in relation to children are screened and directed to the appropriate service.	Substantially compliant
Standard 2.3 Timely and effective action is taken to protect children.	Substantially compliant
Standard 2.5 All reports of child protection concerns are assessed in line with Children First and best available evidence.	Substantially compliant
Standard 2.12 The specific circumstances and needs of children subjected to organisational and/or institutional abuse and children who are deemed to be especially vulnerable are identified and responded to.	Not compliant

Compliance Plan for National Out of Hours Service (OHS) Child Protection and Welfare Service OSV – 0008851

Inspection ID: MON-0044340

Date of inspection: 20 08 2024

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. In this section the provider must consider the overall standard when responding and not just the individual non compliances as listed in section 2.

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 act *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 3.2 Children receive a child protection and welfare service, which has effective leadership, governance, and management arrangements with clear lines of accountability.	**Judgment:** Not Complaint

Outline how you are going to come into compliance with Standard 3.2:

An Urgent compliance plan provided to HIQA on 19.09.24 to provide assurance on effective leadership, governance and management arrangements.

A file audit undertaken by PASM has been completed and draft report issued. The audit focused on the quality of individual case records as well as ensuring that the voice of the child is heard. The findings from the interim report were discussed at the Service Management meetings and action plan was agreed.
A meeting took place with PASM for where the findings discuss, which informed the action plan. This action plan will be monitored every 8 weeks at service meetings.

The scheduled meeting with PASM will also clarify support with the auditing process to facilitate NOHS staff undertaking audits on a monthly basis. A file audit template will be designed in consultation with PASM to assist SWTLs & PSWs to undertake audits which will commence by 18th October 2024 with a focus on the following:

- Supervision
- Recording of rationale for decision making
- Assessment of child's needs need
- Multiple referrals of same child to NOHS
- Consultation with parents and children

The findings of these audits are due by quarter 4 2024 and will be shared with the Area Manager and a robust action plan if required will be put in place which will be monitored and tracked at monthly management meetings.

In the interim the PSW/SWTLs will sign off on TCM regarding cases reviewed. All concerns and themes arising will be brought to the attention of the PSW and Area Manager during management meetings and in supervision.

Person Responsible: Principal Social Worker.

T**imeframe**: October 2024

To evidence monitoring systems and to strengthen oversight at the senior management level, case notes including actions taken by NOHS staff will be signed off at the end of the shift by the Out of Hours shift manager. This will be evidenced by the night SWTL added a note at the end of reports. This will be subject to audit by the Principal Social Worker from 7th October. Action plan will be devised by the PSW following audit. This will be tracked and reviewed during supervision with the Area Manager and at management meetings. All urgent cases for follow-up will be reviewed by the day service SWTL and follow-up case notes approved.

Any complex and urgent cases identified on the handover report will be audited by the PSW every two weeks commencing 30th September. Practice issues identified will be discussed in supervision with team leaders and PSWs. National Out of Hours PSW will discuss themes arising with area manager during supervision and management meetings to agree necessary actions.

Meetings on a six-weekly basis are taking place with On Call PSWs, led by area manager, with a view to strengthen the oversight arrangements and to identify trends/patterns of complex cases.

All On Call PSWs have been requested to complete Need to Know, highlighted to them, on serious issues arising out of hours, the area manager for review for appropriate escalation, to the interim Director of Service and Integration & the relevant RCO and area manager. This process will be incorporated into new SOP that is being developed by the agency. All Need to Knows will be reviewed by the Area Manger and discussed monthly with Interim Service Director to strengthen the oversight in the service.

To evidence monitoring systems and to strengthen oversight at the senior management level, case notes including actions taken by NOHS staff will be signed off at the end of the shift by the Out of Hours manager. This will be evidenced by the night SWTL adding a note at the end of reports. This will be subject to audit by the Principal Social Worker from 7th October. Action plan will be devised by the

PSW following audit. This will be tracked and reviewed during supervision with the Area Manager and at management meetings. All urgent cases for follow-up will be reviewed by the day service SWTL and follow-up case notes approved.
Any complex and urgent cases identified on the handover report will be audited by the PSW every two weeks commencing 30th September. Practice issues identified will be discussed in supervision with team leaders and PSWs. National Out of Hours PSW will discuss themes arising with area manager during supervision and management meetings to agree necessary actions.

Person responsible Area Manager.
Timeframe: October 2024
A new SOP for NOHS will be developed where children require an immediate place of safety. This will be aligned with Tusla's National SOP for SEAs.

Person Responsible: Interim Service Director.
Time Frame: 31st December 2024.

NOHS will continue to operate the HSE/Garda Joint Protocol on Children Missing from Care (2012) by ensuring the Gardai are notified and will seek a response from the area team responsible for the child as to the progress on the report.

Signs of Safety workshop is scheduled for the end of November 2024 to assist staff in developing a robust safety plan for children placed in an NOHS initiated SEA. In the interim staff will record safety plans which will focus on the child's immediate needs including safety & an absence management plan. Implementation of plans will be included in the file audit.

A joint SOP has been agreed with relevant care support agencies on the notification of children placed by NOHS who go missing from a SEA and care placements.
A tracker for children who go missing from SEAs placed by NOHS is being devised. In the interim, any child missing from a NOHS initiated SEA is reviewed the next day by the day team manager, following which contact will be made with the relevant area/team. Any trends regarding children missing from care are notified to relevant area SW teams. This will also be discussed at Regional SEA governance meetings and NOHS Service meetings.

Person Responsible: Principal Social Worker.
Time Frame: October 2024

The Garda Vetting Guidance and memo has been re-issued to all staff and has been discussed at team meetings. Any Garda vetting process that is initiated

NOHS is reviewed by the SWTL to ensure that all actions are undertaken. Any outstanding issues are recorded on the handover report which is followed up by the day service with the relevant area.

The PSW will review a number of Garda Vetting forms initiated by NOHS I during September to ensure all actions are undertaken.

NOHS has engaged with PASM to undertake an audit of the Garda Vetting forms submitted by NOHS for compliance with Tusla practice guidance by Q4 2024.

Person responsible: Principal Social Worker
Timeframe October 2024

A nominated SWTL acts as PSW for leave this is an established practice. The Interim Service Director will be providing necessary oversight, support, and guidance to the A/PSW when the area manager is on leave as required.

Person responsible: Interim Service Director
Timeframe: September 2024

Compliance Plan:

Following on from the review completed in 2023 consultation with EMT to take place re strategic plan for NOHS. The purpose and function of NOHS to be agreed with National Operations Management and will be clearly communicated to staff through correspondence, team meetings and supervision.

A full process mapping exercise will be initiated by the service to identify gaps in compliance with relevant legislation, regulations, national policies, and procedures. A plan will be formulated to ensure compliance which will be monitored at service team meetings on a quarterly basis.

Senior management team to complete full review of the NOHS risk register, to ensure that risks are appropriately escalated to national level. The risk register will be an agenda item at management meetings and NOHS service plan meetings. The appointment of an additional PSW for Quality Risk and Service Improvement will support the service to have a cycle of improvement over information recording, data, audit schedule outcomes and service user feedback and incorporate into service improvement plans. Until this post is in place, the PSW will undertake priority actions as agreed with the I/Service Director and Area Manager.

Training for NOHS staff on Tusla risk management policy will be provided to enable the NOHS risk register to align to the agency's electronic risk register.

The risks in the service will also be tracked via the National Services Operational Risk Management and Service Improvement Committee. Appropriate risks will also be escalated to NORMSIC.

Governance at the senior management level will be enhanced by the Service Director's oversight of the NOHS compliance plan by attending monthly meetings with the Area Manager and PSW. The compliance plan will also be on the agenda for the National Services Operational Risk Management and Service Improvement Committee.

NOHS management have commenced leadership training which will strengthen their management oversight capability as part of overall service improvement.

A Schedule of internal audit will be developed with TLs. The NOHS will engage with PASM to support the audit schedule.

Actions in this compliance plan and the urgent compliance plan will be uploaded to an excel tracker with action owners, to give clarity to staff on expectations of them and to assist in monitoring the progress made in the compliance plan.

Person Responsible: Service Director
Time frame: 28th February 2025

A risk escalation process above the on-call PSW grade for NOHS to be agreed for the management of case related risks outside of normal business hours.

Person Responsible: Service Director
Time frame: 13th December 2024

Senior management will review the service demand and allocation of resources to determine whether additional business cases are required.

Business cases is being submitted for an additional Principal Social Worker who will have responsibility for quality, risk, and service improvement and Business support manager (Grade 7). The PSW will support supervision of nominated staff to enhance the overall governance and management of the service. In the interim, the actions outlined above will be the responsibility of the operational PSW with support from the SWTLs.

Person Responsible: Area Manager
Time frame: 28th February 2025

A review of the functionality of TCM for the service has commenced which will ensure it is designed to collect and report the data required to inform the management, governance, and service improvement. The service is in a position to extract performance reports from TCM with KPIs agreed and is assisting informing the future development of the NOHS. Quarterly reports will be provided to Quality and Risk Directorate for reporting on performance. The activity data will be reviewed monthly by the Area Manger and utilised to inform service need and improvement. Quarterly reports on service activity will be on the agenda in the meetings between I/Service Director, Area Manager and Principal Social Worker which will enhance the information and practice governance structures and will assist in service improvement.

Person responsible: Area Manager
Time Frame: 28th February 2025.

Tusla service user experience and feedback team will be asked to facilitate sessions with the NOHS to increase their awareness of when they should support a child to make a complaint.
All staff have completed the Tusla mandatory complaints management training.
Complaints will continue to be inputted on the service complaints register. The Complaints Register is reviewed by PSW and AM on a bi-monthly basis.
Service planning including quarterly activity data will be discussed at the teams Service quarterly meetings. This will address key challenges, risks, audit feedback, reviews, learning and service improvement. All staff will be encouraged to propose agenda items, and a record of agreed actions will be tracked. The Service Director will attend these meetings twice per year.

Person Responsible: Area Manager
Timeframe: 28th February 2025.

Standard 5.3 All staff are supported and receive supervision in their work to protect children and promote their welfare.	**Judgment:** Not Compliant

Outline how you are going to come into compliance with Standard 5.3:

Action
The action plan from the PASM supervision audit undertaken in July 2024 will be implemented within the agreed time frame.

All staff will receive supervision in accordance with the current Tusla supervision policy to ensure that they are supported in their work to protect children and promote their welfare.

Schedules of supervision and supervision contracts will be included in each supervision file.

Supervision contracts will be reviewed annually.

Where supervision includes case discussion, rationale for decision making to be noted and recorded on TCM child's file.

Staff supervision files will be subject to an audit schedule.

All staff will be supported to progress their PDP's. This will inform the training requirements of the service.

The current rota has flexibility where there is time available for all staff to receive the necessary training to carry out their role and to ensure their professional development.

A Service tracker will highlight any outstanding mandatory training requirements for staff. SWTL to ensure mandatory training is completed as part of the supervision process.

All staff are to be facilitated to complete the supervision/supervisee training on the 2023 policy once available.

A specific service induction programme will be developed by the SSWPs for new staff, overseen by a PSW. This induction programme will be reviewed every year to ensure it remains relevant and includes information on any service developments.

All new staff will be asked to complete U-start the agency induction Programme.

Person responsible: Principal Social Worker
Time Frame: 28th February 2025.

A Business case is being submitted for an additional Principal Social Worker who will have responsibility for quality, risk and service improvement. The PSW will support supervision of nominated staff to enhance the overall governance and management of the service. In the interim, the actions outlined above will be the responsibility of the operational PSW with support from the SWTLs.

Person responsible: Area Manager
Time Frame: 28th February 2025.

Standard 1.3 Children are communicated with effectively and are provided with information in an accessible format.	**Judgment:** Not Compliant

Outline how you are going to come into compliance with Standard 1.3:

Urgent Compliance Plan under this standard was provided to HIQA on 19.09.2024

The NOHS is an emergency service where every effort is made to respond in a timely manner and the service will continue to do so. The NOHS is a demand led service and the service activity levels can be unpredictable. The service is very mindful of responding as soon as is practicable. Where there are any delays the SWTL will ensure that direct contact is made with the child/young person to provide assurances to them while they await direct contact with an NOHS staff member.

Person Responsible: SWTL/PSW.
Time frame: 30th September 2024

All NOHS staff have been advised that in the event a child or young person raises a complaint or issue of concern that they should ask the young person whether they wish to make a formal complaint under the Tell Us policy.

Tusla Tell Us dept have advised if any child or young person who wishes to make a complaint can do so under the Tell Us Policy. The NOHS can redirect the detail to Tell Us who will record the information and input it on Tusla NIMS system.

Tusla Tell Us has stated that they can then re direct the complaint to the relevant area for the appropriate follow up. The Complaint will be added to the NOHS dept's complaints tracker.

If a young person raises a concern that is not a formal complaint, Tusla Tell Us have indicated that the NOHS should continue to redirect such concerns to the local area social work team and request that they follow up on this. To have oversight of this process a SOP will be developed by mid November 2024.

Person Responsible: PSW and Business Support Grade 6.
Time Frame 30th November 2024

The PSW will liaise with Workforce Learning and Development to support staff to strengthen their skills in promoting participation for all children and young people regardless of background or ability. This will include consideration of children and young people with speech and language or communication issues.

Staff will be requested to undertake 'Diversity in Modern Ireland' training to support effective communication with children and young people with additional needs and from diverse backgrounds. Staff will be encouraged to participate in Child and Youth Participation Training, in line with PDPs.

Children and young people who are in direct contact with the NOHS will receive an information leaflet on Tusla Child Protection Services in the relevant language. They will also be given a Tusla NOHS Business Card informing them who they met and what service will be dealing with them.

A targeted approach through team meetings and supervision will ensure that all staff are supported to strengthen their recording and representation of the child/young person's views in each interaction. This will be audited by SWTLs as part of the service's audit schedule and themes arising will be brought to the management team for response and action.

We will implement Tusla guidance on translation and interpreters. This sets out that consideration should be provided to young people on gender when sourcing interpreters. It must be noted that gender preference is not always viable in the context of an emergency service.

If any Child/ young people express dissatisfaction they will be supported to make a complaint via Tulsa's Tell Us. NOHS staff will submit a complaint on the young person's behalf where appropriate. If a complaint relates to NOHS Staff the Area team will be requested to provide necessary support. SWDs will be advised of complaints in the NOHS report to ensure follow-up with the young person.

Person Responsible: Social Work Team Leaders
Timeframe: 28th February 2025

Standard 2.2 All concerns in relation to children are screened and directed to the appropriate service.	**Judgment:** Substantially Compliant

Outline how you are going to come into compliance with Standard 2.2:

All new child protection and welfare referrals including those relating to open cases are screened as per Children First Guidelines and will be signed off by the Social Work Team Leader and directed to the appropriate team.

Guidance has been issued to all staff regarding the importance of recording the rationale for decision-making and the next steps on TCM. To ensure compliance this will be included in file audit which will take place in Q3 2025.

Person Responsible: Principal Social Worker
Timeframe: Q3 2025.

Engagement will take place with the Assistant National Director and Chief Social Worker to
explore how best the NOHS process can align and integrate with the National Approach to Practice. Meetings have commenced with ICT/TCM to agree on where NOHS processes sit with SBP.

Person Responsible: Area Manager
Timeframe: Q3 2025

Standard 2.3 Timely and effective action is taken to protect children.	**Judgment:** Substantially Compliant

Outline how you are going to come into compliance with Standard 2.3:

All new child protection and welfare referrals including those relating to open cases are screened as per Children First Guidelines and will be signed off by the Social Work Team Leader and directed to the appropriate team.

A SOP to be devised with the team for tracking referrals.
Team Leaders and SSWP to support and review practice recording to ensure case analysis and decisions made are clearly identified. PSW and Area Manager scheduled audits of case files to be developed for oversight and governance.

PSW will liaise with Tusla ICT to explore if a phone logging system can be devised for the service, to capture the number and times of calls.

NOHS has engaged with PASM to undertake an audit of the garda vetting forms submitted by the service for compliance with the practice guidance.

Person responsible: Principal Social Worker
Time Frame: Q2 2025.

Area Managers will be requested to ensure that any referrals, case directions and next steps are sent to the NOHS central email account. Area Managers have been asked to copy the relevant Area PSW on this correspondence to ensure their team upload this correspondence onto TCM. The NOHS will ensure that any actions completed by the NOHS team will be uploaded also on TCM.

An email to this effect was sent by the NOHS Area Manager to Area Manager colleagues on the 21st of October 2024.

Person Responsible: Area Manager
Timeframe: Q2 2025.

Standard 2.5 All reports of child protection concerns are assessed in line with *Children First* and the best available evidence.	**Judgment:** Substantially Compliant

Outline how you are going to come into compliance with Standard 2.5:

All new child protection and welfare referrals including those relating to open cases are screened as per Children First Guidelines. Audits of referrals will be undertaken to ensure compliance with Children First.

Current practice guidance will be reviewed to ensure compliance with Tusla SBPs and will outline the responsibilities of staff in relation to Children First.

Refresher training and practice workshops will be provided to all staff on the national approach to practice including the drafting and implementation of safety plans. Guidance is being sought from SOS practice leds to establish how best the approach can be utilised to support the needs of an emergency service. In the interim the PSW and SWTLs will prioritise discussion on using Signs of Safety tools with individual teams.

As part of the engagement with ICT there will be a review of how SOS can be incorporated into the current system of recording for NOHS. In the interim staff will be requested to insert 'Interim Safety Plan' and scaling questions as part of their recording. This recording will be audited by SWTLs as part of the auditing process.

Guidance has been issued to all staff regarding the importance of recording rationale for decision making and next steps on TCM.

This will be reviewed as part of the Service Audit Schedule.

Responsible: Principal Social Worker.

Timeframe: Q3 2025.

Standard 2.12 The specific circumstances and needs of children subjected to organisational and/or institutional abuse and children who are deemed to be especially vulnerable are identified and responded to.	**Judgment:** Not Compliant

Outline how you are going to come into compliance with Standard 2.12:

A new SOP for NOHS will be developed where children require an immediate place of safety. This will be aligned to Tusla's National SOP for SEAs.

Person Responsible I/Service Director

Time frame 31st December 2024

All Social Work Team Leaders have been requested to brief and discuss the Missing from Care Protocol with their teams.

The NOHS will continue to adhere to the HSE/Garda Joint Protocol on children missing from care.
Signs of Safety workshops is scheduled for the end of November 2024 to assist staff in developing robust safety plan for children placed in an NOHS initiated SEA. In the interim staff will record safety plans which will focus on the child's immediate needs including safety & an absence management plan. Implementation of plans will be included in the file audit.

Regular contact to be made with social work teams/services re: outcomes of children who are reported as MIC as an interim measure.

Meetings are scheduled on 11th and 21st November 2024 with Care Agencies to reiterate their obligations in reporting children who go missing from an NOHS initiated SEA which is including a SOP in line with the Missing from Care Protocol. The operation of this SOP will be reviewed in May 2025.

A tracker has been for children who go missing from SEAs placed by NOHS is being devised. In the interim, any child missing from a NOHS initiated SEA is reviewed on the next day by the day team manager, following which contact will be made with the relevant area/team.

The children who have gone missing from NOHS initiated SEA will be subject to a NTKs by the NOHS Principal Social Worker and will be discussed at Regional SEA governance meetings.

Any trends regarding children missing from SEAs are notified to relevant area SW teams. This will also be discussed at Regional SEA governance meetings and NOHS Service meetings.

Training on Child sexual Exploitation and Trafficking has been arranged for the 10 December 2024.

Person Responsible: Principal Social Worker and Area Manager.

Timeframe: 28th February 2025.

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	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.	Not Compliant		February 2025
Standard 5.3 All staff are supported and receive supervision in their work to protect children and promote their welfare.	Not Compliant		February 2025
Standard 1.3 Children are communicated with effectively and are provided with information in an accessible format.	Not Compliant		February 2025
Standard 2.2 All concerns in relation to children are screened and directed to the appropriate service.	Substantially Compliant		30 September 2025
Standard 2.3 Timely and effective action is taken to protect children.	Substantially Compliant		30 June 2025
Standard 2.5 All reports of child protection concerns are assessed in line with Children First and best available evidence.	Substantially Compliant		30 June 2025
Standard 2.12	Not Compliant		February 2025

The specific circumstances and needs of children subjected to organisational and/or institutional abuse and children who are deemed to be especially vulnerable are identified and responded to.			

Published by the Health Information and Quality Authority (HIQA).

For further information please contact:

Health Information and Quality Authority

George's Court

George's Lane

Smithfield

Dublin 7

D07 E98Y

+353 (0)1 8147400

info@hiqa.ie

www.hiqa.ie