Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Child Protection and Welfare Service

Name of service area:	Waterford / Wexford
Name of provider:	Child and Family Agency, Tusla
Type of inspection:	Focused CPNS
Date of inspection:	16 – 18 & 25 – 26 August 2021
Lead inspector:	Olivia O'Connell
Support inspector(s):	Sharron Austin Lorraine O'Reilly Niamh Greevy
Fieldwork ID	MON-0033669

About monitoring of child protection and welfare services

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

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

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

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

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

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

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

How we inspect

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

The key activities of this inspection involved:

- the analysis of data
- interview with the area manager, focus group with five principal social workers
- focus groups with social work team leaders
- focus group with social workers
- the review of local policies and procedures, minutes of various meetings, staff supervision files, audits and service plans
- observation of a child protection conference
- the review of 19 children's case files
- phone conversations with 5 family members
- phone conversations with 2 children

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

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

Profile of the child protection and welfare service

The Child and Family Agency

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

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

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

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

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

Service area

The area comprises of Waterford and Wexford and has a population of 280,260 (Census 2016). According to data published by Tusla in 2018, the service area has a population of children from the ages of 0-17 years of 73,130.

The area was under the direction of the service director for Tusla, South, and was managed by an area manager. The child protection conferencing service was delivered by two principal social workers who reported to the area manager, and administration staff were employed to assist in the delivery of service. The child protection and welfare service was overseen by two principal social workers who in turn managed eight social work team leaders which covered the counties of Waterford and Wexford. The social work teams included duty/intake teams and child protection assessment teams and were spread out between both counties.

At the time of the inspection, there were 10 frontline social work/social care vacancies in the child protection and welfare teams. Out of eight permanent social work vacancies, seven were covered by agency staff. All children on the CPNS were allocated a social worker at the time of the inspection.

At the time of the inspection, there were 54 children listed as active on the CPNS and 60 children who had been de-listed in the previous six months.

Compliance classifications

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

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

This inspection was carried out during the following times:

Date	Times of inspection	Inspector	Role
16/08/2021	10.00 – 16.30 11.00 – 16.30	Olivia O'Connell Lorraine O'Reilly Sharron Austin Niamh Greevy	Lead Inspector Support Inspector Support Inspector Remote Inspector
17/08/2021	09.00 – 17.30	Olivia O'Connell Lorraine O' Reilly Sharron Austin Niamh Greevy	Lead Inspector Support Inspector Support Inspector Remote Inspector
18/08/2021	09.00 – 13.00 09.00 – 17.00	Olivia O'Connell Lorraine O' Reilly Niamh Greevy	Lead Inspector Support Inspector Remote Inspector
25/08/2021	11.30 – 12.30 (interview with Area Manager)	Olivia O'Connell Niamh Greevy	Lead Inspector Remote Inspector
26/08/2021	11.30 – 13.00 (Observation of a Child Protection Conference)	Olivia O'Connell	Lead Inspector

Views of people who use the service

HIQA inspectors spoke with two children individually over the phone. These children spoke positively about their experience of the child protection service. They were satisfied with their level of contact with their social worker, and the support they received. Some of their comments about their social workers included:

"She has helped me a lot."
"She always asks me about my day."
"We talk about things that I'm worried about."
"Me and my mam aren't fighting anymore".

Inspectors talked with six family members who had experienced the child protection conference (CPC) process and whose children were, or had been, listed on the child protection notification system (CPNS). The majority were satisfied with the service they received. However one family member expressed dissatisfaction with the service they received; they felt they were not respected and that family support interventions were not timely.

Five family members described a quality service which had a positive impact on them and their children; as one family member told inspectors, *'It saved my life and my daughter's life'*. *'They helped my child in a way that I couldn't.'* They also described good communication between them, the social work department and the CPC department; as one family member put it, *'I had a lot to say. There were no interruptions or disputes. Everyone was given time to speak'*. They said that they were well prepared for the CPC and felt actively involved in the process. They felt that the CPC was well managed to support their participation and they fully understood the outcomes and the child protection safety plan. They said that social workers and CPC chairs listened to them and their children, and as one family member put it, *'I felt respected'.* They also spoke of how children were involved in the CPC process, *'Someone worked with my child directly and that was in the report'.*

Capacity and capability

Overall this inspection found that this was a well-managed and well led service with good governance arrangements in place to provide a consistent and safe service to children listed on the Child Protection Notification System (CPNS).

The focus of this inspection was on children placed on the CPNS register who were subject to a child protection safety plan and the aligned governance arrangements in place to ensure effective and timely service delivery to these children. As per Children First (2017), if the outcome of the social work initial assessment was that a child was at risk of on-going significant harm, then Tusla is required to organise a Child Protection Conference (CPC). A decision of the CPC may be to place the child's name on the Child Protection Notification System (CPNS). This inspection also reviewed children whose names had recently been removed from the CPNS, either because they had been placed in alternative care, or they were deemed to no longer be at ongoing risk of significant harm.

At the time of the inspection, the service continued to operate within the public health guidance associated with COVID-19. This inspection took place in what has been a challenging time nationally for social work teams and children and families engaging in the services due to both the risks and public health restrictions associated with the COVID-19 pandemic. In addition, Tusla had recently been the target of a major cyber-attack which had severely compromised their national child care information system (NCCIS) for several weeks prior to the inspection. In this context, HIQA acknowledges that services have had to adapt their service delivery in order ensure continuity of essential services to children and families. These issues, and how they have been managed, were reviewed within the overall assessment of local governance.

A new area manager had recently come into post, although he had worked in the area of child protection for many years and had most recently held the role of principal social worker for service development and quality improvement in Waterford Wexford. He described to inspectors the various governance mechanisms he used to be assured about the safe and effective delivery of a CPNS service, such as governance meetings, supervision of principal social workers and the use of trackers to monitor CPNS practice initiatives.

The service area had clearly defined roles and responsibilities for managing children who were subject to a CPC. When children were assessed as being at on-going significant risk, their social worker requested that a CPC would be held. The CPC chairs were responsible for reviewing these and approving where appropriate that a

CPC would be held. The scheduling, organising and facilitation of CPCs was delegated by the area manager to the CPC chairs, while the social worker and their respective managers were responsible for the case management, including the implementation and monitoring of the child protection safety plans. All of these staff were ultimately accountable to the area manager of the service area. Inspectors spoke with social workers, team leaders, principal social workers and CPC chairs who all described clear procedures and processes regarding the referral of cases for CPC, planning and organising a conference, the decision to place a child on the CPNS, reviews and the decision to remove a child's name from the CPNS.

Planning for the service area was good. As well as having a targeted CPNS service improvement plan, the area had an overarching Waterford Wexford service development plan for 2020/2021. Waterford Wexford's service plan was aligned with Tusla's national corporate plan 2021-2023 in what it had identified as priority areas. In the context of child protection and welfare, some of the main objectives included improving staff retention and reducing unallocated cases within duty and intake services. A key priority for Waterford Wexford was related to staff retention and ensuring adequate supports were in place for all staff working in the service. There was a system in place to track progress being made against the area's service plan, whereby actions were clearly outlined to meet these objectives, as well as persons responsible and timelines for completion.

The area management team was found to be committed to improving aspects of the service. A key achievement to date was the establishment of a new structure to monitor children at ongoing risk of significant harm and placed on the CPNS. During the inspection, managers referenced learning from other service areas' HIQA inspections and how they informed service improvement in Waterford Wexford.
A service improvement plan specifically targeted at the CPNS process was developed by the area in September 2020; the purpose of which was to ensure consistent and safe implementation of business processes as they related to the CPNS. The area was in the process of implementing their quality improvement plan at the time of the inspection, but some key service improvements had been identified and achieved prior to this inspection. An area CPNS governance group was established to monitor the implementation of the service improvement plan and to identify any blockages. Members of the governance group included CPC chairs, child protection principal social workers and the principal social worker for service development and quality improvement and met on a quarterly basis. Although still in relatively early stages of implementation, inspectors observed tangible initiatives and their impact on social work practice.

Governance meetings were used effectively to maintain management oversight of the service. There were reporting systems in place to oversee key quality, risk and service improvement activity for the area. These systems included quarterly CPNS governance meetings; bi-monthly management meetings held in each county between principal social workers and their management teams; complex case forum meetings; and an area risk management forum. Inspectors sampled minutes of these meetings held in 2020 and 2021, and found that standing agenda items and associated actions included activity data, progress on complex cases, quality and risk, progress on service improvement plans and risk registers. Quality assurance audits and HIQA inspections were also agenda items. There was evidence that relevant performance data and reports were reviewed and analysed to inform area priorities and drive improvement. It was also clear from the minutes sampled that agenda items were informed by regional senior management meetings and in turn, area governance meetings informed team management meetings across the service. This showed good connectivity across the area.

The service had policies, procedures and processes in place to guide social workers on the application of thresholds for CPC, safety planning and maintaining the CPNS. These national policies reflected the requirements of Children First Act 2015 and Children First (2017). Tusla had national interim guidelines on child protection case conferencing and the child protection notification system which was adopted in 2018, but it had not been subject to review since its implementation. In order to ensure quality and consistent practice nationally, the policy required review to align it with best practice in other jurisdictions. For example, basic minimum requirements relating to the monitoring and implementation of child protection safety plans, such as frequency of visits and safety planning meetings, were not explicit and this could potentially impact on a consistent service being delivered nationally. Furthermore, while the CPNS was maintained in line with Children First, it was limited to only registering the primary type of abuse. However, further to the inspection, inspectors were advised that secondary or additional categories of abuse were routinely recorded in the "notes" section of the CPNS by the area.

In Waterford/Wexford, the area had implemented local guidance documents to provide clarity to staff around some of these practices. Specifically, inspectors reviewed a practice guidance for social workers on how to case manage children listed on the CPNS, as well as new CPNS supervision templates. The latter had been introduced for team leaders and provided greater clarity on how decisions were being made around children listed on the CPNS. Staff told inspectors how they were also given clearer direction on how to conduct effective and timely safeguarding visits with families through the use of a locally designed CPNS safeguarding visit template. This template helped improve the quality as well as providing evidence of the frequency of

safeguarding visits. The area had also introduced their own minimum requirements such as visits to children on the CPNS by their allocated social worker were to occur every two weeks. These local guidelines promoted the protection of children by bridging known gaps in the national policy. Tusla had not addressed these gaps in national policy at the time of inspection which increased the risk of inconsistency in practice in the protection of children across their operational regions.

This inspection found that the area had robust monitoring and auditing systems in place to provide assurances on the service delivered to children on the CPNS, although some improvements were needed. The CPC chairs provided quarterly and yearly reports to the area manager on the CPC service and CPNS activity data. In March 2020, a local audit of cases listed on the CPNS was completed. Findings from this audit identified many areas of good practice, such as all CPNS cases had an allocated social worker and showed good evidence of significant ongoing intervention. However the audit also found areas for improvement such as the recording was not always contemporaneous and up-to-date; child protection safety plans (CPSPs) were not routinely discussed at each supervision; tracking of CPSPs was not clearly recorded on supervision records; and the quality of recording around safeguarding visits was not always consistent. The findings of this inspection showed that many practice deficits identified in the audit were being addressed and practice had improved.

While improvements were required in relation to the area manager's supervision of CPC chairs, there were other mechanisms in place to ensure appropriate oversight of the service being provided to children and families. For example, the CPNS forum was overseen by the area manager who received minutes of all CPNS cases discussed. Inspectors saw evidence in supervision records of how issues arising on cases were discussed by the area manager with child protection principal social workers and CPC chairs. Supervision of the CPC chairs by the area manager was an important method of providing assurance around the service provision of the CPC process, and to identify and address any barriers. Inspectors were provided with supervision records of both CPC chairs by the area manager, both during and after the inspection. While the quality of supervision was good, the frequency of supervision provided was not in line with Tusla's policy. The area manager told inspectors that providing consistent quality supervision to the CPC chairs was an identified priority going forward.

The provision of formal case supervision by team leaders as a method of providing assurance on the quality of service provided to children listed on the CPNS was found to be of good quality. It provided team leader oversight on the implementation of children's safety plans. These records were also reviewed by principal social workers

through case file audits. Decisions were clearly recorded and followed-up on in subsequent supervision records. Furthermore, safeguarding visits were recorded on the National Child Care Information System (NCCIS) as well as a local tracker held by the area NCCIS lead. The purpose of the tracker was to provide an assurance that children on the CPNS were being visited in line with their local policies and to identify any gaps in service provision. The tracker was shared on a monthly basis with the child protection team leaders across the area. Inspectors reviewed this tracker and found it to be effective at providing oversight on the frequency of safeguarding visits. In one instance for example, significant gaps in the recording of visits had been identified through the tracker and inspectors saw evidence of how appropriate action was taken to improve social work practice.

As stated, Tusla had recently been the target of a major cyber-attack which had compromised their national child care information system (NCCIS) for several weeks prior to the inspection. Inspectors found that actions were taken to ensure the continued recording of CPC conferencing as well as other pertinent records in relation to the assessment of children's circumstances and safety. Social work records were detailed and up-to-date.

In 2016 the area had also established a complex case forum chaired by the area manager. Inspectors reviewed some of the complex case forum minutes and found it to be an effective system in providing an objective review of decision making and practice for children listed on the CPNS.

This inspection found that there were risk management systems in place which ensured risks in the service were reported on and managed. A risk register forum was established, chaired by the area manager, which met monthly. This group reviewed the area risk register and was required to update it. The forum also reviewed the implementation of mitigating actions to address known risks. Inspectors reviewed open risks to the service relevant to the focus of this inspection. They included the impact of COVID-19 on service provision, the impact of staff vacancies on the service, including vacant administrative posts and how some of these risks might impact on case management around CPNS. Inspectors found various strategies were being implemented by the area to address deficits, such as a staff care strategy led by the therapeutic team manager. Where required, risks were also placed on the regional risk register after escalation by the area manager. Subsequent to the inspection, the area also provided evidence that delays to the convening of CPCs had been listed on the area's risk register in April 2021. The potential impact on service provision to children on the CPNS was clearly identified and mitigating actions were outlined to address the risks, such as establishing an additional senior social work practitioner

post to support social work practice around children referred for CPC and placed on the CPNS.

Inspectors saw evidence of good communication in the area. There were established working relationships between staff and managers, including CPC chairs. Clear lines of communication allowed information to be shared efficiently and effectively. This was evident for example in regular meetings between principal social workers and CPC chairs. Inspectors reviewed meeting minutes which showed case discussions around children listed on the CPNS, and ensured efficient case transfer between duty intake teams and child protection assessment teams.

A key component of the CPC process lay in the interagency participation to determine the level of risk and what safeguarding actions needed to happen to protect children. This inspection found that there was a strategic approach towards engaging with external stakeholders in Waterford Wexford which was also led by the CPC chairs. They described to inspectors how they analysed referrals to CPC to identify trends to inform where there might be service gaps that could be improved. For example, through this trending they said they had found that a particular minority group within the general population seemed to have a high proportion of CPC referrals. Upon further inquiry they also said they found that there was a lack of community supports for this group and were able to advocate for same.

At interview the area manager described to inspectors a culture of learning that was promoted; for example through practice audits and an analysis of complaints received. Under his leadership the area also established a quality improvement forum, as well as an area literature review & development forum to support best practice. He also outlined his overall vision for the service, which was that the service provided to children and families was effective and delivered in a child-centred and timely manner.

Staff who spoke with inspectors said that there was a good learning culture and they felt assisted through good lines of communication and peer support. Staff felt they could raise concerns with their managers and they were familiar with the protected disclosure policy. They described a culture of collaborative working and team work with a shared goal of providing good quality care for children and families.

Standard 3.1

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

The governance structures in place supported the delivery of a good service to children and families by the Waterford Wexford service area. The service had local policies, procedures and processes in place to guide social workers on the application of thresholds for CPC, safety planning and the management of the CPNS. These policies reflected the requirements of Children First Act 2015 and Children First (2017). At local level, Waterford Wexford had implemented local guidance documents to provide clarity to staff around some of these practices and the protection of children was enhanced.

However, interim national guidelines on child protection case conferencing and the child protection notification systems had not been subject to review and required updating by the Child and Family Agency. In order to ensure quality and consistent practice nationally, the policy required review to align it with best practice in other jurisdictions. For example, basic minimum requirements relating to the monitoring and implementation of child protection safety plans, such as frequency of visits and safety planning meetings, were not explicit and this could potentially impact on a consistent service being delivered nationally. These local guidelines ensured that the gaps in national policy were bridged and as a result, the protection of children was enhanced in this area.

Judgment

Substantially Compliant

Standard 3.2

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

Accountability for the service was clearly defined. The organisational culture encouraged open communication and team working. There was strong leadership and good service planning for the area. This inspection found that there was good management oversight of the service.

Judgment

Compliant

Standard 3.3 The service has a system to review and assess the effectiveness and safety of child protection and welfare service provision and delivery.
This inspection found that the area had robust monitoring and auditing systems in place. There was a proactive culture to sharing learning from previous inspections and identifying service improvements. The area's service improvement plan was clearly defined, relevant to service risks and being implemented in line with corporate plans. Action plans for addressing deficits identified on foot of quality improvement mechanisms were in place, communicated throughout the service as required, and reflected in practice. There were risk management systems in place which ensured that risks in the service were reported on and managed.
Judgment Compliant

Quality and safety

Overall, the service area appropriately managed the CPC process in line with Children First 2017. Although there were some delays in the convening of initial CPCs and review CPCs, these delays did not impact on the immediate safety of children. Safety planning was robust and the quality of social work interventions for children was of a high standard which meant a good service was provided for children and families.

Regarding the convening of initial CPCs, findings from this inspection were mixed. This inspection reviewed 13 files for timeliness of initial CPCs, and found that in seven cases, they were convened within five weeks of a CPC request being made by the social worker. However improvements were required as initial CPCs were not always convened in a timely manner. In six cases, timelines from a request made to CPC and the initial CPC taking place ranged between seven weeks and four months. In three cases CPCs were convened at around seven weeks; one case at around 11 weeks and in a further three cases CPCs were convened at around 16 weeks. Case profiles of children who were waiting for the CPC service showed primary school-aged children and concerns around neglect and emotional abuse. While inspectors found that children were not placed at immediate risk while awaiting a CPC, HIQA was of the view that, given there were significant children protection concerns for these children, these delays were not acceptable. Social work staff and CPC chairs described to inspectors how the process of convening a CPC can take time for a variety of reasons. CPC chairs described to inspectors how in order to get the best outcomes from a CPC, family members and other stakeholders often needed time and support to take part in a meaningful manner. Managers also told inspectors that staffing shortages, such as staff on sick leave, could impact the timeliness of the process. It was acknowledged by managers and staff that further improvements were required in the service, particularly in relation to delays in convening CPCs and review CPCs.

CPCs were comprehensively facilitated by appropriately trained professionals who were not directly involved in the assessment or management of the case. CPC records clearly evidenced the identified risks and decisions made at the CPC to address them; actions were clearly recorded along with persons responsible to implement them. CPC chairs were very thorough, both in preparation for the conference as well as during the conference, by telling family members why children were at risk of significant harm, what needed to change and what would happen if there wasn't change. This robust process ensured that the content of child protection safety plans (CPSPs) devised at CPCs were of good quality. CPSPs clearly recorded the decisions and identified the person with responsibility for the actions. Furthermore, CPSPs were shared appropriately with children and families. Finally, inspectors also found good evidence of written copies of the CPC records and CPSPs being sent to families.

Families, and where appropriate children, attended CPCs either in person or remotely through teleconference. Younger children and children who chose not to attend were advocated for by their child care worker or social worker, and records reflected their views. Inspectors reviewed some of tools used to represent the views of children, and found them to be very appropriate and child-centred. The national approach to practice was reflected in how CPCs were conducted. All views were clearly recorded and incorporated into the overall assessment of risk at the CPC.

It was evident in all cases reviewed that CPCs had multi-disciplinary input. Interagency discussion was well facilitated and a clear and appropriate decision was reached as to whether a child was to remain on the CPNS or not. Principal social workers also spoke of the numerous outreach briefings done with key stakeholders to support their engagement with the CPC process.

Inspectors observed one review CPC by teleconference and found the CPC chair to be confident, appropriate and knowledgeable in their role. Family members as well as professionals external to Tusla were in attendance and all were given opportunities to express their views. As the children were very young, their views were represented by the social work team leader through a child-friendly tool called "Words and Pictures" which had been completed with the children around their safety. Risks were clearly identified by the social worker and social work team leader, and safeguarding actions were appropriately agreed by all present.

Inspectors reviewed 13 active CPNS cases focusing on the length of time that a child was listed on the CPNS. Seven children listed had been on the CPNS for longer than 12 months, four of those for longer than 18 months. One child had been listed on the CPNS for nearly three years at the time of the inspection. At the time of the inspection, inspectors found that this child was receiving a good quality service through appropriate safeguarding and timely interventions. However, prior and subsequent to a transfer from another social work department based in a different Tusla area, there had been significant case drift. Inspectors also noted that the length of time children were on the CPNS did not appear to be routinely discussed at review CPCs.

Where cases were subject to long term drift, the area had mechanisms in place to identify and objectively review these so as to adequately plan for children's safety and welfare long term. The area manager told inspectors that progress was being made in ensuring children did not remain on the CPNS for longer than necessary. CPNS governance group minutes reviewed by inspectors noted that some cases were

not progressing as they needed and consequently these cases were referred to the complex case forum for review by managers not involved in the case.

The implementation and delivery of the child protection safety plans was the responsibility of the social work teams. According to the Tusla guidelines for CPCs and the CPNS, regular safety planning meetings were to be convened following the CPC to create a more detailed child protection safety plan, review the safety for the child and monitor the progress in the case. Inspectors found that social work teams ensured plans were implemented and children were visited in line with local policies.

In all active cases reviewed, inspectors found good evidence of safeguarding visits to monitor the child protection safety plan. Children were seen alone where appropriate, and case notes showed good detail of discussion and/or interaction with children which was comprehensively recorded. Inspectors saw evidence of direct work with children which was often undertaken with community social care workers and leaders to develop child friendly safety plans. This direct work occurred weekly while safeguarding visits by social workers occurred fortnightly. Safeguarding home visit templates were used and there were specific CPNS case supervision templates in files.

Child protection safety plans were implemented through the establishment of 'safety networks', which included all persons who could support the family in achieving the goals set out in the safety plan. Inspectors reviewed nine cases for safety planning implementation and found that there was good multi-agency consultation between social workers and a vast range of services involved with children listed on the CPNS. This provided a level of assurance to social workers as to the safety and welfare of children utilising these services in the community. Safety plans worked where there was a strong network around the child and regular network meetings to track progress. Networks were made up of both professionals and individuals within the family's own support system. In one case inspectors reviewed, there was evidence of a robust safety network of persons in place and safety network meetings were regular, which in turn provided good evidence of the safety plan progressing. In another case inspectors reviewed, there were no identified persons from the family's supports, however there was a network of professionals in place, including the school and addiction services to ensure effective implementation of the safety plan.

The presence of a dedicated multi-disciplinary therapeutic team in the area was also a benefit to the CPC process. At the time of the inspection, the therapeutic team was involved in 13 active cases on the CPNS. There were also 19 cases de-listed from the CPNS that were open to the therapeutic team in 2021. Inspectors reviewed one case where a parenting assessment was being completed by the therapeutic team and

another where therapeutic interventions were being provided to a child. In a third case a referral had recently been made for a child. The therapeutic team's involvement with children on the CPNS meant a timely and proportionate access to therapeutic input and supports.

Safety plans were reviewed by social workers and team leaders, as required, to monitor the effectiveness of safety networks. Inspectors saw delays in safety plan implementation when a safety network was weak and network meetings were irregular. This meant that the plan was not maintaining safety for the child. In these cases action was taken by the social worker and team leader to strengthen the safety network. For example, in one case the safety network around the child was not working due to lack of engagement from one parent; a decision was made to seek a legal supervision order. This improved the robustness of the safety plan. Another example was where the safety plan was no longer providing adequate safety and a child was subsequently placed in alternative care. In a further example, more people joined the safety network and this made it more effective at reducing risk for the child. These examples demonstrated to inspectors social workers' ability to review and refine safety plans while monitoring their success in achieving safety for the child.

Review CPCs were usually held within six months after the previous CPC and played a key role in monitoring the implementation of safety plans. Review CPC records showed that the progress of actions to reduce risks to children was reviewed during the conference and decisions were taken in relation to next steps.

However, in six out of thirteen cases reviewed for timeliness of review CPCs, inspectors found delays averaging two to three months past the six month deadline set out in Children First (2017). From a review of records and feedback from staff in interviews and focus groups, inspectors were informed that delays to the timeliness of review CPCs were caused by: staffing shortages; input from external services such as forensic assessments; delays in transfers from other Tusla areas; COVID-19; and the cyber-attack. However, the rationale for delays was not always clearly recorded on children's files. Delays in review CPCs have the potential to impact progress measurement on the effectiveness of interventions, as well as sharing information from professionals involved with the family. However, case notes and case management supervision records did demonstrate regular contact with relevant parties in between CPCs including those that were delayed. Inspectors were also advised of actions taken by the area to address any delays; for example that the CPC chair will email the principal social worker when reviews were overdue.

Inspectors sampled three cases which had recently been de-listed from the CPNS, as well as one case where a child had been de-listed in 2018 and placed on the CPNS again in 2021. In each case there were clear rationales noted for the decision to close, and the removal of the child's name was appropriately planned and agreed. Family members and relevant parties were written to in a timely manner so as to inform them of this decision. The decision to place a child's name back on the CPNS was appropriate in order to ensure the child's safety, as their family circumstances had deteriorated again.

Standard 2.6

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

CPCs had multi-disciplinary input and there was effective inter-agency cooperation. Interagency discussion was well facilitated and a clear and appropriate decisions were reached as to whether a child was to be placed on the CPNS or not. Families, and where appropriate children, attended CPCs either in person or by teleconference. Younger children and children who chose not to attend were advocated for by their child care worker or social worker, and records reflected their views. Safety planning was robust and the quality of social work interventions for children was of a high standard which meant a good service was provided for children and families.

Initial CPCs were not always convened in a timely manner. There was no consistent practice as to what constituted a timely process between a request for an initial CPC and a CPC taking place. While inspectors found that children were not placed at immediate risk while awaiting a CPC, given there were significant child protection concerns for these children, these delays were not acceptable. It is for this reason that the judgement is not compliant.

Judgment

Not Compliant

Standard 2.7 Children's protection plans and interventions are reviewed in line with requirements in Children First.
Overall the implementation, delivery and monitoring of child protection safety plans was in line with Children First and ensured that a safe and effective service was being delivered to children and families. It was evident that the safety and well-being of children was central to decision making throughout the CPC process. However not all review CPCs were convened in a timely manner, nor the reasons for the delays always recorded.
Judgment Substantially compliant
Standard 2.9 Interagency and inter-professional cooperation supports and promotes the protection and welfare of children.
Inspectors found that the area had an effective and strategic approach towards partnership working and engagement between the service and external stakeholders in the area. Close inter-agency and intra-agency working was found on cases reviewed. The service liaised with external agencies and professionals to promote their awareness of their responsibilities under the Children First Act 2015.
Judgment Compliant

Compliance Plan for Waterford Wexford Child Protection and Welfare Service OSV – 0004386

Inspection ID: MON-0033669

Date of inspection: 16 – 18 August 2021

Introduction and instruction

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

The provider is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when

making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Standard Heading	Judgment
Standard 3.1	Substantially Compliant
Outline how you are going to come into compliance with Standard 3.1: The service performs its functions in accordance with relevant legislation, regulations, national policies and standards to protect children and promote their welfare. **'At local level, Waterford Wexford had implemented local guidance documents to provide clarity to staff around some of these practices and these were effective. However, interim national guidelines on child protection case conferencing and the child protection notification systems had not been subject to review and required updating by the Child and Family Agency. In order to ensure quality and consistent practice nationally, the policy required review to align it with best practice in other jurisdictions. For example, basic minimum requirements relating to the monitoring and implementation of child protection safety plans, such as frequency of visits and safety planning meetings, were not explicit and this could potentially impact on a consistent service being delivered nationally'** • The matter has now been formally escalated to TUSLA National. The area will seek regular updates on progress. • The area will continue to operate standard operating procedures that seek to remediate and improve practice pending a National review of the CPNS guidelines	
Standard 2.6	Not Compliant
Outline how you are going to come into compliance with Standard 2.6: Children's protection plans and interventions are reviewed in line with requirements in Children First. **'Initial CPCs were not always convened in a timely manner. There was no consistent practice as to what constituted a timely process between a request**	

for an initial CPC and a CPC taking place. While inspectors found that children were not placed at immediate risk while awaiting a CPC, given there were significant child protection concerns for these children, these delays were not acceptable. It is for this reason that the judgement is not compliant'

An area standard operating procedure will be drafted to assist guide all staff on the following key areas

1. Timeframes which constitute a safe and timely response to CPC requests will be clearly agreed and implemented.
2. The SOP will outline a measurable timeframe that can be tracked and adhered to.
3. The SOP will give staff guidance on the need to record blockages in reaching CPC conference appropriately within the NCCIS system.
4. CPC chairs will develop an educational program ensuring that social work staff are further supported to understand the SOP and the importance of timeframes. This will take the format of team briefings

Standard 2.7	Substantially Compliant

Outline how you are going to come into compliance with Standard 2.7: Children's protection plans and interventions are reviewed in line with requirements in Children First.

'Overall the implementation, delivery and monitoring of child protection safety plans was in line with Children First and ensured that a safe and effective service was being delivered to children and families. It was evident that the safety and well-being of children was central to decision making throughout the CPC process. However not all review CPCs were convened in a timely manner, nor the reasons for the delays always recorded'

An area standard operating procedure will be drafted to assist guide all staff on the following key areas

1. Timeframes which constitute a safe and timely response to CPC reviews will be clearly agreed and implemented.
2. The SOP will outline a measurable timeframes for CPC reviews that can be tracked and adhered to.

3. The SOP will give staff guidance on the need to record blockages in CPC reviews.
4. CPC chairs will develop an educational program ensuring that social work staff are further supported to understand the SOP and the importance of timeframes. This will take the format of team briefings

Section 2:

Standards to be complied with

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

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

Standard	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Standard 3.1	The service performs its functions in accordance with relevant legislation, regulations, national policies and standards to protect children	Substantially Compliant	Yellow	Local area cannot agree timeframe as it rests with National

	and promote their welfare.			
Standard 2.6	Children's protection plans and interventions are reviewed in line with requirements in Children First.	Not compliant	Orange	1/12/21
Standard 2.7	Children's protection plans and interventions are reviewed in line with requirements in Children First.	Substantially compliant	Yellow	1/12/21